| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235660 | A. Building<br>B. Wing | 05/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Oaks at Woodfield | 5370 E Baldwin Road<br>Grand Blanc, MI 48439 |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944<br><br>Based on interview and record review the facility failed to ensure that baseline care plans were completed within 48 hours of admission for two residents (Resident #2, Resident #40) of 20 residents reviewed, resulting in incomplete baseline care plans, falls, and unmet care needs.<br><br>Findings include:<br><br>Resident #2 (R2):<br><br>R2 is [AGE] years old and was admitted to the facility on [DATE], diagnoses include right lower leg fracture, Alzheimer disease, dementia and metabolic encephalopathy.<br><br>On 05/13/24 at 03:32 PM, record review revealed the R2 has had multiple unwitnessed falls since admission to the facility on [DATE].<br><br>Record review of R2's admission assessment from 10/24/23 revealed they were at high risk for falls with a score of 17.<br><br>Record review of care plans revealed that a care plan and interventions were not put in place for falls until 11/27/23.<br><br>On 05/15/24 at 03:47 PM, an interview was conducted with the Minimum Data Set nurse (MDS). MDS was asked why the resident wouldn't have had a care plan in place for falls on admission despite being high risk for falls. MDS stated they aren't sure why it wasn't put in place until a month later and that it was just missed. MDS was asked if the care plan for falls should have been present on the baseline care plan. MDS responded that it should've been on the baseline care plan.<br><br>Review of the facility policy titled 48 Hour Baseline Care Plan Guidelines, revised and reviewed on 12/31/23 revealed:<br><br>PROCEDURES<br><br>1. The 48-hour baseline care plan will be completed within 48 hours of resident admission.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | a. The admitting nurse will be responsible completing the baseline care plan with the admission nursing observation.<br><br>b. The admitting nurse will then add information from 48-hour baseline care plan to the CareAssist profile.<br><br>2. The admitting nurse will add the following information to e-CareAssist profile<br><br>-Transfer status<br><br>-Diet<br><br>-Safety (All fall interventions selected from Falls intervention section)<br><br>-Ted Hose/Splits<br><br>-Glasses, dentures, and hearing aides<br><br>-Continence status<br><br>-Showers (preferences)<br><br>-Skin (Pressure prevention interventions)<br><br>-Cultural preferences and trauma triggers<br><br>-Other (Any information pertinent for CRCA's caring for resident)<br><br>3. The MDS coordinator or MDS nurse will review baseline care plan and profile on the next business day to ensure completion and accuracy. The 48 hour baseline care plan will be printed and provided to the resident or resident representative during the initial resident first meeting.<br><br>4. The 48-hour baseline care plan will serve as our temporary working care plan until the comprehensive care plan is developed per RAI guidelines.<br><br>5. Any changes to the residents care will be care planned accordingly until the comprehensive care plan is developed and then will be included on the comprehensive care plan.<br><br>37666<br><br>Resident #40:<br><br>Pressure Ulcer/Injury<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated Resident #40 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Alzheimer's dementia, rheumatoid arthritis, hypertension, weakness, anemia and dizziness. The MDS assessment dated [DATE] revealed the resident needed some assistance with all care including partial to moderate assistance with bed mobility, transfers and toileting.<br><br>A review of the Readmission assessment dated [DATE] indicated the resident had redness on the right great toe. An Event Report dated 5/11/2024 for Resident #40 revealed the resident had redness on her right great toe and provided I will heal this with proper medication and care plan.<br><br>A review of the Care plans indicated there was no Care plan mentioning the right great toe redness on readmission until 5/14/2024: over 72 hours later.<br><br>Skin Integrity: Resident has a skin impairment (Redness of right great toe- present on admission), dated 5/14/2024.<br><br>On 5/14/24 at 2:56 PM , Nurse D was interviewed about Resident #40. She said she had completed the admission assessment and nurses note for the resident. They indicated the resident had redness on the right great toe. There were no orders for treatment or monitoring and there was no Care plan to aid in healing the wound.<br><br>There was no baseline care plan related to Resident #40's right great toe until 5/14/2024. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944<br><br>This Citation pertains to Intake Number MI00142646.<br><br>Based on observation, interview and record review the facility failed to ensure timely dressing changes for two residents (Reside#5, Resident #117) of four residents reviewed for wounds, resulting in missed dressing changes and the potential for worsening wounds.<br><br>Findings include:<br><br>Resident #5 (R5):<br><br>R5 is [AGE] years old, was admitted to the facility on [DATE] with diagnoses that include a right humerus fracture, heart failure, dementia, dysphagia and hypertension.<br><br>On 05/14/24 at 03:00 PM, an in person conversation was conducted with the complainant. The complainant stated that on 4/17/24 a wound dressing on the left shin was dated 4/7, complainant stated the bandage was leaking blood. The complainant said that based on the date on the dressing, it had not been changed in 10 days, The complainant stated that once the dressing was removed, there was green colored drainage present.<br><br>On 05/15/24 at 09:04 AM, the Director of Nursing (DON) provided a physicians wound care order for R5's left lower extremity (shin) skin tear, the order had a start date of 2/22/24, the order was to change the dressing every five days, cleanse the wound with wound cleanser or normal saline, apply skin prep and cover with an Allevyn dressing and to change the dressing every five days.<br><br>On 05/15/24 09:13 AM, an interview was conducted with the DON. The DON was asked when the skin tear dressing was last changed changed for R5. The DON stated that dressing was changed on the morning of 4/17/24. The DON was asked if they were aware that the dressing was dated 4/7 on the afternoon of 4/17/24. The DON stated they were aware that the dressing present on R5 on 4/17/24 was dated 4/7. The DON stated that it was an error on the nurses part and they meant to put 4/17 on the dressing. When asked why the dressing had a large amount of drainage in it if it was changed the morning of 4/17/24, the DON stated that those dressings are built to have some drainage in them.<br><br>On 05/15/24 at 09:28 AM, two pictures, time stamped 4/17/24 at 2:52 PM and 4/17/24 at 2:54 PM were provided by the complainant. One picture showed the intact dressing on the left lower extremity of R5, the dressing was dated 4/7 and wound drainage was present near the edges of the dressing. The second picture revealed the exposed skin tear with the dressing removed, there was scant serosanguinous drainage(drainage with blood present) and a pocket of purulent drainage present. There was an order to change the dressing every five days.<br><br>22348<br><br>Resident #117 (R117):<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During the initial observation and interview on 05/13/24 at 11:43 AM, Resident #117 (R117) was lying in her room, alert and oriented to time, place, and person. R117 stated she was admitted for a short-term stay and is currently on antibiotic therapy after abdominal surgery. R117 showed a drain dressing on the right side of the abdomen with a slight old blood stain (dry, dark brown color) surrounding the tube. The drain tube was attached to a drainage bag attached to the bed. When queried, R117 did not know when the dressing was last changed. The wound dressing did not have a date written for when it was last assessed or when the dressing was changed. The drainage bag had yellowish-to-brownish fluid drainage in the canister. The breathing treatment- tubing and mask were placed on the side table next to the food tray and all other resident's personal items. The respiratory treatment mask and tubing were not secured in a clean bag, and no date label was found on the tubing or mask.<br><br>The Infection Control Nurse L was in R117's room on 5/13/24 at 11:58 AM. Nurse L examined the wound drainage tube and dressing on the right side of the abdomen. Nurse L confirmed that the wound drain dressing was not labeled nor dated. Nurse L could not tell when it was last assessed or changed. Nurse L stated that this(referring to the R117's breathing treatment apparatus) should be put away appropriately in a sanitary way and labeled accordingly.<br><br>Resident R117 Electronic Medical Record was reviewed on 5/14/24 at 1:00 PM. R117 was [AGE] years old and admitted to the facility on [DATE]. According to the facility's Admission Assessment performed on 4/29/24, R117 was admitted with a history of Peritoneal Abscess, Acute Renal Failure, and Gastroesophageal Reflux Disease or GERD in addition to other diagnoses. R117 was alert, oriented with person, place, time, and situation, and responded to questions appropriately.<br><br>A weekly skin assessment or treatment was ordered. However, there was nothing specific for the care for R117's abdominal wound drain. There was no specific treatment order to monitor, assess, and change the wound drain dressing and document abnormal findings and observations specific to R117's Right Abdomen wound drain.<br><br>R117's medication and active physician's orders list were reviewed on 5/14/24 at 1:05 PM, and no treatment order for the wound drain tube was found. There was no indication when the drain tube dressing would be assessed, and wound care instructions were not specified.<br><br>Policy for wound dressing change was requested and reviewed on 5/16/24 at 11:10 AM. The Facility's Bruise, Rash, Lesion, Skin Tear, Laceration Assessment Guidelines dated 5/10/2016 was submitted for review in place for the requested Wound Dressing Change Policy. The purpose: Utilized to describe and monitor bruises, rashes, lesions, skin tears, and lacerations. The facility did not include in the policy a wound or post-surgical drain pertinent for assessment (daily or weekly on the wound status, such as an abdominal wound drain or a surgical site wound drain.) However, the policy had specific skin tear/ laceration guidance:<br><br>1. May complete Skin Tear/ Laceration Event in HER (Electronic Health Record) by an RN/LPN if the skin Tear/Laceration warrants documentation due to the extent and/or location.<br><br>2. Complete the event for each skin Tear/ Laceration.<br><br>3. One weekly follow-up assessment may be completed to ensure Skin Tear/ Laceration are resolved or in the process of healing. If further follow-up is needed, documentation may be placed in a progress note . |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666<br><br>Based on observation, interview and record review, the facility failed to ensure appropriate interventions were in place and supervision was provided to prevent a fall with injury for one resident (Resident #52) and repeated falls for one resident (Resident #15) of 2 residents reviewed for falls, resulting in Resident #52 falling and sustaining a fracture and Resident #15 falling multiple times and injuring his face.<br><br>Findings Include:<br><br>Resident #15:<br><br>A review of the Face sheet and Minimum Data Set (MDS) assessment for Resident #15, indicated the resident was admitted to the facility on [DATE] with diagnoses: Left leg above the knee amputation, diabetes, chronic kidney disease, atrial fibrillation, COPD, morbid obesity, depression, anxiety, dementia, chronic pain, weakness. The MDS assessment, dated 3/25/2024, revealed the resident had full cognitive abilities with a Brief Interview for Mental Status (BIMS) score of 13/15 and the resident needed some assistance with all care.<br><br>A record review of the Incident and Accident reports for Resident #15 revealed the resident had several falls at the facility: 1/24/2024, 2/6/2024, 3/14/2024, 3/28/2024.<br><br>During a review of the monthly Pharmacy Recommendations for Resident #15, Pharmacist B made recommendations on 1/25/2024 and 3/31/2024 to change the resident's medication for Depression as it may lead to falls: A fall review was performed for this resident for a fall that occurred on 1/24. After evaluation, please consider the following: (Resident #15) has an order for paroxetine (Paxil) and SSRI (Selective Serotonin Reuptake Inhibitor-for depression). This medication is on the Beers list of medications that are potentially inappropriate for the elderly. (Cleveland Clinic: The Beers Criteria for Potentially Inappropriate Medication Use in Older Adults is a list of medications that healthcare providers reference to safely prescribe medications for people above age 65 .). Paroxetine is considered highly anticholinergic and can cause sedation, orthostatic hypotension, confusion, and other side effects. Please consider switching to another SSRI such as escitalopram (Lexapro) or sertraline (Zoloft) which are more appropriate choices for the elderly population. If declined, please document. The resident continued to receive the medication.<br><br>Resident #15 fell 3 more times after this: 2/6/2024, 3/14/2024 and, 3/28/2024.<br><br>The Incident and Accident reports for Resident #15 identified the following:<br><br>1/24/2024 at 4:32 PM: Unwitnessed fall in bedroom . Resident observed on floor in front of wheelchair . Resident states he was trying to get clothes out of closet and slipped out of chair .<br><br>2/6/2024 at 10:32 AM: Resident fell in bathroom . transferring self .<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3/14/2024 at 5:12 PM: Fall in bedroom .transferring self . mild pain . Mental Status: sleepiness . Resident was found on floor by staff. He stated that he was trying to get himself into bed and slid out of his wheelchair .<br><br>3/28/2024 at 4:44 AM: Resident fell off bed while brief change . abrasion . Slight redness to nose and small amount of blood from nostrils . Patient hit nose on floor, has small abrasion .<br><br>On 3/31/2024 another Pharmacy Recommendation was initiated by Pharmacist B: A fall review was performed for this resident for a fall that occurred on 3/28. After evaluation, please consider the following: (Resident #15) has an order for paroxetine (Paxil), an SSRI that started on 3/21/24. This medication is on the Beers list of medications that are potentially inappropriate for the elderly. Paroxetine is considered highly anticholinergic and can cause sedation, orthostatic hypotension, confusion, and other side effects. Please consider switching to another SSRI such as escitalopram or sertraline (Zoloft) which are more appropriate choices for the elderly population.<br><br>During an interview with the Director of Nursing on 5/15/2024 at 3:45 PM, she was asked about the Pharmacy recommendations for Resident #15 and said the recommendation on 1/25/2024 was missed and not followed up on until 4/16/2024. The DON was asked about Resident #15's continued falls, including falling and injuring his face and she said the resident had experienced several falls and the pharmacy recommendations were now enacted.<br><br>A review of the Care plans for Resident #15 identified the following:<br><br>Psychotropic Drug Use: Resident is at risk for developing adverse effects from the use of anti-depressant medications, date initiated 12/12/2023, with Interventions including: Notify MD of any adverse effects noted, date initiated 12/12/2023.<br><br>A review of the facility policy titled, Falls Management Program Guidelines, dated 5/31/17 and reviewed 12/31/23, provided (The facility) strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures . Identified risk factors should be evaluated for the contribution they may have to the resident's likelihood of falling . discuss risks and interventions with resident and/or responsible party .<br><br>22348<br><br>Resident #52 (R52):<br><br>Accidents<br><br>During the resident observation and interview on 05/13/24 at 11:00 AM, Resident #52 (R52) was lying in bed and had indicated that he fell in March and broke his hip (pointing at the left side). R52 revealed that he underwent surgery at the hospital. Although R52 denied pain at the time of the interview, he expressed being unable to get up and walk on his own after surgery.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/14/24 at 4:00 PM, the facility's incident report (I/A), dated 3/16/24, was reviewed. It noted on the description: On 3/16/24, at 10:50 AM, Resident in wheelchair in front of the nurse's station when nursing heard someone call for help and observed resident sitting on his bottom in front of his wheelchair. When writer asked resident how did he fall, resident verbalized he was trying to stand up. The Evaluation Section of the Event (incident) Report noted:<br><br>.Resident discharge to the hospital post fall, readmitted to facility for rehab:<br><br>Fall resulted in fracture? Yes<br><br>Resident sent to hospital and returned Yes<br><br>Resident sent to hospital and did not return No<br><br>Incident reported to State Agency No<br><br>Did Fall result in serious injury, harm, impairment, or death to the resident Yes .<br><br>The Hospital Discharge Records were reviewed on 5/15/24 at 4:00 PM. R52 was at the emergency room (ER) at a nearby hospital on 3/16/24 for evaluation and was admitted on [DATE] for surgical intervention for a displaced intertrochanteric fracture of the left hip. R52 was discharged back to the facility on [DATE] with a discharge diagnosis of Hip Fracture. R52's discharge instructions included pain medications, post-surgical staples, and wound dressing care.<br><br>A review of the Electronic Medical Record (EMR) on 5/14/24 at 11:00 AM revealed that R52 was admitted to the facility on [DATE]. He was at high risk for fall, and on 3/16/24, R52 sustained a displaced intertrochanteric fracture of the left femur as a result of a fall. Among R52's listed primary diagnoses, R52 had Parkinson's Disease, repeated Falls, and age-related physical debility in addition to other diagnoses. R54's Brief Interview of Mental Status (BIMS) Score, dated 2/28/24, was 13/15. A BIMS score of 13-15 suggests the patient is cognitively intact. A review of R52's Minimum Data Set (MDS) assessment, dated 2/28/24, revealed that R52 ambulated, walking 10 feet, required substantial maximum assistance with no functional limitation in the upper and lower extremities ROM. R52 required substantial maximum assistance with toileting, personal hygiene, and transfers. R52, on the 2/28/24 assessment, was occasionally incontinent with bladder elimination pattern but was frequently incontinent for bowel elimination pattern.<br><br>In a review of R52's clinical record, dated 3/26/24, there was a change in R52's BIMS score of 09/15. A score of eight to twelve suggests moderately impaired. A significant change in R52's MDS dated [DATE] assessment revealed that R52 was dependent on staff with mobility, toileting, and most activities of daily living (ADL), especially personal hygiene. Ambulating ten feet did not occur, and a one-step assessment was not attempted. Another significant change noted was R52's status for bowel and bladder elimination patterns, which changed from occasional to frequent for both urinary and bowel elimination patterns.<br><br>(continued on next page) |

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|---|---|
| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During the interview on 05/15/24 at 12:12 PM, Nurse C, indicated that she was the nurse caring for R52 on 3/16/24 when R52 had a fall. Nurse C further revealed that she had left R52 alone in the day room facing the nurse's station when he fell at 10:50 AM. He fell at least twice before this fall. Nurse C had indicated that R52's care plan was to place him in a common area so everyone can see and watch him when he tries to get up. Nurse C stated: R52 was showing signs of frequent restlessness and was trying to get up on his own. I placed him in the day room across from the nurse's station with the TV on. There were no other staff assigned to watch R52 at that time, and I then proceeded to pass my meds to the residents, hoping there would be other staff that would pass by to see him and keep an eye out. Nurse C confirmed that R52 was left unattended and unsupervised when she left him in the day room. When Nurse C was queried, she revealed that the call light was inaccessible or within reach. R52 did not have access to the call light in the day room. Nurse C clarified that there was no staff in the nurse's station at that time or nearby. Nurse C further described that R52's aide was attending to other guests (residents). There was only one nurse and one nursing aide assigned in the hall. The nurse aide provided patient care when the fall occurred. Nurse C further indicated that another resident yelled that someone was on the floor, and that's how she was alerted. Staff from other units came to help with assessing and transferred R52 to his room. Nurse C revealed that R52 was sent to the hospital after the X-ray. R52 complained of pain, and limited ROM of the left lower extremity was observed. The Physician was notified, and EMS was called to send him to the hospital. Nurse C indicated that R52 was sent to the hospital because the resident complained of pain in his left lower extremity and could barely move it. There was an obvious limited Range of Motion (ROM) due to extreme pain in the left lower extremity. Nurse C further indicated that she recalled that R52, upon post-fall assessment, did not show any problems with moving his right leg. After the X-ray was performed, R52 was sent to the hospital because of severe pain, and the X-ray results revealed a fracture.<br><br>According to the Director of Nursing (DON), during an interview conducted on 3/16/24 at 11:00 AM, she recalled that the weekend supervisor called to inform her of R52's fall and that he was being sent to the hospital for a fracture. The facility did not report this to the state because R52 could tell what happened. The DON revealed that R52 was placed in the common area for easier eyes and clarified that it means staff can observe him by the nurse's station and more people walk by. When queried, the DON denied staff was present during the fall, and there were no witnesses. The DON stated: I'm not sure who was there to find him.<br><br>On 5/14/24 at 3:59 PM, Nurse E confirmed that R52 fell sometime in March (2024), but Nurse E stated she could not recall the details because she was not the nurse assigned when it happened. Nurse E had indicated that R52 was at high risk for fall and that R52 had an unwitnessed fall and underwent surgical hip repair due to a fracture sustained after a fall.<br><br>R52's Family G was interviewed on 4/15/25 at 3:30 PM. She stated that the goal for R52 was to go through rehabilitation (physical therapy and occupational therapy) to strengthen him so he can return home. Because of the fall which resulted to fracture, he was unable to come home sooner than planned. R52 previously was able to walk with assistance using a walker.<br><br>R52's fall care plan was reviewed on 4/16/24 at 10:00 AM. Although R52's admitted was 2/23/24, the fall care plan was created on 3/12/24 and was last updated on 4/24/24. It revealed: Resident was at risk for falling r/t Parkinson's Disease, poor safety awareness, non-compliance with utilizing assistance, has a history of falling with left hip fracture. The following are the interventions/approaches:<br><br>(continued on next page) |

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| | 235660 | A. Building<br>B. Wing | 05/16/2024 |

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| The Oaks at Woodfield | 5370 E Baldwin Road<br>Grand Blanc, MI 48439 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Care Plan Interventions/Approaches dated 3/12/24 (before the fall that resulted in fracture)<br><br>c Therapy eval and treat as needed. Therapy to offer services after breakfast.<br><br>c Staff to assist Resident with transfers.<br><br>c Provide nonskid footwear.<br><br>c Keep personal items and frequently used items within reach.<br><br>c Keep call light within reach.<br><br>c Encourage/assist resident to assume a standing position slowly.<br><br>c Assure the floor is free of liquids and foreign objects.<br><br>c Stay close to the resident in restroom as he allows. (action was added dated 3/15/24)<br><br>Upon readmission after hospitalization , care plan approaches added:<br><br>c Move to a room closer to the nurse's station. (updated 3/20/24)<br><br>c Round on resident between 3-4 PM. (updated 4/24/24)<br><br>c Dycem to wheelchair. (updated 4/24/24)<br><br>Upon review of R52's Fall Care Plan on 4/16/24 at 10:05 AM, there was no indication to place R52 in the day room or common area unsupervised as one of the planned approaches, as Nurse C had mentioned to prevent R52 from falling. The Fall Care Plan for R52 was initiated on 3/12/24, nine days after the first fall on 3/4/24. It was also revealed that no other updates were noted from 3/12/24 when the Fall care plan was initiated, until R52 returned from the hospital.<br><br>A review of R52's Fall Incident reports occurred on various dates described:<br><br>. On 3/4/24, Resident fell on the floor in his room attempted to ambulate without the walker .<br><br>. On 3/15/24, Resident was found alone sitting on buttocks on the bathroom floor with pants around the ankles with multiple skin tears. Fall in the bathroom after self-transfer .<br><br>.On 3/16/24, Resident was found on the floor alone in the day room. There was no call light access in the day room. No staff was present at the nurse's station across the day room. No witnesses .Fall resulted in left hip fracture, hospitalization , and surgical repair .<br><br>The facility's Fall Management Program Guidelines, dated 5/31/2017, were reviewed. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22348<br><br>Based on observation, interview, and record review, the facility failed to ensure that weight loss was monitored, addressed with updated nutritional interventions, and notify the registered dietician of the weight loss for one resident (Resident #52) of two residents reviewed for weight loss of a total sample of 20 residents, resulting in the potential for continued rapid weight loss and compromised health condition.<br><br>Findings include:<br><br>Resident #52 (R52):<br><br>During the observation tour and resident interview on 05/13/24 at 11:00 AM, Resident 52 (R52) verbalized that the food was not enough. When queried, R52 further revealed that he needed more food because it seemed like he was losing weight. During the interview, a friend, Mr. H, who often visited R52, indicated that he was not getting feeding assistance from staff or provided any assistive device during meals. The visitor, Mr. H, further revealed that because R52's hands shake as part of his Parkinson's, he drops and spills more food than getting them in his mouth. Mr. H stated, There are times he (R52) would need feeding assistance, but not all the time. He (R52) definitely could use some adaptive feeding utensils to minimize his hands from shaking during meals.<br><br>A review of the Electronic Medical Record (EMR) on 5/14/24 at 11:00 AM revealed that R52 was admitted to the facility on [DATE]. He was at high risk for a fall, and on 3/16/24, R52 sustained a displaced intertrochanteric fracture of the left femur as a result of a fall. Among R52's listed primary diagnoses, R52 had Parkinson's Disease, repeated Falls, and age-related physical debility in addition to other diagnoses. R52's clinical record, dated 3/26/24, showed a significant decline in R52's MDS assessment compared to the admission assessment. On 3/26/24, after hospitalization and repair of left hip fracture, R52 was dependent on staff with mobility, toileting, and most personal hygiene and Activities of Daily Living (ADL). An ambulation assessment was not attempted. Another significant change noted was R52's status for bowel and bladder elimination patterns, which changed from occasional to frequent for both urinary and bowel elimination patterns.<br><br>A record of his weight was reviewed:<br><br>2/24/24 Admission 164.6 lbs. (pounds)<br><br>2/29/24 167.8 lbs.<br><br>3/7/24 167.2 lbs.<br><br>3/14/24 167.0 lbs.<br><br>3/21/24 165.6 lbs.<br><br>4/8/24 163.8 lbs.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 5/3/24 156.2 lbs.<br><br>On 02/24/2024, the resident weighed 164.6 lbs. On 05/03/2024, the resident weighed 156.2 pounds, a -5.10 % weight loss. There was a difference of 6.91 percent (%) in weight loss from 2/29/24 to 5/3/24.<br><br>R52 was observed eating lunch at the supervised dining area (Safe Eat Room) on 05/14/24 at 12:32 PM. R52 did not finish his meal (R52 ate less than 50%) but had asked for a bowl of vanilla ice cream for dessert. There were no adaptive utensils, such as divided plate during observation, as written in R52's meal ticket, but the beverages were served with sip lids and straws. R52 used regular silverware. When CNA I was queried, she revealed that R52 does not eat much, but the staff made sure we set (cut) up his food and monitored his food intake.<br><br>On 5/14/24 at 12:00 PM, The nutritional/dietary notes were reviewed dated 3/4/24. It noted an RD (Registered Dietician) Review of notes revealed the admission weight was recorded as 167.8# on 2/29/24. BMI:22.76 (WNL). Weight remained stable. No RD entries following the initial nutritional notes were found. There were no nutritional progress notes found after the readmitted after hospitalization , with a new diagnosis of Left Hip Fracture upon return to the facility on [DATE].<br><br>R52's Nutrition Care Plan was reviewed on 4/15/24 at 4:00 PM, R52's care plan was initiated on 3/12/24 and noted last reviewed by facility staff on 4/2/24 at 11:54 AM. Problem: Resident has potential for alteration in nutritional status related to diagnoses, medication, fluid balance, diet, intake, physical activity and metabolic demands. All Approaches and interventions listed were dated 3/12/24. No updates were noted at the date and time of review despite weight loss and other significant changes such as Fall resulting in Left Hip Fracture, decrease ADL function, pain and weight loss. The following approaches were noted in the nutritional care plan:<br><br>1. Assist with meals as needed. (Approach start date 3/12/2024)<br><br>2. Obtained weight as ordered/needed. (Approach start date 3/12/2024)<br><br>3. Offer Alternative food and beverage items as needed. (Approach start date 3/12/2024)<br><br>4. Provide diet, supplement, medications, and adaptive equipment as ordered. (Approach start date 3/12/2024)<br><br>No updates and additional approaches/interventions were added to address R52's weight loss as recorded above.<br><br>On 5/14/24 at 10:30 AM, the Director of Nursing was asked about the weight loss policy or process and a copy of the weight record for R52. When queried, she explained that R52 did not trigger a weight loss because it did not have a red flag. It is triggered if the weight loss is significant, and R52 did not trigger a significant weight loss.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The RD J(Registered Dietician) during the phone interview on 5/16/24 at 10:30 AM. RD J revealed that she did not get a red flag notification unless it was a significant weight loss. RD J explained that red flag means a 5% weight loss or more. RD J did not recall getting a call or email from the facility about R52's weight loss concerns. She evaluates residents every quarterly unless there are changes and concerns. RD J ensured the surveyor during the interview and stated, I will review the records and update the care plan with the team for R52.<br><br>R52's Family G was interviewed on 4/15/25 at 3:30 PM. Family G stated that the goal for R52 was to go through rehabilitation (physical therapy and occupational therapy) to strengthen him to return home. Because of the fall, he ended up having a fracture and was unable to come home sooner than planned. Family G did not recall attending a care conference with the facility staff or team and discussing approaches to encourage his eating and food preferences. Family G denied attending a care conference on the date and time of the interview.<br><br>The Facility Weight Monitoring Policy dated 1/1/21 was reviewed. Clinical Standard Operating Procedure noted:<br><br>.Review of error weights, daily, in CCM<br><br>a. Re-weights as needed<br><br>b. Correct weights as needed<br><br>c. Invalidate weights as needed .<br><br>i. May be reviewed by DHS, ADHS, MDS<br><br>.4. Weekly review of 5% weight changes in KeyStats<br><br>a. May be delegated to DHS, ADHS, or MDS<br><br>i. Open weight event for true 5% or greater weight changes<br><br>1. Refer true 5% weight changes to RD for evaluation .<br><br>i. Open weight event for true 5% or greater weight changes<br><br>1. Refer true 5%weight changes to RD for evaluation . |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666<br><br>Based on interview and record review, the facility failed to ensure that the drug regimen review recommendations were reviewed by the physician in a timely manner for one resident (Resident #15) of five residents reviewed for medications, resulting in the resident receiving a medication with potential adverse effects, including falling.<br><br>Findings Include:<br><br>Resident #15:<br><br>Unnecessary Meds, Psychotropic Meds, and Med Regimen Review<br><br>A review of the Face sheet and Minimum Data Set (MDS) assessment for Resident #15, indicated the resident was admitted to the facility on [DATE] with diagnoses: Left leg above the knee amputation, diabetes, chronic kidney disease, atrial fibrillation, COPD, morbid obesity, depression, anxiety, dementia, chronic pain, weakness. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a Brief Interview for Mental Status (BIMS) score of 13/15 and the resident needed some assistance with all care.<br><br>A record review of the Incident and Accident reports for Resident #15 revealed the resident had several falls at the facility: 1/24/2024, 2/6/2024, 3/14/2024, 3/28/2024.<br><br>During a review of the monthly Pharmacy Recommendations for Resident #15, Pharmacist B made recommendations on 1/25/2024 and 3/31/2024 to change the resident's medication for Depression as it may lead to falls: A fall review was performed for this resident for a fall that occurred on 1/24. After evaluation please consider the following: (Resident #15) has an order for paroxetine (Paxil) and SSRI (Selective Serotonin Reuptake Inhibitor-for depression). This medication is on the Beers list of medications that are potentially inappropriate for the elderly. Paroxetine is considered highly anticholinergic and can cause sedation, orthostatic hypotension, confusion, and other side effects. Please consider switching to another SSRI such as escitalopram (Lexapro) or sertraline (Zoloft) which are more appropriate choices for the elderly population. If declined, please document.<br><br>There were initials on the paper recommendation and they were dated 1/30/24. However, the Evaluation section of the document had 3 options: 1. The physician agrees with the recommendation; 2. The physician does not agree with the recommendation; 3. The resident/resident representative informed to the extent possible with recommendations. Each option had a checkmark with NA next to it. Resident #15 fell 3 more times after this: 2/6/2024, 3/14/2024 and 3/28/2024.<br><br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 3/31/2024 another Pharmacy Recommendation was initiated by Pharmacist B: A fall review was performed for this resident for a fall that occurred on 3/28. After evaluation please consider the following: (Resident #15) has an order for paroxetine (Paxil), an SSRI that started on 3/21/24. This medication is on the Beers list of medications that are potentially inappropriate for the elderly. Paroxetine is considered highly anticholinergic and can cause sedation, orthostatic hypotension, confusion, and other side effects. Please consider switching to another SSRI such as escitalopram or sertraline (Zoloft) which are more appropriate choices for the elderly population.<br><br>On 4/16/2024 the recommendation was signed and on 4/18/2024 the physician initiated a new order for Zoloft (an antidepressant).<br><br>During an interview with the Director of Nursing on 5/15/2024 at 3:45 PM, she was asked about the Pharmacy recommendations for Resident #15 and said the recommendation on 1/25/2024 was missed and not followed up on. She said the Nurse Practitioner signed she saw it, but there was no clarification if the provider wished to continue the Paxil or replace it with something else. The NA's were not addressed. The DON was asked about Resident #15's continued falls, she said the resident had fallen. The DON confirmed the Pharmacy recommendation for Resident #15 was not addressed until he fell the 4th time. She said the facility was working to ensure the pharmacy recommendations were not missed again. |