| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245229 | A. Building<br>B. Wing | 05/02/2024 |

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| Friendship Village of Bloomington | 8100 Highwood Drive<br>Bloomington, MN 55438 |

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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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18618<br><br>Based on observation, interview and document review, the facility failed to recognize and report injuries of unknown origin to the administrator and/or the State Agency (SA) for 4 of 4 residents (R18, R57, R30, and R46) with suspicious bruises.<br><br>Findings include:<br><br>R18<br><br>During observation on 4/10/24, at 8:30 a.m., R18 was observed seated in a Broda (reclining wheelchair) in the activity room. R18 had a fading purple bruise approximately two inches in diameter on the left side of R18's chin and neck area. R18 was unable to respond when questioned about the bruise.<br><br>During interview on 4/10/24 at 12:11 p.m., family member (FM)-A stated R18 had sustained a large bruise on the left side of their chin/neck area; however, the facility was unable to explain to FM-A how the bruise occurred.<br><br>R18's quarterly Minimum Data Set (MDS) dated [DATE] and annual MDS dated [DATE], identified R18 with severe cognitive impairment and diagnoses including dementia, Parkinson's disease, and anxiety disorder. The MDS also identified R18 as requiring substantial assistance with all activities of daily living.<br><br>R18's Progress Note (PN) dated 3/27/24 at 6:00 a.m., indicated a night nursing assistant had reported a big bruise on the left side of chin. R18 was questioned if she had fallen or hit her face and reported no.<br><br>R18's initial Incident Report dated 3/27/24, identified the bruise with no witnesses to an event which resulted in bruising. The completed investigation dated 4/2/24, identified the bruise as 7 centimeters (cm) by 5 cm on the left chin. The investigation indicated the nurse practitioner would assess the area and determine if the bruise could be dental in origin. The report further indicated the bruise may have also been due to R18's chin pressing against clavicle or shoulder as R18 had a history of resting their head in a dependent position. R18 was not displaying concerns with meal intake or pain at the time of the assessment. The conclusion of the investigation indicated Intentional harm is not suspected.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | R18's Geriatrics for Follow Up Nursing Home (nurse practitioner examination) dated 3/28/24, indicated R18 was seen due to possible dental issues resulting in a bruise to the left side of chin. R18 had a history of sleeping in a bent position leaning toward the left side with her head and chin nearly touching her shoulder. R18 denied pain and no pain was observed as she ate all her lunch. The nurse practitioner assessment identified the facial bruising to the left distal chin as of unknown etiology differential included trauma to jaw or dental concern of broken tooth, cavity, or abscess. The nurse practitioner indicated an abscess was unlikely due to no reports of pain or other infectious symptoms.<br><br>During interview on 4/11/24 at 9:54 a.m., licensed practical nurse (LPN)-B stated R18 had sustained a bruise from something in her mouth. LPN-B could not recall what had caused the bruise.<br><br>During interview on 4/11/24 at 1:45 p.m., LPN-A stated injuries of unknown origin included physical injuries which were not witnessed, and the resident was not able to explain how the injury was obtained. LPN-A indicated she had been notified of R18's facial bruise on 3/28/24, and due to the location, LPN-A had determined the bruise was consistent with a dental issue. LPN-A verified R18 had last been evaluated by a dentist in January of 2024 and had not expressed any type of dental concerns from the time of the evaluation to 4/11/24. LPN-A stated due to the location of the bruise, LPN-A determined the cause would be dental. LPN-A confirmed the facility had not reported the bruise to the SA.<br><br>During interview on 4/11/24 at 2:31 p.m., registered nurse (RN)-A confirmed a facial bruise which was 7 cm x 5 cm of unknown origin would be considered suspicious and stated staff should have reported the bruise to the SA.<br><br>During interview on 4/11/24 at 2:57 p.m. the administrator stated the bruise had been discussed as a dental concern and none of the staff identified the bruise as a possible injury of unknown origin or abuse. Upon review of the bruise, the administrator confirmed the facial bruise should have been reported to the SA.<br><br>During telephone interview on 4/19/24 at 9:53 a.m., LPN-A stated R18 frequently bent her neck and had her chin positioned next to her left side of the body. LPN-A had interviewed R18 on 3/27/24, and R18 was orientated to self, place (the name of the facility) and the month only. R18 denied being fearful of any staff members thus LPN-A documented no intentional harm and reported that [R18] felt safe.<br><br>During telephone interview on 4/19/24 at 10:08 a.m., the director of nurses (DON) stated the facility felt the bruise was due to dental concerns and the facility had not reported the bruise to the SA.<br><br>During telephone interview on 4/19/24 at 10:40 a.m., LPN-A stated they had completed an abnormal involuntary movement scale (AIMS) on 3/26/24, (the day before the bruise was identified) which included observation of R18's face. At that time R18 did not have any type of facial bruising. In addition, LPN-A stated R18 was to be transferred by one staff and a gait belt.<br><br>During telephone interview on 4/19/24 at 11:15 a.m., RN-C stated NA-E reported R18 had facial bruising on 3/27/26 at 6:00 a.m. RN-C assessed R18 by looking into her mouth, R18 denied pain but did wince when the area was touched. R18 denied any type of maltreatment. RN-C completed the facility incident report. RN-C did not report the bruise to the SA.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | During telephone interview on 4/19/24 at 11:36 a.m., NA-G stated R18 required assistance with transfers which included one staff member. NA-G stated they frequently would assist R18 by placing one arm under R18's shoulder/neck area and one under R18's buttocks/thighs. NA-G would then pick up R18 from the reclining chair and place them into bed or vice versa. NA-G stated they did not have any type of problems with the transfer as R18 was small in stature and did not weigh very much. R18 was not resistive during the transfers and R18's body did not touch NA-G's body during the transfer. NA-G stated they were not aware any other staff members transferring R18 like this, but it worked well for them. NA-G denied any instance in which they had difficulties transferring R18 such as near miss falls or quick sudden adjustments while positioned in their arms.<br><br>During telephone interview on 4/19/24 at 2:46 p.m., NA-E stated R18 required two staff for transfers. R18 was not resistive to cares. NA-E had reported the facial bruising to the nursing staff the morning of 3/27/24. During the night, the staff did not turn the overhead lights on until R18 was ready to get out of bed. During the night, R18 received incontinence cares via light from the bathroom or hallway. The main overhead light was not turned on until 3:00 - 5:00 a.m. At that time R18 was noted to have facial bruising which was reported to the nursing staff. NA-E unaware of how R18 would have sustained facial bruising.<br><br>On 4/19/24 at 3:00 p.m. the DON, administrator and LPN-A were interviewed. The DON stated the cares for each resident were communicated to the staff members via a Kardex system (written notes), on the Tasks section of the electronic medical record and on the resident care plans. The staff members were to transfer R18 with assistance of two staff as directed by the care plan. The nursing staff supervised the direct care staff to ensure they were following the resident care plans. The DON, administrator and LPN-A were informed of the discrepancies between the transfers styles utilized by the staff: one person transfer, two-person transfer and full body lift without a mechanical lift, placing one arm under the shoulder/neck area and one under buttocks. The DON confirmed a potential for personal injury for a resident transferred this way. The DON stated if the facility had been aware of the discrepancies of transfer styles, they may have approached the facial bruising that R18 sustained differently. The DON confirmed the bruise was not reported to the SA.<br><br>38053<br><br>33562<br><br>R57<br><br>R57's significant change MDS dated [DATE], identified R57 was severely cognitively impaired and had diagnoses which included Alzheimer's disease and dementia.<br><br>R57's PN dated 4/11/24, authored by LPN-B, identified LPN-B was notified by an aide of a bruise to R57's wrist. LPN-B assessed the bruise and noted a 5.5 x 4 centimeter (cm) bruise around R57's left wrist. LPN-B notified LPN-A. R57 was unable to state how she obtained the bruise.<br><br>R57's PN dated 4/11/24, authored by LPN-A, identified LPN-A interviewed R57 regarding the bruise. R57 stated she did not know how she obtained the bruise, did not know it was there, and felt she might have bumped it on something.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | R57's incident report dated 4/11/24, included the information from LPN-B and LPN-A's progress notes in the nursing description of the incident. Predisposing environmental factors were identified as none. Predisposing physiological factors were identified as confused, fragile skin, history of falls and impaired memory. There were no predisposing situation factors identified. The report identified no witnesses found. The report included the text of R57's PN dated 4/19/24 which identified the investigation of the incident. R57 was noted to have bruising to left wrist. R57 was interviewed regarding bruising and denied intentional harm and reported she felt safe. R57 was happy and laughing during the interview, mood was pleasant and outgoing. R57 was unsure how the bruise occurred but stated she might have bumped it on something. R57 used a Broda chair (a tilt in space positioning chair) when out of bed and frequently was seated at tables in common area, occasionally attempted to exit chair/stand independently. Bruise likely occurred due to unintentional contact between extremity and furniture or fixture, such as table.<br><br>During interview on 4/30/24 at 1:56 p.m., LPN-B reviewed R57's electronic medical record and stated she thought the bruise to R57's wrist wrapped around part of the wrist but was not sure if it was the inner or outer portion of the wrist. The bruise curved but did not go around the entire wrist. It did not look like anyone had grabbed her but with any bruises to the wrist she liked to be sure to update the manager so they could look at it. She did not identify the bruise to be suspicious.<br><br>During interview on 4/30/24 at 2:14 p.m., NA-A stated she had worked with R57 on 4/10/24 and had not noticed any bruising on that day. She worked with R57 again on 4/11/24 and in the morning noticed black/purple bruises on the top of both of R57's wrists that were approximately the size of a walnut. They almost looked like thumb marks. She notified LPN-B of the bruises.<br><br>During follow-up interview on 4/30/24 at 2:44 p.m., LPN-B stated she didn't recall bruises on both of R57's wrists. She had only looked at one bruise.<br><br>During interview on 5/1/24 at 4:04 p.m., RN-E recalled seeing a purple/reddish bruise on the inner side of R57's wrist. She was not sure how R57 obtained the bruise and noted it was reported by the day shift nurse. She had not reported the bruise to the SA.<br><br>During interview on 5/2/24 at 7:51 a.m., LPN-A identified she investigated R57's bruise. She stated although the progress note indicated the bruise was around R57's wrist, the bruise curved around the inner left wrist but did not encircle the wrist. R57 believed she may have bumped it on something. She sat in a Broda chair at the table most of her day and would push herself from the armrests to move the chair and try to stand/transfer. It looked like more of an edge of table bump. LPN-A stated she had spoken extensively with LPN-B regarding the bruise but could not specifically remember if she had spoken with NA-A. She had no further documentation of her investigation such as interviews and had not reported the bruise to the SA as she had not considered the bruise suspicious even though it wrapped around. LPN-A stated NA-A's description of bruises that looked like thumb marks would have prompted her to report to the SA, however, stated It didn't, I saw it.<br><br>During interview on 5/2/24 at approximately 8:00 a.m., the DON indicated she was aware of R57's bruise and had signed off on the incident report. There was no report of the area looking like a thumb mark, but such a report should have initiated an investigation and report to the SA.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | R57's Highwood Park Incident Check List dated 4/11/24, identified a 5.5 x 4 cm bruise to R57's left wrist. The check list included an injury decision tree to identify concerns reportable to the state agency. The first question in the decision tree asked, Was the resident able to explain injury? The choice of No was circled. The second question asked Is the injury suspicious because of extent of injury, location of injury and/or pattern of numerous injuries to one location, or numerous injuries over a period of time. The choice of No was circled. The decision tree directed if the injury was not suspicious in any way listed, there was no need to file a report to the SA. The report did not identify the bruise to the right wrist.<br><br>18987<br><br>R30<br><br>R30's quarterly MDS dated [DATE], identified R30 had severe cognitive impairment and diagnoses which included Alzheimer's disease, dementia, and anemia. The MDS also identified R30 had no hallucinations or delusions and did not exhibit any physical, verbal or other behavioral symptoms during the look back period.<br><br>On 4/30/24, review of a nursing progress dated 4/2/24 at 10:05 p.m., revealed R30's family reported to RN-C that a bruise was noted on resident's left lower extremity. RN-C assessed and documented that a bruise of 4 inches (10 cm) was noted from the resident's left middle calf to left foot. When asked, R30 was unable to recall. RN-C and the family member believed R30 bumped the left foot on something. It is unknown how R30 may kick or bump the front causing a bruise on the left middle calf and foot.<br><br>Interview of RN-C on 5/1/24 at 4:00 p.m., revealed she received a shift report that R30 was agitated and kicked on that day. Therefore, she believed the bruise was due to kicking or bumping. However, review of the Respond History related to Behavior Monitoring and Intervention dated 4/2/24, and the nursing progress note dated 4/2/24, revealed there was no incident reported that may contribute to the bruise on the left middle calf and left foot as a result of kicking or bumping.<br><br>On 5/1/24, review of the facility incident report dated 4/11/24, revealed LPN-A documented R30 self-propels in a wheelchair around the unit and receives anticoagulant therapy. At times, the resident kicks out or strikes out at caregivers. LPN-A documented Bruising likely occurred due to resident striking left foot on, unintentionally or while attempting to kick out. There is no incident prior to 4/2/24 which may contribute to the bruise on left calf and left foot.<br><br>On 5/1/24 at 2:30 p.m., interview of LPN-A revealed he/she reported the bruise to the administrator and the DON on their routine meetings. The routine meetings run twice a day. LPN-A stated no further action was taken after the meeting. However, LPN-A did not recall the date of the meeting.<br><br>On 5/1/24 at 2:30 p.m., interview of DON revealed the facility did not report the alleged violation related to a bruise of unknown origin to the SA.<br><br>R46<br><br>R46's annual MDS dated [DATE], identified R46 had mild cognitive impairment and diagnoses which included non-traumatic brain dysfunction and dementia.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | On 4/30/24, review of health status note dated 3/26/24 at 8:08 a.m., revealed R46 was found sitting on the floor at 6:15 a.m., but unable to recall what caused the fall. LPN-E completed a head to toe skin check and no injuries were noted. Telephone interview of LPN-E on 5/2/24 at 6:00 a.m., revealed LPN-E explained R46's head, neck, back, chest and all extremities were observed on 3/26/24 at 8:08 a.m. No bruise was noted at that time.<br><br>Further review of the skin evaluation dated 3/26/24 at 1:31 p.m., revealed RN-D documented four new bruises were noted on right forearm (4.5 cm x 4 cm) , right lower arm (3.8 cm x 3.5 cm) , right anterior elbow (3.8 cm x 3 cm) and right medial (inner) thigh (2.4 cm x 2.6 cm). It is unknown whether these bruises were the result of the fall in the morning on 3/26/24. Interview of RN-D on 4/30/24 at 4:15 p.m., revealed a nursing assistant asked her to look into the above bruises on 3/26/24 after R46 received a shower. RN-C did not know the cause of the right inner thigh bruise.<br><br>On 5/1/24 at 12:30 p.m., observation of R46's room revealed the grab bars were secured on the each side of the bed. No padding was noted.<br><br>On 5/1/24 at 2:30 p.m., interview of LPN-A, who completed an incident report related to a fall on 3/26/24, revealed she did not document the four new bruises were noted on 3/26/24 after a fall in the morning. When asked, LPN-A suspected R46 hit the grab bar or siderail during the fall on 3/26/24 from bed to floor, which might cause the bruise on the right medial (inner) thigh.<br><br>On 5/1/2424 at 2:40 p.m., interview of the DON revealed she suspected the bruise on the right inner thigh was due to the use of Hoyer's (full body mechanical lift) sling on 3/26/24 when lifting the resident up from the floor.<br><br>On 5/1/24 at 2:50 p.m., interview of the administrator revealed he/she was not aware of R46's right inner thigh bruise.<br><br>The cause of the bruise on the right inner thigh was unknown. There was no evidence that the facility reported this bruise of unknown origin to the SA.<br><br>The Facility Responsibilities for Reporting Allegations policy dated 9/22, directed the staff to identify a injury of unknown source when all of the following criteria are met:<br><br>- The source of the injury was not observed by any person; and<br><br>- The source of the injury could not be explained by the resident: and<br><br>- The injury is suspicious because of: the extent, location, number of injuries or incident of injuries over time.<br><br>The Abuse, Neglect, Exploitation or Misappropriation- Reporting Investigating policy dated 9/22, directed the staff to report allegations of abuse, neglect, exploitation, misappropriation of resident property or injuries of unknown source immediately (within two hours) if the allegation involves bodily injury and within 24 hours if the allegation does not involve abuse or result in serious bodily injury to the administrator and other officials according to state law. |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18618<br><br>Based on observation, interview and document review, the facility failed to thoroughly investigate injuries of unknown origin for 4 of 4 residents (R46, R18, R57, and 30) who had bruises where the injury was not witnessed, the resident could not explain the injury and the bruises were suspicious. The facility's pattern of failure to investigate injuries of unknown origin constituted an immediate jeopardy (IJ) situation.<br><br>The IJ began on 3/26/24, when R46 was identified with a 2.4 centimeter (cm) x 2.6 cm inner thigh bruise and continued 3/27/24 when R18 was identified with a 7 cm x 5 cm facial bruise, 4/2/24 when R30 was identified with a 10 cm calf bruise, and 4/11/24 when R57 was identified with a 5.5 cm x 4 cm wrist bruise. The facility's system failure to identify suspicious injuries and thoroughly investigate injuries of unknown origin resulted in unverified rationale and lacked implementation of corrective action to protect resident from further sustaining injuries. The administrator, director of nursing (DON), executive director (ED) and administrative intern were notified of the IJ on 5/2/24 at 10:20 a.m. The facility implemented corrective action and the IJ was removed on 5/2/24 at 6:50 p.m. However, non-compliance remained at the lower scope and severity of E, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.<br><br>Findings include:<br><br>R46<br><br>R46's annual Minimum Data Set (MDS) dated [DATE], identified R46 had mild cognitive impairment and diagnoses which included non-traumatic brain dysfunction and dementia.<br><br>On 4/30/24, review of health status note dated 3/26/24 at 8:08 a.m. revealed R46 was found sitting on the floor at 6:15 a.m. but was unable to recall what caused the fall. Licensed practical nurse (LPN)-E completed head to toe skin check and no injuries noted. During a telephone interview on 5/2/24 at 6:00 a.m., LPN-E explained he observed R46's head, neck, back, chest and all extremities on 3/26/24 at 8:08 a.m. and no bruises were noted at that time.<br><br>Further review of the skin only evaluation dated 3/26/24 at 1:31 p.m., revealed registered nurse (RN)-D documented four new bruises noted on right forearm (4.5 cm x 4 cm), right lower arm (3.8 cm x 3.5 cm), right anterior elbow (3.8 cm x 3 cm) and right medial (inner) thigh (2.4 cm x 2.6 cm). It was unknown whether these bruises were the result of the fall in the morning on 3/26/24. Interview of RN-D on 4/20/24 at 4:15 p.m. revealed a nursing assistant asked her to look into the above bruises on 3/26/24 after R46 received a shower. RN-D did not know the cause of the right inner thigh bruise.<br><br>On 5/1/24 at 2:30 p.m., interview of LPN-A, who completed an incident report related to a fall on 3/26/24, revealed she did not document the four new bruises were noted on 3/26/24 after a fall in the morning. When asked, LPN-A suspected R46 hit the grab bar or siderail during the fall from bed to floor causing the bruise on the right medial (inner) thigh. However, there was no evidence an investigation was done to rule out the root cause.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | On 5/1/24 at 2:40 p.m., interview of the director of nursing (DON) revealed she suspected the bruise on the right inner thigh was due to the use of Hoyer (full body mechanical lift) sling on 3/26/24 when lifting the resident up from the floor, however, there was no evidence an investigation was done to rule out the root cause. When asked, the DON did not know who operated the Hoyer lift on 3/26/24 to lift up R46.<br><br>On 5/1/24 at 2:50 p.m., interview of the administrator revealed she was not aware of R46's inner thigh bruise.<br><br>There was no evidence that the facility conducted a thorough investigation related to right inner thigh bruise, which was identified on 3/26/24.<br><br>R18<br><br>During observation on 4/10/24, at approximately 8:30 a.m., R18 was observed seated in a Broda (reclining wheelchair) in the activity room. R18 had a fading purple bruise approximately two inches in diameter on the left side of R18's chin and neck area. R18 was unable to respond when questioned about the bruise.<br><br>During interview on 4/10/24 at 12:11 p.m., family member (FM)-A stated R18 had sustained a large bruise on the left side of their chin/neck area; however, the facility was unable to explain to FM-A how the bruise occurred.<br><br>R18's quarterly Minimum Data Set (MDS) dated [DATE] and annual MDS dated [DATE], identified R18 with severe cognitive impairment and diagnoses including dementia, Parkinson's disease, and anxiety disorder. The MDS also identified R18 as requiring substantial assistance with all activities of daily living.<br><br>R18's Progress Note (nurses note) dated 3/27/24 at 6:00 a.m., indicated a night nursing assistant had reported a big bruise on the left side of chin. R18 was questioned if she had fallen or hit her face and reported no.<br><br>R18's Progress Note dated 3/27/24 at 8:05 a.m., indicated LPN-A met with R18 to evaluate the bruising to the left jaw/chin area. LPN-A noted some hardened swelling to jaw. R18 denied pain and did not allow an oral examination. LPN-A assessed R18 who was able to currently report the place and month to the staff. R18 denied intentional harm and reported they felt safe.<br><br>R18's initial Incident Report dated 3/27/24, identified the bruise with no witnesses to an event which resulted in bruising. The completed investigation dated 4/2/24, identified the bruise as 7 cm by 5 cm on the left chin. The investigation indicated the nurse practitioner would assess the area and determine if the bruise could be dental in origin. The report further indicated the bruise may have also been due to R18's chin pressing against clavicle or shoulder as R18 had a history of resting their head in a dependent position. R18 was not displaying concerns with meal intake or pain at the time of the assessment. The conclusion of the investigation indicated Intentional harm is not suspected.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | R18's Geriatrics for Follow Up Nursing Home (nurse practitioner examination) dated 3/28/24, indicated R18 was seen due to possible dental issues resulting in a bruise to the left side of chin. R18 had a history of sleeping in a bent position leaning toward the left side with her head and chin nearly touching her shoulder. R18 denied pain and no pain was observed as she ate all her lunch. The nurse practitioner assessment identified the facial bruising of the left distal (lower) chin as of unknown etiology (cause) and differential (list of possible conditions that share the same symptoms) included trauma to jaw or dental concern of broken tooth, cavity, or abscess. The nurse practitioner indicated an abscess was unlikely due to no reports of pain or other infectious symptoms.<br><br>During continuous observations on 4/11/24 from 8:05 a.m. to 9:00 a.m., R18 ate her breakfast meal without expressing any type of facial or dental pain.<br><br>During interview on 4/11/24 at 9:54 a.m., LPN-B stated R18 had sustained a bruise from something in her mouth. LPN-B could not recall what had caused the bruise.<br><br>During interview on 4/11/24 at 1:45 p.m., LPN-A stated injuries of unknown origin included physical injuries which were not witnessed, and the resident was not able to explain how the injury was obtained. LPN-A indicated she had been notified of R18's facial bruise on 3/28/24, and due to the location, LPN-A had determined the bruise was consistent with a dental issue. LPN-A verified R18 had last been evaluated by a dentist in January of 2024 and had not expressed any type of dental concerns from the time of the evaluation to 4/11/24. LPN-A stated due to the location of the bruise, LPN-A determined the cause would be dental. When asked if LPN-A had interviewed any staff or completed any type of investigation to rule out alternative possibilities such as abuse, LPN-A confirmed the facility had not interviewed any of the direct care staff or investigated the bruise as a potential abuse or as an injury sustained during the provision of care.<br><br>During interview of 4/11/24 at 2:31 p.m. RN-A confirmed a facial bruise which was 7 cm x 5 cm of unknown origin would be considered suspicious. The staff should have reported the bruise and investigated the origin to decide if the bruise was sustained due to abuse or inappropriate provision of care. RN-A confirmed the bruise was not investigated.<br><br>During interview on 4/11/24 at 2:57 p.m., the administrator stated the bruise had been discussed as a dental concern and none of the staff identified the bruise as a possible injury of unknown origin or abuse. Upon review of the bruise, the administrator confirmed the facial bruise should have been investigated to ensure abuse had not occurred.<br><br>During telephone interview on 4/19/24 at 9:53 a.m., LPN-A stated R18 frequently bent her neck and had her chin positioned next to her left side of the body. LPN-A had interviewed R18 on 3/27/24, and R18 was orientated to self, place (the name of the facility) and the month only. R18 denied being fearful of any staff members thus LPN-A had documented, no intentional harm and reported that [R18] felt safe. LPN-A had not performed any investigation to rule out potential abuse, or inappropriate care causing the bruising.<br><br>During telephone interview on 4/19/24 at 10:08 a.m., the DON stated the facility felt the bruise was due to a dental concern and the facility had not completed any type of investigation to determine the origin of the bruise.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | During telephone interview on 4/19/24 at 10:40 a.m., LPN-A stated they had completed an abnormal involuntary movement scale (AIMS) on 3/26/24, (the day before the bruise was identified) which included observation of R18's face. At that time R18 did not have any type of facial bruising at the time of the assessment. In addition, LPN-A stated R18 was to be transferred by one staff and a gait belt.<br><br>During telephone interview on 4/19/24 at 11:15 a.m., RN-C stated NA-E reported R18 had facial bruising on 3/27/26 at 6:00 a.m. and RN-C assessed R18 by looking into her mouth, R18 denied pain but did wince when the area was touched. R18 denied any type of maltreatment. RN-C completed the facility incident report.<br><br>During telephone interview on 4/19/24 at 11:22 a.m., NA-F stated R18 transferred with two staff members and did not require any type of additional assistive devices. According to NA-F, R18 was not resistive to cares and NA-F was unaware of how R18 had sustained the bruise.<br><br>During telephone interview on 4/19/24 at 11:36 a.m., NA-G stated R18 required assistance with transfers which included one staff member. NA-G stated they frequently would assist R18 by placing one arm under R18's shoulder/neck area and one under R18's buttocks/thighs. NA-G would then pick up R18 from the reclining chair and place them into bed or vice versa. NA-G stated they did not have any type of problems with the transfer as R18 was small in stature and did not weigh very much. R18 was not resistive during the transfers and R18's body did not touch NA-G's body during the transfer. NA-G stated they were not aware any other staff members transferring R18 like this, but it worked well for them. NA-G denied any instance in which they had difficulties transferring R18 such as near miss falls or quick sudden adjustments while positioned in their arms.<br><br>During telephone interview on 4/19/24 at 2:36 p.m., NA-H stated R18 transferred with assistance of two staff members. R18 was not resistive to transfers and was able to stand, pivot and sit on the bed or chair without difficulties. NA-H denied R18 having difficulties or resistive behaviors during transfers.<br><br>During telephone interview on 4/19/24 at 2:46 p.m., NA-E stated R18 required two staff for transfers. R18 was not resistive to cares. NA-E had reported the facial bruising to the nursing staff the morning of 3/27/24. During the night, the staff did not turn the overhead lights on until R18 was ready to get out of bed. During the night, R18 received incontinence cares via light from the bathroom or hallway. The main overhead light was not turned on until 3:00 - 5:00 a.m. At that time R18 was noted to have facial bruising which was reported to the nursing staff. NA-E unaware of how R18 would have sustained facial bruising.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | On 4/19/24 at 3:00 p.m. the DON, administrator and LPN-A were interviewed. The DON stated the cares for each resident were communicated to the staff members via a Kardex system (written notes), on the Tasks section of the electronic medical record and on the resident care plans. The staff members were to transfer R18 with assistance of two staff as directed by the care plan. The nursing staff supervised the direct care staff to ensure they were following the resident care plans. The DON, administrator and LPN-A were informed of the discrepancies between the transfers styles utilized by the staff: one person transfer, two-person transfer and full body lift without a mechanical lift with arm under neck/shoulder and other under buttocks. The DON confirmed a potential for personal injury for a resident transferred being picked up. The DON stated if the facility had been aware of the discrepancies of transfer styles, they may have approached the facial bruising that R18 sustained differently. The DON verified the facility had not completed any type of investigation of R18's bruise of unknown origin since the SA interviewed staff members on 4/11/24.<br><br>During a follow-up interview on May 1, 2024, at 12:40 pm, LPN-A explained that if the IDT (Interdisciplinary Team) found the extent and location of bruises suspicious in cases of unknown origin injuries, they were considered reportable. LPN-A conducted an investigation into the left facial bruising of R18 on 3/27/24 and completed a summary on 4/2/24. However, LPN-A stated that she had not interviewed any staff and added, There is no other documentation of investigations prior to my summary on 4/2/24, in the incident report. Whatever I have in the progress notes, is all I have. When asked what actions the facility took in response to R18's injury of unknown origin, LPN-A said, I notified the Nurse Practitioner to assess the resident for dental issues. LPN-A explained that the extent and location of a bruise determined if it should be considered an injury of unknown origin as reportable and that no formal tool was utilized to investigate the root causes of incidents that included bruises and injuries of unknown origin.<br><br>During a follow-up interview on 5/1/24 at 1:44 p.m., the DON clarified LPN-A was responsible for collecting information and not assessing a resident. The DON expected LPN-A to promptly complete her investigation of R18's left chin bruise within the five-day window and document all investigations in the progress notes and facility incident report. The DON expected LPN-A to interview the staff that worked at the time of R18's incident on 3/27/24 and prior to 3/27/24. The DON stated, I was notified of the incident via text message on 3/27/24 at 7:41 a.m., and I did not see or assess R18. The DON also indicated that no formal tool was utilized to thoroughly investigate the root causes of incidents. When asked what actions were taken to protect R18 from further incurring a bruise, the DON stated, I do not know. Further, the DON indicated that there was no abuse and neglect training conducted between when the incident occurred on 3/26/24 until the date of the interview on 5/1/24.<br><br>During a follow-up interview on 5/1/24 at 2:53 p.m., the administrator stated LPN-A had collected and summarized all the information regarding R18's left facial bruising on 3/27/24 in the facility's internal incident report. When asked who was responsible for investigating allegations of abuse and/or injuries of unknown origin, the administrator replied that it depended on who and that she primarily served as a contact person. The administrator also acknowledged R18's left facial bruising could have been considered suspicious due to its location, but it was not deemed reportable [by the facility]. Furthermore, the administrator revealed that no formal tool was utilized to investigate the root causes of incidents, and it was based on their practical knowledge. Finally, when asked if R18's left facial bruising was suspicious, the administrator responded, I was not worried.<br><br>R57<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | R57's significant change MDS dated [DATE], identified R57 was severely cognitively impaired and had diagnoses which included Alzheimer's disease and dementia.<br><br>R57's progress note (PN) dated 4/11/24, authored by LPN-B, identified LPN-B was notified by aide of a bruise to R57's wrist. LPN-B assessed the bruise and noted a 5.5 x 4 cm bruise around R57's left wrist. LPN-B notified LPN-A. R57 was unable to state how she obtained the bruise.<br><br>R57's PN dated 4/11/24, authored by LPN-A, identified LPN-A interviewed R57 regarding the bruise. R57 stated she did not know how she obtained the bruise, did not know it was there, and might have bumped it on something.<br><br>R57's incident report dated 4/11/24, included the information from LPN-B and LPN-A's progress notes in the nursing description of the incident. Predisposing environmental factors were identified as none. Predisposing physiological factors were identified as confused, fragile skin, history of falls and impaired memory. There were no predisposing situation factors identified. The report identified no witnesses found. The report included the text of R57's PN dated 4/19/24 which identified the investigation of the incident. R57 was noted to have bruising to left wrist. R57 was interviewed regarding bruising and denied intentional harm and reported she felt safe. R57 was happy/laughing during interview, mood pleasant and outgoing. R57 was unsure how bruise occurred but stated that she might have bumped it on something. R57 used a Broda chair (a tilt in space positioning chair) when out of bed and frequently was seated at tables in common area, occasionally attempted to exit chair/stand independently. The report indicated bruise likely occurred due to unintentional contact between extremity and furniture or fixture, such as table.<br><br>During interview on 4/30/24 at 1:56 p.m., LPN-B reviewed R57's electronic medical record and stated she thought the bruise to R57's wrist wrapped around part of the wrist but was not sure if it was the inner or outer portion of the wrist. The bruise curved but did not go around the entire wrist. It did not look like anyone had grabbed her but with any bruises to the wrist she liked to be sure to update the manager so they could look at it. She did not identify the bruise to be suspicious.<br><br>During interview on 4/30/24 at 2:14 p.m., NA-A stated she had worked with R57 on 4/10/24 and had not noticed any bruising on that day. She worked with R57 again on 4/11/24 and in the morning noticed black/purple bruises on the top of both of R57's wrists that were approximately the size of a walnut. They almost looked like thumb marks. She notified LPN-B of the bruises.<br><br>During follow-up interview on 4/30/24 at 2:44 p.m., LPN-B stated she didn't recall bruises on both of R57's wrists. She had only looked at one bruise.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | During interview on 5/1/24 at 12:40 p.m., LPN-A stated in general if someone had a skin injury or bruise, she would evaluate the bruise, interview the resident, and interview the team. She checked for resident pain, looked at the injury and looked for potential causes of the bruise such as use of blood thinner, combative behaviors or resident known health issues. She looked at the extent, location, resident statements about the injury, and team member voiced concerns to help determine if an injury was suspicious. Injuries of unknown cause would be suspicious if the injury was in an area such as a breast or if it was like a handprint for example. The investigation was documented in the incident report and progress notes, however she did not keep details of the investigation such as interviews, unless the incident was determined to be reportable to the SA. She gathered information and brought the incidents to leadership for a decision as to what needed to occur going forward such as a report to the SA, further investigation etc. Incidents were also discussed at the interdisciplinary team (IDT) meetings which occurred twice daily. The meetings were informal, and no notes were taken. She did not utilize a formal tool such as root-cause analysis to conduct the investigation or analyze the incidents.<br><br>During interview on 5/1/24 at 1:44 p.m., the DON verified the facility did not use a formal tool for the investigation of incidents. However, stated if an incident was determined to be reportable to the SA, they did use some rudimentary tools to help document the investigation that were not required for use with non-reportable incidents. The facility did not record why an incident was determined not to be reportable. A bruise would be reported related to the circumstances around the bruise such as location, suspicion such as sexual assault or a handprint. The size the bruise would be a factor as well. She would expect LPN-A to gather information related to devices used, knowledge of the resident and to interview staff working at the time. The facility had recently changed their process related to incidents from their previous use of written witness statements to their electronic medical record system which was paperless. She stated they probably have some work to do on their process.<br><br>During interview on 5/1/24 at 2:52 p.m. the administrator stated they were the contact person for all abuse and neglect reportable concerns, and she reviewed all incidents in the electronic medical record. If an incident was reportable, they would interview all other residents to ensure residents were safe. They would also assess the affected resident and take into consideration predisposing factors and risk factors. If any of these factors were off they would report the incident. She would at times expect the investigation of incidents to include interviews of staff.<br><br>During interview on 5/1/24 at 4:04 p.m., RN-E recalled seeing a purple/reddish bruise on the inner side of R57's wrist. She was not sure how R57 obtained the bruise and noted it was reported by the day shift nurse.<br><br>During interview on 5/2/24 at 7:51 a.m., LPN-A identified she investigated R57's bruise. She stated although the progress note indicated the bruise was around R57's wrist, the bruise curved around the inner left wrist but did not encircle the wrist. R57 believed she may have bumped it on something. She sat in a Broda chair at the table most of her day and would push herself from the armrests to move the chair and try to stand/transfer. It looked like more of an edge of table bump. LPN-A stated she had spoken extensively with LPN-B regarding the bruise but could not specifically remember if she had spoken with NA-A. She had no further documentation of her investigation such as interviews and she had not considered the bruise suspicious. LPN-A stated NA-A's description of bruises that looked like thumb marks would have prompted a full investigation, however LPN-A stated It didn't, I saw it. R57's record lacked documentation regarding the right wrist.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | During interview on 5/2/24 at approximately 8:00 a.m., the DON indicated she was aware of R57's bruise and had signed off on the incident report. There was no report of the area looking like a thumb mark, but such a report should have initiated an investigation and report to the SA.<br><br>R30<br><br>R30's quarterly MDS dated [DATE], identified R30 had severe cognitive impairment and diagnoses which included Alzheimer's disease, dementia, and anemia. The MDS also identified R30 had no hallucinations or delusions and did not exhibit any physical, verbal or other behavioral symptoms during the look back period.<br><br>Interview and observation of R30 on 4/30/24 at 3:50 p.m., revealed the resident was alert but oriented to person only. The resident reported leaving the facility and planning to move back to the United States.<br><br>On 4/30/24, review of a nursing progress note dated 4/30/2024 at 10:05 p.m., revealed R30's family reported to RN-C a bruise was noted on resident's left lower extremity. RN-C assessed and documented that a bruise of 4 inches (10 cm) was noted from the resident's left middle calf to left foot. When asked, R30 was unable to recall. RN-C and the family member believed R30 bumped the left foot on something.<br><br>On 5/1/24, review of the facility incident report dated 4/11/24, revealed LPN-A documented R30 self-propels in a wheelchair around the unit and receives anticoagulant therapy. At times, the resident kicks out or strikes out at caregivers. LPN-A documented Bruising likely occurred due to resident striking left foot on, unintentionally or while attempting to kick out. There was no incident on 4/2/24 which might contribute to the bruise on left calf and left foot.<br><br>On 5/1/24 at 2:30 p.m., interview of LPN-A revealed he/she reported the bruise to the administrator and DON on their routine interdisciplinary team (IDT) meetings. The IDT meetings ran twice a day. LPN-A stated no further action was taken after the meeting. However, LPN-A did not recall the date of the meeting.<br><br>Further review of Respond History related to Behavior Monitoring and Intervention dated on 4/2/24 and the nursing progress note dated 4/2/24, revealed R30 did not have any behavior issue which might contribute to the bruise as a result of kicking or bumping.<br><br>It is unknown how R30 might kick or bump at the front causing a bruise on the left middle calf and foot and which object might pose a risk to R30 causing future bruising. There was no thorough investigation completed to rule out the root cause.<br><br>Interview of RN-C on 5/1/24 at 4 p.m., revealed a purple bruise was first noted on the top of left foot and left shin on 4/2/24 in the evening, which is inconsistent with the skin assessment he/she documented on 4/2/24. See F684.<br><br>The Facility Responsibilities for Reporting Allegations policy dated 9/2022, directed an injury should be classified as an injury of unknown source when all of the following criteria are met:<br><br>The source of the injury was not observed by any person; and<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | The source of the injury could not be explained by the resident; and<br><br>The injury is suspicious because of:<br><br>o The extent of the injury, or<br><br>o The location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma), or<br><br>o The number of injuries observed at one particular point in time, or<br><br>o The incidence of injuries over time<br><br>The Abuse, Neglect, Exploitation, or Misappropriation - Reporting and Investigating policy dated 9/2022 directed upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents. The policy also directs the individual conducting the investigation at minimum:<br><br>a. reviews the documentation and evidence;<br><br>b. reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident;<br><br>c. observes the alleged victim, including his or her interactions with staff and other residents;<br><br>d. interviews the person(s) reporting the incident;<br><br>e. interviews any witnesses to the incident;<br><br>f. interviews the resident (as medically appropriate) or the resident's representative;<br><br>g. interviews the resident's attending physician as needed to determine the resident's condition;<br><br>h. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident;<br><br>i. interviews the resident's roommate, family members, and visitors;<br><br>j. interviews other residents to whom the accused employee provides care or services;<br><br>k. reviews all events leading up to the alleged incident; and<br><br>l. documents the investigation completely and thoroughly.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | The immediate jeopardy that began on 3/26/24, was removed on 5/2/24, at 6:50 p.m., when the facility conducted interviews with all interviewable residents regarding their perception of safety in the facility and completed a physical assessment of all residents to identify any injuries of unknown origin. Nursing leadership, including the facility unit managers, DON and administrator were educated on investigating injuries of unknown origin by the facility's regional director of health services. The facility's policy regarding injuries of unknown source was reviewed and all staff were educated on identification of injuries of unknown source. The administrator will monitor compliance daily to ensure complete investigation practices are followed and will complete an audit of incidents of unknown source or bruising for four weeks. Any identified concerns will be addressed immediately and if trends or patterns are identified, the facility will conduct an ad-hoc Quality Assurance and Performance Improvement meeting to address any additional interventions needed to ensure compliance. However, non-compliance remained at the lower scope and severity of an E, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.<br><br>38053<br><br>33562<br><br>18987 |

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| F 0623<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>33562<br><br>Based on interview and document review, the facility failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of facility-initiated transfers for 12 of 12 residents (R72, R19, R175, R27, R45, R174, R12, R47, R173, R69, R171, R44) who had been hospitalized .<br><br>Findings include:<br><br>An e-mail correspondence with the OOLTC, dated 4/3/24, identified the facility had not completed monthly reporting of transfers and discharges to the OOLTC as required.<br><br>R19's HSN dated 1/1/24, identified R19 transferred to the hospital emergency department (ED) for further evaluation for unresponsiveness. HSN dated 1/4/24, identified R19 readmitted to the facility. The medical record lacked evidence notice of the transfer was provided to the OOLTC.<br><br>R175's HSN dated 1/6/24, identified R175 transferred to the hospital for evaluation of low oxygen saturation. The medical record lacked evidence notice of the transfer was provided to the OOLTC.<br><br>R27's HSN dated 1/7/24, identified R27 transferred to the hospital per family request. The HSN dated 1/13/24, identified R27 was readmitted to the facility. R27's HSN dated 2/7/24, identified R27 again transferred to the hospital per family request. The medical record lacked evidence notice of the transfers were provided to the OOLTC.<br><br>R45's HSN dated 1/29/24, identified R45 transferred to the hospital via ambulance due to inability to transfer in family vehicle. R45 admitted to the hospital for an infection of a toe. The medical record lacked evidence notice of the transfer was provided to the OOLTC.<br><br>R174's HSN dated 2/4/24, identified R174 transferred to the hospital for further evaluation of decreasing oxygen saturation. The medical record lacked evidence notice of the transfer was provided to the OOLTC.<br><br>R12's HSN dated 2/8/24, identified R12 transferred to the ED after a fall with injury. The HSN dated 2/14/24, identified R12 was readmitted to the facility after a hospital stay. The medical record lacked evidence notice of the transfer was provided to the OOLTC.<br><br>R47's HSN dated 2/9/24, identified R47 transferred to the ED for increased respirations, productive cough and decreased oxygen saturation. The HSN dated 2/10/24, identified R47 admitted to the hospital. The medical record lacked evidence notice of the transfer was provided to the OOLTC.<br><br>R173's HSN dated 2/10/24, identified R173 transferred to the hospital. The HSN dated 2/10/24, identified R173 admitted to the hospital for pleural effusion (an accumulation of fluid around the lungs) and intravenous antibiotics. The medical record lacked evidence notice of the transfer was provided to the OOLTC.<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | R69's HSN dated 2/10/24, identified R69 transferred to the hospital for weakness and decreased oxygen saturation. The HSN dated 2/11/24, identified R69 admitted to the hospital for pneumonia and pulmonary edema. The medical record lacked evidence notice of the transfer was provided to the OOLTC.<br><br>R172's Health Status Note (HSN) dated 3/1/24, identified R172 transferred to the hospital for further evaluation and treatment of low hemoglobin. The medical record lacked evidence notice of the transfer was provided to the OOLTC.<br><br>R171's HSN dated 3/4/24, identified R171 transferred to the hospital for unresponsiveness. The medical record lacked evidence notice of the transfer was provided to the OOLTC.<br><br>R44's HSN dated 3/17/24, identified R44 transferred to the ED for chest pain. The HSN dated 3/23/24, identified R44 was readmitted to the facility. The medical record lacked evidence notice of the transfer was provided to the OOLTC.<br><br>During interview on 4/10/24 at 2:59 p.m., the director of health center sales and services (DHCSS) stated she was the person responsible to notify the OOLTC of resident discharges and transfers and the last time she had done so was 1/3/24. She stated she had let them accumulate for about three months prior to sending them. DHCS provided a green three-ring binder and identified the notices in the left hand pocket of the binder were notices she had not yet sent to the OOLTC. Notices stored within the rings of the binder were those which had previously been sent to the OOLTC with documentation of the date and time the communication took place. Review of the identified unsent notices in the left hand pocket of the binder included documents titled Friendship Village of Bloomington Notice of Transfer or Discharge for the aforementioned transfers.<br><br>During interview on 4/11/24 at 10:08 a.m., DHCSS verified hospital transfer notices had not been sent to the OOLTC for R19, R175, R27, R45, R174, R12, R47, R173, R69, R172, R171, or R44 and she was not aware they should be sent monthly.<br><br>During interview on 4/11/24 at 2:26 p.m., the administrator stated transfer notices should be sent to the OOLTC monthly. She verified the facility policy did not include a timeframe for reporting and it should be updated.<br><br>The Transfer and Discharge (30 Day Notice) policy dated 1/13/20, directed before the facility transferred or discharged a resident, the community must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. The policy lacked a timeframe for reporting emergency transfers to the OOLTC monthly and a timeframe for facility-initiated transfers to be reported to the OOLTC within 30 days prior to the discharge or as soon as practicable. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18618<br><br>Based on observation, interview and document review, the facility failed to ensure the resident status was accurately identified on the Minimum Data Set (MDS) assessment for 1 of 3 resident (R18) reviewed for behaviors.<br><br>Findings include:<br><br>The Center for Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) manual Version 3.0 Manual dated October 20, 2023, directs facilities to assess residents' behavioral symptoms by:<br><br>1. Review the medical record for the seven-day look-back period.<br><br>2. Interview staff, across all shifts and disciplines, as well as others who have close interactions with the resident during the seven day look back period, including family or friends who visit frequently or have frequent contact with the resident.<br><br>3. Observe the resident in a variety of situations during the seven-day look-back period.<br><br>R18's quarterly Minimum Data Set (MDS) dated [DATE], identified R18 with moderate cognitive impairment and diagnoses including dementia, Parkinson's disease and anxiety disorder. The assessments indicated R18 did not display behavior of any type.<br><br>R18's physician orders dated 2/26/24, indicated R18 had received Lorazepam (Ativan- antianxiety medication) 0.5 milligram (mg) in the morning and 1 mg in the evening since 1/23/24. However, on 2/26/24, the order was decreased to 0.5 mg every two hours as needed for anxiety because R18 had displayed lethargy.<br><br>R18's care plan dated 3/4/24, indicated R18 utilized psychotropic and antianxiety medications related to behaviors. The plan identified R18's behaviors as pulling at /our hair, biting nails and yelling out. The plan directed the staff to monitor R18's behaviors.<br><br>R18's March 2024, MAR indicated R18 had received Lorazepam 0.5 mg on 3/23/24, at 12:28 p.m. and at 5:33 p.m.<br><br>R18's Progress Notes (nurses notes) from 3/23/24 - 4/2/24 (seven day look back period for MDS completion) revealed the following information:<br><br>-On 3/23/24 at 12:28 p.m., indicated R18 had received Lorazepam as R18 was very restless, repeatedly calling out: Please help me, I'm stuck.<br><br>-On 3/23/24 at 1:16 p.m., the follow up documentation indicated the medication administration was effective.<br><br>-On 3/23/24 at 5:33 p.m., R18 was received a second dose of Lorazepam 0.5 mg. The clinical record lacked documentation as to why the medication was given.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | -On 3/23/24 at 6:32 p.m., the follow up documentation indicated the medication was effective.<br><br>R18's Behavior Monitoring and Intervention Reports from 3/26/24- 4/2/24 (MDS seven day look back period) , indicated R18 did not display any type of behavior.<br><br>During interview on 4/10/24 at 12:05 p.m., family member (FM)-A stated R18 frequently called out repetitive phrases and questioned if the staff responded to R18's concerns. FM-A stated R18 had dementia and had recently lost their spouse after many years of marriage.<br><br>During observations on 4/11/24, the following behaviors were identified:<br><br>-At 9:20 a.m., R18 was seated in a Broda chair (reclining wheelchair) in the dining room and stated, Take me back to my room.<br><br>-At 9:22 a.m., R18 stated, Get me out of here.<br><br>-At 9:23 a.m., R18 stated please help me I am stuck nursing assistant (NA)-B directed R18 and informed R18 they were fine. R18 stated No I am not, I am stuck. Please help me.<br><br>-At 9:26 a.m., NA-A wheeled R18 to their room NA-A left the room as R18 stated Please help me.<br><br>-From 9:26 a.m. to 9:50 a.m. R18 repeated the phrases Help me, I am stuck. while seated in R18's room<br><br>During interview on 4/11/24 at 9:50 a.m., licensed practical nurse (LPN)-B stated R18 called our repeatedly.<br><br>On 4/11/24 at 10:00 a.m., NA-A assisted R18 from the private room to the activity room.<br><br>On 4/11/24 at 10:02 a.m., R18 stated, I am stuck. activity aide (AA)-A spoke to R18 and reclined the Broda chair.<br><br>On 4/11/24 at 11:02 a.m., NA-A was observed to assist R18 with cares as R18 stated, Please help me, I am stuck. NA-A stated R18 called out all the time.<br><br>On 4/11/24 at 2:04 p.m., licensed practical nurse (LPN)-A stated R18 displayed daily behaviors of yelling out repeatedly. R18 utilized Lorazepam as needed for anxiety and the behaviors were to be monitored. The nursing staff documented what type of behavior R18 displayed at the time of the medication administration and one to two hours later would identify if the medication was effective.<br><br>On 4/11/24 at 2:31 p.m., registered nurse (RN)-A stated R18 did not display behaviors, R18 simply yelled out phrases like I am stuck repeatedly throughout the day. RN-A stated when this happened, the staff were to offer comfort measures such as assisting R18 to the restroom, offering a drink of water, engage R18 in an activity or conversation. RN-A confirmed repetitive yelling was indicative of a behavior and staff responded to R18. RN-A verified R18's care plan identified yelling out as a behavior.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | On 4/11/24 at 3:33 p.m., the administrator verified the MDS was to be completed in accordance to the Centers for Medicare and Medicaid (CMS) instruction Resident Assessment Instrument (RAI) manual.<br><br>On 4/11/24 at 3:34 p.m., RN-B (facility MDS coordinator) stated the mood and behavior sections of the MDS were completed by the licensed social workers (LSW). RN-B stated they did not visit R18 on a routine basis and were not familiar with R18's behaviors.<br><br>On 4/11/24 at 4:00 p.m. the director of health center sales and services (DHCSS) (a licensed social worker) stated R18 had displayed repetitive calling out behaviors for a long time. DHCSS stated to complete the MDS, the LSW reviewed the Behavior Monitoring and Intervention Reports. The reports during the look back period indicated R18 had not displayed behaviors, however, confirmed the progress notes did identify behaviors. The director of health center sales and services confirmed the MDS did not accurately reflect R18's behaviors during the look back period. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33562<br><br>Based on observation, interview and record review, the facility failed ensure transfer interventions were consistently implemented for 1 of 1 resident (R18) reviewed for injuries of unknown origin. Additionally, the facility failed to implement interventions for monitoring and documenting bruising for 2 of 2 residents (R30 and R46) reviewed for injuries of unknown origin.<br><br>Findings include:<br><br>R18's quarterly Minimum Data Set (MDS) dated [DATE], identified R18 had severe cognitive impairment and diagnoses which included dementia, Parkinson's disease, and anxiety disorder. The MDS also identified R18 weighed less than 100 pounds and required substantial/maximal assistance with transfers.<br><br>R18's care plan dated 10/23, directed staff to provide extensive assistance of two staff for transfers.<br><br>During observation on 4/11/24 at 11:05 a.m., R18 was seated in a Broda chair (reclining wheelchair) next to R18's bed. Nursing assistant (NA)-A stood in between the chair and the bed, squatted in front of R18 and directed R18 to give me a big hug. R18 placed arms around NA-A's upper body as NA-A lifted R18 out of the chair, pivoted R18 and assisted R18 into bed. At no time was NA-A observed to utilize a gait belt or have assistance from another staff member during the transfer.<br><br>During observation on 4/11/24 at 11:27 a.m., NA-A and registered nurse (RN)-A assisted R18 to sit on the edge of the bed. NA-A squatted down in front of R18 and directed R18 to give me a big hug. RN-A backed away from the resident as NA-A assisted R18 from the bed back into the Broda (reclining wheel) chair. At no time was NA-A observed to utilize a gait belt or request assistance from RN-A for the transfer. RN-A stood next to NA-A but did not attempt to assist with the transfer.<br><br>During interview on 4/11/24 at 11:27 a.m., NA-A confirmed a gait belt was not utilized during the transfer as R18 was light enough to assist without a belt.<br><br>During interview on 4/11/24 at 11:30 a.m., RN-A confirmed NA-A did not utilize a gait belt, or two staff members as directed by the care plan.<br><br>During interview on 4/11/24 at 2:11 p.m., unit manager, licensed practical nurse (LPN)-A, confirmed the staff were to utilize gait belt for transfers and the number of staff as directed on the care plan.<br><br>During interview on 4/11/24 at 3:33 p.m., the administrator indicated all residents were to receive care according to their individualized care plans.<br><br>During a telephone interview on 4/19/24 at 8:30 a.m. the administrator gave permission for the State agency to complete telephone interviews with staff members.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During telephone interview on 4/19/24 at 10:40 a.m., LPN-A stated R18 was to be transferred by one staff and a gait belt.<br><br>During telephone interview on 4/19/24 at 11:36 a.m., NA-G stated R18 required assistance with transfers which included one staff member. NA-G stated they frequently would assist R18 by placing one arm under R18's shoulder/neck area and one under R18's buttocks/thighs. NA-G would then pick up R18 from the reclining chair and place them into bed or vice versa (like one would pick up a child). NA-G stated they did not have any type of problems with the transfer as R18 was small in stature and did not weigh very much. NA-G stated they were not aware any other staff members transferring R18 in this manner, but it worked well for them.<br><br>On 4/19/24 at 3:00 p.m. the DON, administrator and LPN-A were interviewed. The DON stated the cares for each resident were communicated to the staff members via a Kardex system (written notes), on the Tasks section of the electronic medical record and on the resident care plans. The staff members were to transfer R18 with assistance of two staff as directed by the care plan. The nurses supervised the direct care staff to ensure they were following the resident care plans. The DON, administrator and LPN-A were informed of the discrepancies between the transfers styles utilized by the staff: one person transfer, two-person transfer and full body lift without a mechanical lift, like you would pick up a child. The DON confirmed a potential for personal injury to a resident transferred using the aforementioned, non-care planned method.<br><br>18987<br><br>R30<br><br>Interview of R30 on 4/30/24 at 3:50 p.m., revealed the resident was alert, but oriented to person only. The resident reported leaving the facility and planning to move back to the United States.<br><br>On 4/30/24, review of R30's care plan related to anticoagulant therapy dated 5/24/23, revealed the facility intervention was to monitor/document bruising.<br><br>Further review of R30's nursing progress note dated 4/2/24 at 10:05 p.m., revealed R30 was an [AGE] year old senior who has been residing in the facility over a year. R30's family reported to registered nurse (RN)-C that a bruise was noted on resident's left lower extremity. RN-C assessed and documented a bruise of four inches was noted from the resident's left of middle calf to left foot. However, there was no measurement of the width. The color of the bruise was unknown. See F684 for additional information.<br><br>Further review of the skin only evaluation dated on 4/3/24 at 2:21 p.m., within 24 hours when the bruise was first identified by RN-C and R30's family member, revealed LPN-C documented skin warm & dry, skin color WNL (within normal limit) and turgor is normal. Resident does not have an external device. Interview of LPN-C on 5/1/24 at 12:00 p.m. revealed she could not recall R30's skin condition on 4/3/24, but she documented her observations on the electronic clinical record.<br><br>There was no evidence the facility staff implemented the care plan to monitor and document the bruise after a bruise was identified on 4/2/24 until it was resolved.<br><br>R46<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/30/24 at 11:30 a.m., observation of R46, who was sitting in a wheelchair in the hallway, revealed the resident is alert and oriented to person. A quarter size purple bruise was noted on the resident's right forearm, close to the right wrist. The resident reported having bruises all over her body by pointing to the body trunk. No sign or symptom of pain or fear was noted. Observation of R46 on 4/30/2424 at 4:00 p.m., during toileting, which was provided by NA-I, revealed no other bruises were noted on the resident's body trunk (chest, abdomen and back).<br><br>On 4/30/24, review of the skin only evaluation dated 3/26/24 at 1:31 p.m., revealed RN-D documented four new bruises were noted on the right forearm (4.5 cm x 4 cm) , right lower arm (3.8 cm x 3.5 cm) , right anterior elbow (3.8 cm x 3 cm) and right medial thigh (2.4 cm x 2.6 cm), however, the color of each bruise was unknown.<br><br>R46's care plan related to skin injury due to fragile skin dated 11/14/23, instructed licensed nurses and nursing assistants to monitor, document and report changes in skin status including appearance, color and wound healing, sign/symptom of infection, wound size and stage. The licensed nurses documented the measurements of these bruises on 3/26/24, 4/2/24, 4/9/24, 4/16/24, 4/23/24 and 4/30/24. The size of each bruise remained the same without resolving. However, the color of these bruises were unknown.<br><br>There was no evidence the facility staff implemented the care plan to monitor and document the color of the four bruises since they were first identified on 3/26/24. |

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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** 18987<br><br>Based on observation, interview, and record review, the facility failed to assess and monitor the bruise on R18's left facial area, R46's right and left forearm, right and left anterior legs, and right and left inner thigh and failed to accurately document the location and monitor R30's bruise of unknown origin of four residents reviewed for quality of care.<br><br>Findings include:<br><br>R30<br><br>Interview of R30 on 4/30/24 at 3:50 p.m., revealed the resident was alert, but oriented to person only. The resident reported leaving the facility and planning to move back to the United States.<br><br>On 4/3024, review of a nursing progress dated 4/2/24 at 10:05 p.m., revealed R30 is a [AGE] year old senior who has been residing in the facility over a year. R30's family reported to registered nurse (RN)-C that a bruise was noted on resident's left lower extremity. RN-C assessed and documented that a bruise of four inches was noted from the resident's left of middle calf to left foot. When asked, R30 was unable to recall. Therefore, RN-C and the family member had believed R30 bumped the left foot on something.<br><br>Based on health status note written by RN-C on 4/2/24 at 10:05 p.m., RN-C only documented the length of the bruise, but no width or color of the bruise. Review of the care plan related to activities of daily living (ADL) revealed due to aggressive behavior, the resident requires extensive assistance by 1-2 staff to transfer. Review of Respond History related to Behavior monitoring and intervention dated on 4/2/24 and the nursing progress note dated 4/2/24 revealed R30 did not have any behavior issue, which may contribute to the action of kicking. There was no further investigation done to support RN-C's belief the bruise was due to bumping. It is unknown what kind of object could cause a bruise of four inches (10 centimeters) on the calf when R30 bumped the left lower extremity at the front. See F610.<br><br>Interview of RN-C on 5/1/24 at 4:00 p.m., revealed a purple bruise was noted on the top of left foot and left shin on 4/2/24 in the evening, which is inconsistent with the skin assessment RN-C documented on 4/2/24.<br><br>Review of the skin only evaluation dated on 4/3/24 at 2:21 p.m., within 24 hours when the bruise was first identified by RN-C and R30's family member, revealed LPN-C documented skin warm & dry, skin color WNL (within normal limit) and turgor is normal. Resident does not have an external device. Interview of LPN-C on 5/1/24 at 12:00 p.m. revealed she could not recall R30's skin condition on 4/3/24, but she documented her observations on the electronic clinical record.<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 | Further review of the facility's incident report dated 4/11/24, nine days after the bruise was first identified, revealed LPN-A documented a bruise was 6 centimeters (cm) in length on 4/2/24 at 9:09 p.m., which was located on the resident's left foot. LPN-A's skin assessment on 4/2/24 at 9:09 p.m. is inconsistent with RN-C's on 4/2/24 at 10:05 p.m. Interview of LPN-A on 5/1/24 at 12:30 p.m. revealed she did not observe the bruise of 6 cm on 4/2/24 as stated on the facility's incident report. She converted the measuring unit of inch to cm based on RN-C's assessment on 4/2/24 into the facility' incident report. However, she was not aware that 4 inches is equal to 10 cm. LPN-A did not provide any information related to the width or color of the bruise that was identified on 4/2/24 by the family member because LPN-A did not observe the bruise on 4/2/24 and 4/11/24.<br><br>On 4/30/24, review of R30's care plan related to anticoagulant therapy dated 5/24/23, revealed the facility intervention is to monitor/document bruising. However, the measurements and location of the bruise, which was first identified by the family member on 4/2/24, are inconsistent among RN-C, LPN-C and LPN-A. There is no monitoring of the bruise noted on 4/10/24, 4/17/24 and 4/27/24 when the skin assessments were conducted on shower day by LPN-C. It is unknown when the bruise was resolved.<br><br>On 5/1/24 at 2:30 p.m., interview of director of nursing (DON) revealed she did not have additional information provided.<br><br>On 5/1/24 at 4:00 p.m., observation of R30's bilateral lower extremities in presence of NA-I revealed no bruise was noted on left foot, left shin or left calf.<br><br>On 5/2/24 at 1200 p.m., surveyor communicated with the family member, who first noted the bruise on 4/2/24, via email, which revealed the bruise was in purple color and about 2-2.5 inch wide x 3-3.5 inch length. The bruise was noted on the top of the foot and lower calf, which was covered by the resident's sock.<br><br>R46<br><br>On 4/30/24 at 11:30 a.m., observation of R46, who was sitting in a wheelchair in the hallway, revealed the resident is alert and oriented to person. A quarter size purple bruise was noted on the resident's right forearm, closed on the right wrist. The resident reported having bruises all over her body by pointing the body trunk. No sign or symptom of pain or fear was noted. Observation of R46 on 4/30/2424 at 4:00 p.m., during toileting, which was provided by NA-I, revealed no bruise was noted on the resident's body trunk (chest, abdomen and back).<br><br>On 4/30/24, review of health status note dated 3/26/24 at 8:08 a.m., revealed R46 was found sitting on the floor at 6:15 a.m., but unable to recall what caused the fall. LPN-E completed head to toe skin check and no injuries noted. Telephone interview of LPN-E on 5/2/24 at 6:00 a.m. revealed LPN-E observed R46's head, neck, back, chest and all extremities on 3/26/24 at 8:08 a.m No bruise was noted at that time.<br><br>Further review of the skin only evaluation dated 3/26/24 at 1:31 p.m., revealed RN-D documented four new bruises were noted on right forearm (4.5 cm x 4 cm) , right lower arm (3.8 cm x 3.5 cm) , right anterior elbow (3.8 cm x 3 cm) and right medial thigh (2.4 cm x 2.6 cm), however, the color of each bruise was unknown.<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 | R46's care plan related to skin injury due to fragile skin dated 11/14/23, instructed licensed nurses and nursing assistants to monitor, document and report changes in skin status including appearance, color and wound healing, sign/symptom of infection, wound size and stage. The licensed nurses documented the measurements of these bruises on 3/26/24, 4/2/24, 4/9/24, 4/16/24, 4/23/24 and 4/30/24. The size of each bruise remains the same without resolving. The color of these bruises were unknown.<br><br>On 4/30/24 at 4:00 p.m., observation of NA-I assisting R46 with toileting revealed purple/brown bruises were noted on the the both lateral (outer) forearms and anterior (top) of both lower legs. The resident was asked to keep her hands and elbows on the lap when transporting in a wheelchair.<br><br>Interview of R46 on 4/30/24 at 4:00 p.m.,revealed the resident did not recall the fall on 3/26/24.<br><br>On 5/1/24 at 2:30 p.m., interview of LPN-A, who completed an incident report related to a fall on 3/26/24, revealed LPN-A suspected R46 hit the grab bar or side rail while falling from bed to floor, which might cause the bruise on the right medial (inner) thigh.<br><br>On 5/1/24 at 2:30 p.m., interview of the DON revealed DON suspected the bruise on the right inner thigh was due to the use of a Hoyer (mechanical lift) sling because R46 was picked up from the floor on 3/26/24 using a Hoyer lift.<br><br>A care conference was held on 4/824, however, there is no revision made to address the risks of the grab bar or the use of Hoyer lift sling.<br><br>On 5/2/24 at 6:45 p.m., observation, R46 revealed a grab bar was secured on each side of the bed. No padding was noted.<br><br>On 5/2/24 at 6:45 p.m., observation of R46 in the presence of DON and NA-I revealed a bruise was noted resident's left inner thigh in addition to a bruise on the right inner thigh. DON suspected these bruises were due to the use of a Hoyer lift sling. However, the care plan related to Therapy Gait Recommendations indicated R46 transfers with a transfer belt with verbal cues.<br><br>38053<br><br>R18<br><br>During observation on 4/10/24, at 8:30 am, R18 was seated in a Broda (reclining wheelchair) in the activity room. R18 had a fading purple bruise approximately two inches in diameter on the left side of R18's chin and neck area. R18 was unable to respond when questioned about the bruise.<br><br>A review of R18's quarterly Minimum Data Set (MDS) dated [DATE], and annual MDS dated [DATE], identified R18 with severe cognitive impairment and diagnoses including dementia, Parkinson's disease, and anxiety disorder. The MDS also identified R18 as requiring substantial to maximal assistance with all activities of daily living.<br><br>A review of R18's progress note revealed the following:<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 | 3/27/24 6:00 a.m .Health Status note: The NOC [night] aide [name of NA-E] informed the writer about a big bruise on the resident's left side chin. The writer went to give the resident her AM [morning] medications and confirmed a bruise of a small ball size. She asked the resident if she could remember falling or hitting her face, and she replied, No, but she does not remember. The writer informed the lead nurse [name of LPN-A] .<br><br>3/27/24 8:05 a.m .Health Status note: Writer met with resident to evaluate bruising to left jaw/chin area- noted some hardened swelling to jaw, resident denies pain. Resident did not allow oral/teeth check. Writer interviewed resident, alert and oriented to self, stated location as Friendship Village, unable to answer year or day of week/date, but did report month as March .<br><br>3/30/24 7:18 p.m .Skin Only Evaluation: Skin warm and dry, skin color WNL [within normal limit]<br><br>4/1/24 1:58 p.m .nursing order TX [treatment] TO WOUND ON LEFT THIGH: Cleanse wound, apply bacitracin and cover with telfa .<br><br>Review of R18's progress notes following the discovery of R18's bruise, dated 3/27/24 to 3/30/24, revealed no documented evidence that facility nursing staff continued to assess and monitor R18's bruise for healing, worsening, or pain associated with the presence of the bruise.<br><br>A review of R18's Skin Only Evaluation dated 3/30/24, revealed R18's skin was warm and dry, skin color WNL, normal turgor, and skin tears on bilateral upper and lower extremities. In addition, the items under Care Planning and Clinical Conditions were blank. Upon further review of the document, no mention was made of monitoring the healing or worsening of R18's left facial bruise.<br><br>A review of R18's care plan revealed under<br><br>Focus: The resident has potential/actual impairment to skin integrity .r/t [related to] skin breakdown, immobility, decreased function, revised on 4/4/24 .<br><br>Goal: The resident's skin injury will be healed by review date .<br><br>Intervention .Monitor/document location, size and treatment of skin injury. Report abnormalities,<br><br>failure to heal, s/sx [signs and symptoms] of infection, to MD [physician]. Date Initiated: 10/04/22 .<br><br>Review of the facility's internal Incident Report of R18's facility dated 3/27/24, revealed that R18 had a bruise on her left facial/chin area. No witnesses were present at the time of the incident. The investigation report dated 4/2/24, stated that the bruise measured seven cm [centimeter] by five cm. The report also mentioned that the nurse practitioner would examine the area to determine whether the bruise was dental in origin. Additionally, the report suggested that the bruise might have been caused by R18's chin pressing against their clavicle or shoulder, as R18 had a history of resting their head in a dependent position. At the time of the assessment, R18 did not display any concerns regarding their meal intake or pain.<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 an interview on 5/2/24 at 2:05 pm, RN-E stated that nurses were expected to monitor any resident bruises every shift for 72 hours post indentification fo the incident. RN-E read back R18's nursing order to Start date: 4/1/24 Monitor bruising to left chin/jaw; update NP/hospice with changes or concerns, monitor for pain, decreased meal intakes every shift. RN-E did not document monitoring or assessment of R18's left facial bruise from 3/28/24 to 3/31/24, except for the initial note on 3/27/24.<br><br>In an interview with the DON on 5/1/24 at 1:44 pm, when asked what the facility's protocol in monitoring for residents with bruises was, the DON revealed, It depends, if it is a bruise, we keep an eye, but if we are not concerned, then we do not do routine monitoring.<br><br>A policy for monitoring of resident bruises was requested on 5/1/24 at approximately 1:44 pm and followed up on 5/2/24 at 2:05pm, the DON indicated that the facility did not have a policy.<br><br>Based on Clinical Nursing Skills textbook, Ninth Edition, revealed under .Monitoring Skin Condition .15. Check for skin discoloration (e.g ecchymosis [commonly known as burise], petechiae, purpura, erythema .) Rationale: These signs may indicate generalized disease states .<br><br>Based on an article Adult Safeguarding Practice Guidance: Injuries of Unknown Origin: revealed .An injury of unknown source is a physical injury that 1. Was not observed and/or 2. cannot be immediately and adequately explained .Unexplained injuries or marks/bruising of unknown origin can appear for a variety of reasons. These may or may not be related to abusive interactions or safeguarding concerns and can include self-harm and self-injurious behaviors. Persons with disabilities and older persons should not be prevented from living as full a life as possible and there is clearly no way to prevent people experiencing bruises and scratches in any active or engaged lifestyle .Managers should routinely monitor and review data about incidents of unexplained injury. This is particularly important when the service user is the subject of repeated reports to ensure there are sufficient measures in place. Older/frail service users may be more prone and at greater risk of developing bruising for example .skin breakdown (as they may have thinner, drier skin) . Careful and ongoing monitoring, including assessing the severity of injury, where on the body the injuries are (using a body map[1]), noting the number of injuries (and whether it is one point in time or over period of time) .requires careful assessment/care planning and communication in order to ensure good practice . Services should have an agreed policies and procedure to assess, analyze, monitor and record any injuries of unknown origin on the body of the service user, as part of the overall safeguarding response .<br><br>https://www.hse.ie/eng/about/who/socialcare/safeguardingvulnerableadults/injuriesunknown.pdf |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18618<br><br>Based on observation, interview and document review, the facility failed to provide timely assistance with repositioning to minimize the development of pressure ulcer risk for 1 of 1 resident (R18) in accordance with the individualized care plan.<br><br>Findings include:<br><br>R18's quarterly Minimum Data Set (MDS) dated [DATE] and annual MDS dated [DATE], identified R18 with severe cognitive impairment and diagnoses including dementia, Parkinson's disease and anxiety disorder. The MDS also identified R18 was at risk for the development of pressure ulcers and requiring substantial/maximum assistance with bed mobility and transfers.<br><br>R18's pressure ulcer Care Area Assessment (CAA) dated 1/9/24, indicated R18 was at risk for the development of pressure ulcers.<br><br>R18's Braden Scale (pressure ulcer risk assessment) dated 4/3/24, identified R18 at moderate risk for the development or pressure ulcers.<br><br>R18's care plan dated 10/31/23, identified R18 at risk for the development of pressure ulcers and directed to reposition R18 every two hours while in bed. The care plan did not direct the staff on the frequency to reposition R18 while in a chair.<br><br>R18's April 2024, treatment record indicated R18 had an open area on buttocks which had resolved and the treatment had been discontinued on 4/5/24.<br><br>During continuous observations on 4/11/24 from 8:00 a.m. to 11:00 a.m., R18 was observed to be seated in a Broda (reclining wheelchair with bilateral supportive cushions) chair. At 8:00 a.m., R18 was in the dining room waiting for breakfast. At 8:13 a.m., R18 began eating breakfast independently. At 8:22 a.m. registered nurse (RN)-A sat next to R18 and assisted her with breakfast. At 9:11 a.m., R18 fell asleep in her chair. At 9:26 a.m., R18 was assisted to her room by nursing assistant (NA)-A and positioned in front of her television. At 10:00 a.m., NA-A wheeled R18 to the activity room. At 10:48 a.m., activity aide (AA)-A reclined R18's Broda chair a few inches.<br><br>During interview on 4/11/24 at 10:56 a.m., NA-A stated R18 had been assisted out of bed by the night shift and NA-A had not assisted R18 with repositioning since arriving at work at 6:30 a.m. (a total of four hours and thirty minutes). NA-A stated R18 was to receive assistance with repositioning every two to three hours.<br><br>During observation on 4/11/24, at 11:05 a.m., NA-A assisted R18 to transfer from the Broda chair to the bed. R18's Broda chair was observed to be equipped with a pressure redistribution cushion. Once in bed, R18's buttocks skin was observed to be bright pink, blanchable (adequate blood profusion when touched) and intact.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During interview on 4/11/24, at 1:55 a.m. licensed practical nurse (LPN)-A stated R18 was to receive assistance with repositioning before and after meals while up in the chair and every two hours while in bed in accordance with the care plan.<br><br>During interview on 4/11/24, at 3:20 p.m., the administrator stated the staff were to provide assistance with repositioning in accordance with the care plan.<br><br>The Wound Care Policy dated 4/1/22, directed the staff to provide wound care prevention in accordance to the National Pressure ulcer Advisory Panel. The policy did not direct the staff on a process to determine how frequently to assist dependent residents with repositioning to prevent pressure ulcer development. |

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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** 18618<br><br>Based on observation, interview, and document review, the facility failed to provide adequate supervision during the provision of care for 1 of 1 residents (R18) observed to be transferred inappropriately and had an injury of unknown origin. In addition, the facility failed to provide adequate supervision including an assistance devices, anti-roll back, timely for R46.<br><br>Findings include:<br><br>R18's quarterly Minimum Data Set (MDS) dated [DATE] and annual MDS dated [DATE], identified R18 with severe cognitive impairment and diagnoses including dementia, Parkinson's disease, and anxiety disorder. The MDS also identified R18 as weighing less than 100 pounds and requiring substantial assistance with transfers.<br><br>R18's care plan dated 10/23, directed staff to provide extensive assistance of two staff for transfers.<br><br>R18's clinical record lacked a comprehensive transfer assessment.<br><br>R18's Progress Note (nurses note) dated 3/27/24 at 6:00 a.m., indicated a night nursing assistant (NA)-E had reported a, big bruise on the left side of chin. R18 was questioned if she had fallen or hit her face and reported, no.<br><br>R18's initial Incident Report dated 3/27/24, identified the bruise with no witnesses to an event which resulted in bruising. The completed investigation dated 4/2/24, identified the bruise as 7 centimeters (cm) by 5 cm on the left chin. The investigation indicated the nurse practitioner would assess the area and determine if the bruise could be dental in origin. The report further indicated the bruise may have also been due to R18's chin pressing against clavicle or shoulder as R18 had a history of resting their head in a dependent position. R18 was not displaying concerns with meal intake or pain at the time of the assessment. The conclusion of the investigation indicated, Intentional harm is not suspected.<br><br>R18's Geriatrics for Follow Up Nursing Home (nurse practitioner examination) dated 3/28/24, indicated R18 was seen due to possible dental issues resulting in a bruise to the left side of chin. R18 had a history of sleeping in a bent position leaning toward the left side with her head and chin nearly touching her shoulder. R18 denied pain and no pain was observed as she ate all of her lunch. The nurse practitioner assessment identified the facial bruising ot the left distal chin as of unknown etiology, differential included trauma to jaw or dental concern of broken tooth, cavity, or abscess. The nurse practitioner indicated an abscess was unlikely a due to no reports of pain or other infectious symptoms.<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 observation on 4/11/24 at 11:05 a.m., R18 was seated in a Broda chair (reclining wheelchair) next to R18's bed. R18 had a fading dark purple to yellow bruise on the left side of her chin/jaw/neck, which was approximately 2 inches in diameter. Nursing assistant (NA)-A stood in between the chair and the bed, squatted in front of R18 and directed R18 to give me a big hug. R18 placed arms around NA-A's upper body as NA-A lifted R18 out of the chair, pivoted R18 and assisted R18 into bed. At no time was NA-A observed to utilize a gait belt or have assistance from another staff member during the transfer.<br><br>During observation on 4/11/24 at 11:27 a.m., NA-A and registered nurse (RN)-A assisted R18 to sit on the edge of the bed. NA-A squatted down in front of R18 and directed R18 to give me a big hug. RN-A backed away from the resident as NA-A assisted R18 from the bed back into the Broda (reclining wheel) chair. At no time was NA-A observed to utilize a gait belt or request assistance from RN-A for the transfer. RN-A stood next to NA-A but did not attempt to assist with the transfer.<br><br>During interview on 4/11/24 at 11:27 a.m., NA-A confirmed a gait belt was not utilized during the transfer as R18 was light enough to assist without a belt.<br><br>During interview on 4/11/24 at 11:30 a.m., RN-A confirmed NA-A did not utilize a gait belt, or two staff members as directed by the care plan.<br><br>During interview on 4/11/24 at 2:11 p.m., licensed practical nurse (LPN)-A confirmed the staff were to utilize gait belt for transfers and the number of staff as directed on the care plan.<br><br>During interview on 4/11/24 at 3:33 p.m., the administrator indicated all residents were to receive care according to their individualized care plans.<br><br>During a telephone interview on 4/19/24 at 8:30 a.m. the administrator gave permission for the State agency to complete telephone interviews with staff members.<br><br>During telephone interview on 4/19/24 at 9:53 a.m., LPN-A stated R18 frequently bent her neck and had her chin positioned next to her left side of the body. LPN-A had interviewed R18 on 3/27/24, and R18 was orientated to self, place (the name of the facility) and the month only. R18 denied being fearful of any staff members thus LPN-A documented no intentional harm and reported that [R18] felt safe.<br><br>During telephone interview on 4/19/24 at 10:08 a.m., the director of nurses (DON) stated the facility felt the bruise was due to a dental concerns and the facility had not completed any type of investigation to determine the origin of the bruise even after the NP had determined it was not likely dental related.<br><br>During telephone interview on 4/19/24 at 10:40 a.m., LPN-A stated they had completed an abnormal involuntary movement scale (AIMS) on 3/26/24, (the day before the bruise was identified) which included observation of R18's face. At that time R18 did not have any type of facial bruising at the time of the assessment. In addition, LPN-A stated R18 was to be transferred by one staff and a gait belt.<br><br>During telephone interview on 4/19/24 at 11:15 a.m., RN-C stated NA-E reported R18 had facial bruising on 3/27/26 at 6:00 a.m. and RN-C had completed the facility incident report.<br><br>(continued on next page) |

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| | 245229 | A. Building<br>B. Wing | 05/02/2024 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During telephone interview on 4/19/24 at 11:22 a.m., NA-F stated R18 transferred with two staff members and did not require any type of additional assistive devices. According to NA-F, R18 was not resistive to cares and NA-F was unaware of how R18 had sustained the bruise.<br><br>During telephone interview on 4/19/24 at 11:36 a.m., NA-G stated R18 required assistance with transfers which included one staff member. NA-G stated they frequently would assist R18 by placing one arm under R18's shoulder/neck area and one under R18's buttocks/thighs. NA-G would then pick up R18 from the reclining chair and place them into bed or vice versa (like one would pick up a child). NA-G stated they did not have any type of problems with the transfer as R18 was small in stature and did not weigh very much. R18 was not resistive during the transfers and R18's body did not touch NA-G's body during the transfer. NA-G stated they were not aware any other staff members transferring R18 in this manner, but it worked well for them. NA-G denied any instance in which they had difficulties transferring R18 such as near miss falls or quick sudden adjustments while positioned in their arms. NA-G had transferred R18 in this manner on 3/26/24, prior to the bruising being noted.<br><br>During telephone interview on 4/19/24 at 2:36 p.m., NA-H stated R18 transferred with assistance of two staff members. R18 was not resistive to transfers and was able to stand, pivot and sit on the bed or chair without difficulties. NA-H denied R18 having difficulties or resistive behaviors during transfers.<br><br>During telephone interview on 4/19/24 at 2:46 p.m., NA-E stated R18 required two staff for transfers. R18 was not resistive to cares. NA-E had reported the facial bruising to the nursing staff the morning of 3/27/24. During the night, the staff did not turn the overhead lights on until R18 was ready to get out of bed. During the night, R18 received incontinence cares via light from the bathroom or hallway. The main overhead light was not turned on until 3:00 - 5:00 a.m. At that time R18 was noted to have facial bruising which was reported to the nursing staff. NA-E was unaware of how R18 would have sustained facial bruising.<br><br>On 4/19/24 at 3:00 p.m. the DON, administrator and LPN-A were interviewed. The DON stated the cares for each resident were communicated to the staff members via a Kardex system (written notes), on the Tasks section of the electronic medical record and on the resident care plans. The staff members were to transfer R18 with assistance of two staff as directed by the care plan. The nurses supervised the direct care staff to ensure they were following the resident care plans. The DON, administrator and LPN-A were informed of the discrepancies between the transfers styles utilized by the staff: one person transfer, two-person transfer and full body lift without a mechanical lift, like you would pick up a child. The DON confirmed a potential for personal injury for a resident transferred like a child. The DON stated if the facility had been aware of the discrepancies of transfer styles, they may have approached the facial bruising that R18 sustained differently.<br><br>The undated Policy on Transfers directed the staff to utilize appropriate assistive device to assist with transfers.<br><br>18987<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 4/3024, review of R46's clinical record revealed this is a [AGE] year old senior who has been residing in the facility over a year. Upon admission, the facility identified R46 is at high risk of fall and developed a care plan related to fall prevention. The licensed nurses should review information on past falls and attempt to determine the cause. Record possible root causes. Alter/remove any potential causes if possible. Educate resident, family, caregiver, Interdisciplinary team (IDT) as to causes. In addition, the facility staff remind R46 to lock wheelchair if independently completing ADL (activities of daily living) in wheelchair.<br><br>On /30/24 at 11:30 a.m., observation of R46, who was sitting in a wheelchair in the hallway, revealed the resident is alert and oriented to person. A quarter size purple bruise was noted on the resident's right forearm, closed on the right wrist. The resident reported having bruises all over her body by pointing to the body trunk. No sign or symptom of pain or fear was noted.<br><br>Review of health status note dated 3/26/24 at 8:08 a.m., revealed R46 was found sitting on the floor at 6:15 a.m., but unable to recall what caused the fall. LPN-E completed head to toe skin check and no injuries noted. LPN-E documented that R46 apparently trying to self-transfer without assistance from bed to wheelchair, which was next to the bed. The wheelchair was found unlocked. Further review of Documentation Survey Report v2 Mar-24 revealed the facility staff documented on 3/26/24 that R46 had been reminded to lock the wheelchair. It is unknown who unlocked the wheelchair while the resident was in bed on 3/26/24 and whether any additional intervention was implemented after the fall on 3/26/24.<br><br>Review of the Post Fall Evaluation dated 3/29/24 at 11:00 a.m., revealed an unwitnessed fall was recorded. R46 reported that I was reaching for the phone and slide out of my wheelchair. The wheelchair was unlocked at time of the fall. No new injury was noted. Further review of Documentation Survey Report v2 Mar-24 revealed the facility staff documented on 3/29/24 that R46 had been reminded to lock the wheelchair.<br><br>On 4/1/24, LPN-A documented in the facility's incident report that the fall on 3/26/24 likely occurred due to attempted self-transfer into unlocked wheelchair with wheelchair moving, resulting of the fall. A work order to install an anti-rollback device was completed.<br><br>However, review of the fall prevention on 4/30/24 and 5/1/24 revealed the facility staff reminded R46 to lock wheelchair if independently completing ADL in wheelchair, but no additional preventative measures provided before the installment of the anti-rollback device.<br><br>On 4/8/24, a care conference was held, but there is no evidence the care plan of fall prevention was updated to include the anti-rollback device.<br><br>On 4/30/24 at 4:00 p.m., observation of R46 during toileting, which was provided by NA-I, revealed no anti-rolling back device was found on the resident's wheelchair. No bruise was noted on the resident's body trunk (chest, abdomen and back).<br><br>On 5/1/24 at 12:00 p.m., R46 was found lying in bed with her eyes closed. A wheelchair (without anti-rolling device) with a folded pink cloth pad was seen next to the bed. There was a wheelchair with an anti-rolling device and a seat cushion with a hump in the front of cushion found next to the TV stand. The TV stand was located at the end of the bed.<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 5/1/24 at 2:30 p.m., interview of LPN-A revealed the wheelchair with anti-rolling device and a seat cushion with a hump in the front of the cushion was delivered to the resident's room in the morning of 5/1/24.<br><br>On 5/1/24 at 4:00 p.m., observation of R46 revealed the resident was sitting in the wheelchair (without anti-rolling back device) at the table next to NA-K in a common area. NA-I and NA-K were planning to return the wheelchair (with anti-rolling back device and a seat cushion with a hump in the front of the cushion) to the lower level before dinner. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18618<br><br>Based on observation, interview and document review, the facility failed to provide timely assistance with incontinence cares for 1 of 1 resident (R18) in accordance with the individualized care plan.<br><br>Findings include:<br><br>R18's quarterly Minimum Data Set (MDS) dated [DATE] and annual MDS dated [DATE], identified R18 with severe cognitive impairment and diagnoses including dementia, Parkinson's disease and anxiety disorder. The MDS also identified R18 as being dependent on staff for toileting hygiene, frequently incontinent of bowel and bladder and requiring substantial assistance with transfers.<br><br>R18's urinary incontinence Care Area Assessment (CAA) dated 1/9/24, indicated R18 was incontinent of urine and required extensive assistance for toileting.<br><br>R18's Comprehensive and Restorative Bowel and Bladder Evaluation dated 4/8/24, directed the staff to provide scheduled incontinent care and comfort.<br><br>R18'2 care plan dated 10/31/23, directed the staff to check R18 every two hours and assist with toileting as needed.<br><br>During continuous observations on 4/11/24 from 8:00 a.m. to 11:00 a.m., R18 was observed to be seated in a Broda (reclining wheelchair with bilateral supportive cushions) chair. At 8:00 a.m., R18 was in the dining room waiting for breakfast. At 8:13 a.m., R18 began eating breakfast independently. At 8:22 a.m. registered nurse (RN)-A sat next to R18 and assisted her with breakfast. At 9:11 a.m., R18 fell asleep in her chair. At 9:26 a.m., R18 was assisted to her room by nursing assistant (NA)-A and positioned in front of her television. At 10:00 a.m., NA-A wheeled R18 to the activity room. At 10:48 a.m., activity aide (AA)-A reclined R18's Broda chair a few inches.<br><br>During interview on 4/11/24 at 10:56 a.m., NA-A stated R18 had been assisted out of bed by the night shift and NA-A had not assisted R18 with toileting since arriving at work at 6:30 a.m. (a total of four hours and thirty minutes). NA-A stated R18 was to receive assistance with toileting two to three hours.<br><br>During observation on 4/11/24, at 11:05 a.m., NA-A assisted R18 to transfer from the Broda chair to the bed. NA-A assisted R18 with incontinence cares as R18 was incontinent of urine.<br><br>During interview on 4/11/24, at 1:55 a.m. licensed practical nurse (LPN)-A stated R18 was to receive assistance with incontinence cares every 2-3 hours.<br><br>During interview on 4/11/24, at 3:20 p.m., the administrator stated the staff were to provide assistance with incontinence cares in accordance with the care plan. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18618<br><br>Based on observation, interview and document review, the facility failed to provide nonpharmacological interventions prior to the administration of as needed antianxiety medications for 1 of 1 resident (R18) utilizing antianxiety medications.<br><br>Findings include:<br><br>R18's quarterly Minimum Data Set (MDS) dated [DATE] and annual MDS dated [DATE], identified R18 with severe cognitive impairment and diagnoses including dementia, Parkinson's disease and anxiety disorder. The assessments indicated R18 displayed no mood or behavior concerns.<br><br>R18's psychotropic medication Care Area Assessment (CAA) dated 1/9/24, indicated R18 received psychotropic medications for behavior management. The CAA did not include nonpharmacological interventions the staff were attempt prior to the administration of medications.<br><br>R18's physician orders dated 2/26/24, indicated R18 had been receiving Lorazepam (Ativan- antianxiety medication) .5 milligram (mg) in the morning and 1 mg in the evening since 1/23/24. However, on 2/26/24, the order was decreased to .5 mg every two hours as needed for anxiety because R18 had displayed lethargy.<br><br>R18's care plan dated 3/4/24, indicated R18 utilized psychotropic and antianxiety medications related to behaviors. The plan identified R18's behaviors as pulling at /our hair, biting nails and yelling out. The plan directed the staff to monitor R18's behaviors. The care plan did not direct the staff to administer antianxiety medications or nonpharmacological interventions to be attempted prior to the administration of medications.<br><br>R18's February 2024 medication administration record (MAR) indicated R18 had received Lorazepam 0.5 mg on :<br><br>- 2/27/24 at 8:36 a.m.<br><br>R18's March 2024, MAR indicated R18 had received Lorazepam 0.5 mg on:<br><br>-3/14/24 at 8:57 a.m.<br><br>-3/19/24 at 12:37 p.m.<br><br>-3/21/24 at 3:54 p.m.<br><br>-3/23/24 at 12:28 p.m.<br><br>-3/23/24, at 5:33 p.m.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -3/28/24 at 4:05 p.m.<br><br>R18's April 2024 MAR indicated R18 had received Lorazepam 0.5 mg on:<br><br>- 4/3/24 at 4:39 p.m.<br><br>- 4/6/24 at 12:04 p.m.<br><br>- 4/7/24 at 12:42 p.m.<br><br>-4/9/24, at 8:24 a.m.<br><br>R18's Behavior Monitoring and Intervention Reports from 1/5/24 - 4/11/24, indicated R18 did not display any type of behavior and no non-pharmacological interventions had been attempted prior to giving the Lorazepam for any of the doses provided during this time frame.<br><br>R18's clinical record lacked identification of the nonpharmacological interventions prior to the administration of the medication doses given 1/5/24 through 4/11/24.<br><br>During interview on 4/10/24 at 12:05 p.m., family member (FM)-A stated R18 frequently called out repetitive phrases and questioned if the staff responded to R18's concerns. FM-A stated R18 had dementia and had recently lost their spouse after many years of marriage.<br><br>During observations on 4/11/24, the following expressions of distress/behaviors were identified:<br><br>- At 9:20 a.m., R18 was seated in a Broda chair (reclining wheelchair) in the dining room and stated, Take me back to my room.<br><br>- At 9:22 a.m., R18 stated, Get me out of here.<br><br>-At 9:23 a.m., R18 stated please help me I am stuck nursing assistant (NA)-B directed R18 and informed R18 they were fine. R18 stated No I am not, I am stuck. Please help me.<br><br>- At 9:26 a.m., NA-A wheeled R18 to their room NA-A left the room as R18 stated Please help me.<br><br>- From 9:26 a.m. to 9:50 a.m. R18 repeated the phrases Help me, I am stuck. while seated in R18's room.<br><br>No staff approached and provided any type of non-pharmacological observations to R18, even though they were calling out from 9:20 a.m. to 9:50 a.m.<br><br>R18's Progress Notes (nurses notes) from 3/14/23 - 4/11/24, identified each time R18 was given a Lorazepam tablet for anxiety. The rational was identified for repetitive phrases such as help me, I am stuck. Two hours after the administration of the medication, a second note was documented indicating the medication was effective. The clinical record lacked a comprehensive evaluation of the scheduled Lorazepam vs when the Lorazepam was decreased to an as needed basis.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During interview on 4/11/24 at 9:50 a.m., licensed practical nurse (LPN)-B stated R18 called our repeatedly.<br><br>On 4/11/24 at 10:00 a.m. NA-A assisted R18 from the private room to the activity room.<br><br>On 4/11/24 at 11:02 a.m., NA-A was observed to assist R18 with cares as R18 stated, Please help me, I am stuck. NA-A stated R18 called out all the time, however, there were no specific interventions to assist her to stop calling out.<br><br>On 4/11/24 at 2:04 p.m., licensed practical nurse (LPN)-A stated R18 displayed daily behaviors of yelling out repeatedly. R18 utilized Lorazepam as needed for anxiety and the behaviors were to be monitored. The nursing staff documented what type of behavior, R18 displayed at the time of the medication administration and one to two hours later would identify if the medication was effective. LPN-A confirmed the clinical record lacked a comprehensive evaluation of R18's repetitive phrases in relationship to the medication. In addition, LPN-A verified the record lacked nonpharmacological interventions to be utilized prior to the administration of antianxiety medications.<br><br>On 4/11/24 at 2:31 p.m., registered nurse (RN)-A stated R18 did not display behaviors, R18 simply yelled out phrases like I am stuck repeatedly throughout the day. RN-A stated when this happened, the staff were to offer comfort measures such as assisting R18 to the restroom, offering a drink of water, engage R18 in an activity or conversation. RN-A confirmed repetitive yelling was indicative of a behavior and staff responded to R18. RN-A verified R18's care plan identified yelling out as a behavior and confirmed the plan did not include nonpharmacological interventions to be attempted prior to the administration of antianxiety medications.<br><br>On 4/11/24 at 3:33 p.m., the administrator confirmed R18 received as needed antianxiety medication. R18 was discussed at the facility behavior meetings. Upon review of the behavior committee meeting minutes, the administrator stated R18's medication were discussed, however, specific nonpharmacological interventions were not included in the minutes. The administrator verified nonpharmacological interventions were to be implemented prior to the administration of antianxiety medications.<br><br>On 4/11/24 at 4:00 p.m. the director of health center sales and services (a licensed social worker) stated R18 had displayed repetitive calling out behaviors for a long time. The director of health services verified the care plan did not include nonpharmacological interventions for manage behaviors.<br><br>A policy related to antianxiety medication was requested and none was provided. |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | Administer the facility in a manner that enables it to use its resources effectively and efficiently.<br><br>38053<br><br>Based on interview and document review, the facility's Administration failed to take appropriate action in a timely manner to address injuries of unknown origin and bruises for 4 of 4 residents (R18, R30, R46, & R57) reviewed for Administration.<br><br>Findings include:<br><br>1. Review of the facility's internal incident report regarding R18's facial bruise, dated 3/27/24, revealed that R18 suffered a big bruise on the left side of the chin. Nursing assistant (NA)-E reported the incident to registered nurse (RN)-C and confirmed that R18's bruise was about the size of a small ball. The unit manager, licensed practical nurse (LPN)-A was informed by RN-C about R18's left facial bruising at 6:17 a. m. on 3/27/24. A summary of the investigation was completed on 4/2/24.<br><br>During an interview on 4/30/24 at 12:36 p.m., the director of nursing (DON) stated LPN-A had informed her about R18's left facial bruising on 3/27/24, at around 8:00 am. The incident was also discussed in an interdisciplinary team (IDT) stand-up meeting. The DON mentioned that LPN-A's initial assessment was that it [R18's facial bruise] could be related to dental issues, and the DON had informed their Nurse Practitioner about it. When asked, the DON confirmed that the administrator was the investigator for the facility and was aware of the left facial bruising. The DON also verified that the facility had determined the bruising to be an injury of unknown origin. Furthermore, when informed by LPN-A, the DON did not see or assess R18.<br><br>On 4/30/24 at 1:00 p.m., the DON presented a screenshot of LPN-A's text message to the DON and the administrator regarding R18's left facial bruise on 3/27/24 at 7:41 a.m., indicating that the administrator and the DON were aware of R18's facial bruise. Despite the DON and administrator being aware of R18's facial bruise with unknown origin, survey investigations from 4/10/24 to 5/1/24. revealed the facility failed to report the injury of unknown origin to the state agency, conduct thorough investigation, and implement appropriate action to prevent incurring further bruises and/or injuries.<br><br>In a follow-up interview on 5/1/24 at 1:44 p.m., the DON indicated that no formal tool was utilized by the facility to investigate the root causes of incidents thoroughly. When asked what actions were taken to protect R18 from further incurring a bruise, the DON stated, I do not know.<br><br>In an interview on 5/1/24 at 2:53 p.m., the administrator stated LPN-A had collected and summarized all the information regarding R18's left facial bruising on 3/27/24 in the facility's internal incident report. When asked who was responsible for investigating allegations of abuse and/or injuries of unknown origin, the administrator replied that it depended on who [which facility staff discovers an injury of unknown origin?] and that she [the administrator] primarily served as a contact person. The administrator also acknowledged that R18's left facial bruising could have been considered suspicious due to its location, but it was not deemed reportable by the facility. The administrator also indicated that no formal tool was utilized by the facility to investigate the root causes of incidents thoroughly, and stated, We learn through practice.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245229 | A. Building<br>B. Wing | 05/02/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Friendship Village of Bloomington | 8100 Highwood Drive<br>Bloomington, MN 55438 |

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

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | 2. Review of R30's progress notes revealed 4/2/24 10:05 pm .The resident [sic] daughter called the attention of the writer regarding a bruise she found on her mother, from the middle calf to her left foot. The nurse confirmed it after looking at the leg and assessing it, which is about four inches in length. The writer asked how she got the bruise; she said she didn't remember. The writer and her daughter believe she bumped her foot into something .<br><br>A review of the [Electronic Medical Record, EMR] Risk Management notes revealed that the DON and administrator were notified of R30's left calf and foot bruise on 4/11/24, indicating that the DON and administrator were aware of R30's bruise of unknown origin. However, despite the DON and administrator being aware of R30's left calf/foot bruise with unknown origin, survey investigations from 4/30/24 to 5/1/24 revealed the facility failed to report the injury of unknown origin to the state agency, conduct thorough investigation, and implement appropriate action to prevent incurring further bruises and/or injuries.<br><br>3. Review of R46's progress notes revealed, 3/26/24 8:08 am .Resident [R46] was found on the floor at 0615 by CNA after she was heard calling out she was sitting on the floor .<br><br>3/26/24 1:31pm .new, Issue Type: bruising. Location: Right forearm. Length (cm - [centimeter]) 4.5 Width (cm) 4;<br><br>New. Issue type: Bruising. Location: Right lower arm. Length (cm) 3.8 Width (cm) 3.5;<br><br>New. Issue type: Bruising. Location: Right medial thigh. Length (cm) 2.4 Width (cm) 2.6;<br><br>New. Issue type: Bruising. Location: Right anterior elbow. Length (cm): 3.8 Width (cm): 3 .<br><br>A review of the [EMR] Risk Management notes revealed that the DON and administrator were notified regarding R46 being found on the floor with bruising on 4/1/24, indicating that the DON and administrator were aware of R46's incident. However, despite the DON and administrator being aware of R46's bruises on right forearm, right lower arm, right anterior (upper) elbow, and right medial (inner) thigh with unknown origin, survey investigations from 4/30/24 to 5/1/24 revealed the facility failed to report the injury of unknown origin to the state agency, conduct thorough investigation, and implement appropriate action to prevent incurring further bruises and/or injuries.<br><br>4. Review of R57's progress notes revealed, 4/11/24 3:41 pm .Writer was told by [nurses'] aide that she seen [sic] a bruise on resident's wrist. Writer assessed bruise and noted a 5.5 cm x 4 cm bruise around resident's [R57] left wrist. Writer notified [name of LPN-A] nurse manager .<br><br>Review of the facility's internal incident report dated 4/11/24 revealed R57 had sustained a 5.5 cm x 4 cm bruise around her left wrist area. LPN-A completed a summary of the investigation on 4/19/24.<br><br>A review of the [EMR] Risk Management notes revealed that the DON and administrator were notified of R57's wrist bruise with unknown origin on 4/22/24, indicating that the administrator and DON were aware of R57's incident. However, despite the DON and administrator being aware of R57's bruise around her left wrist with unknown origin, survey investigations from 4/30/24 to 5/3/24 revealed the facility failed to report the injury of unknown origin to the state agency, conduct thorough investigation, and implement appropriate action to prevent incurring further bruises and/or injuries.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | During an interview on 5/1/24 at 1:44 p.m., the DON was asked about the facility's process for identifying, reporting, and investigating injuries of unknown origin and/or bruises and actions implemented to prevent further occurrence of bruises. The DON explained that the unit managers were responsible for collecting information about such incidents, which was then discussed during the facility's interdisciplinary team stand-up meetings held twice a day. During these meetings, the DON and/or the administrator would determine whether an incident was reportable to the state agency. Additionally, the unit managers would investigate these incidents and provide a summary of their findings in the facility's internal incident report system within five days.<br><br>During an interview on 5/1/24 at 2:53 p.m., the administrator was asked about the facility's process for identifying, reporting, and investigating injuries or bruises of unknown origin and actions implemented to prevent further occurrence of bruises. In response, the administrator stated LPN-A (unit manager) was responsible for gathering information and summarizing the investigation. The administrator indicated the DON and LPN-A worked together to investigate concerns, she also acknowledged there was no formal process in place. She mentioned she held IDT stand-up meetings twice daily to review and discuss all incidents and noted her role as the Contact Person. When asked about who the facility's investigator was, the administrator stated she was not the investigator herself and it depended on whose responsibility it was. The administrator went on to state the facility's unit managers were responsible for sending reports to the state agency. |