STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245490	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Hills Living Center	1314 Eighth Street North New Ulm, MN 56073

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49616 Based on observation, interview, and document review the facility failed to develop and implement an individualized toileting care plan based off the comprehensive assessment for 1 of 3 residents (R1) who were identified for toileting. Findings include: R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 had moderate cognitive impairment. R1 had no falls in the past six months. R1 required supervision/touch assist for sit to stand, chair to bed, bed to chair, walking, toileting, and toileting hygiene. R1 required intermittent catheterization and had not done a toileting program. R1's bladder evaluation dated 1/18/24, identified R1 had a history of urinary incontinence and urinary tract infections (UTI). R1 was frequently incontinent. Conditions impacting urinary status included pain, edema, diabetes, and urinary disorders. Physical functioning status listed one-person physical assist for bed mobility, transfer, walking, toileting, and personal hygiene. Voiding status identified R1 had the perception of needing to void, dribbled after void, and urinary retention. R1's usual elimination was upon rising, after breakfast, after lunch, after dinner, at bedtime, during the night, and intermittent cath after voiding. Evaluation for bladder program potential left blank. Summary of frequency plan identified schedule bathroom use per schedule listed in 'other' category per resident request. R1's bladder evaluation dated 2/6/24, identified R1 had a history of urinary incontinence and urinary tract infections (UTI). R1 was frequently incontinent. Conditions impacting urinary status included pain, edema, diabetes, and urinary disorders. Physical functioning status listed one-person physical assist for bed mobility, transfer, walking, toileting, and personal hygiene. Voiding status identified R1 had the perception of needing to void, dribbled after void, urinary retention, and fills bladder/voids large amounts. R1's usual elimination was upon rising, after breakfast, after lunch, after dinner, at bedtime, during the night, and intermittent cath after voiding. Post-voiding perception and residual urine evaluation left blank, residual urine marked yes and amount emptied was unknown with intermittent cath after voiding. Evaluation for bladder program potential left blank. Summary of frequency plan identified schedule bathroom use per schedule listed in 'other' category per resident request. (continued on next page)

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's activities of daily living care plan dated 1/11/24, identified R1 had altered self-care performance, limited physical mobility and need for assist. Interventions included: -one-person physical assist with toileting and transferring on/off toilet, use four wheeled walker (4WW). -one-person assist with transfers and ambulation using gait belt and 4WW. R1's elimination care plan dated 1/11/24, identified altered urinary pattern related to functional incontinence, history of urinary tract infection, stress incontinence, urinary retention, neurogenic bladder, and straight catheter use. Goal was that R1 would show no signs or symptoms of urinary infection. Interventions included: -attempt to identify individual toileting habits/voiding pattern through observation & interview with resident/family/caregivers. 1/11/24 In review of R1's record it was not evident R1's care plan was developed and/or revised with R1's usual toileting times that were identified on the comprehensive bowel and bladder assessment dated [DATE] and 2/6/24. R1's record identified that R1 sustained nine falls between 1/11/24 and 3/29/24. Seven of R1's falls were related to R1 self-transferring to the toilet; all of those falls occurred after 8:00 p.m. on the evening and overnight shift. During an interview on 4/10/24 at 10:40 a.m., with nursing assistant (NA)-A and NA-B, NA-A stated before R1's fall that led to his fracture he would self-transfer and staff knew if the bed alarm went off he was up in the bathroom toileting. During an interview on 4/11/24 at 1:24 p.m., NA-D stated most of the time staff would just catch R1 in the bathroom toileting himself. NA-D was unaware of any specific toileting times for R1. During an interview on 4/11/24 at 2:22 p.m., RN-A stated R1 did not have an individualized toileting plan and she was not sure why. During an interview on 4/11/24 at 2:41 p.m., director of nursing (DON) stated that it was the expectation that all residents are screened for toileting by the therapy department. Policy was not provided

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49616 Based on observation, interview, and document review, the facility failed to comprehensively assess each fall and identify causal factors to determine reason for falls, identify potential effective interventions to decrease the risk for falls, failed to comprehensively evaluate and implement fall interventions for 2 of 3 residents (R1, R3) reviewed for falls. The facility's failures resulted in an immediate jeopardy for R1 who sustained a right hip fracture from the 9th fall. The IJ began on 3/28/24, when the facility failed to complete a comprehensive causal analysis, and implement appropriate interventions after R1 self-transferred to the bathroom resulting in his 9th fall from self-transfers which subsequently resulted in, hospitalization , and right hip fracture with surgical repair. The administrator and director of nursing (DON) were notified of the IJ on 4/11/24 at 6:17 p.m. The IJ was removed on 4/12/24 at 5:22 p.m. after it could be verified that the facility had implemented an acceptable removal plan, however, non-compliance remained at D isolated severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's face sheet identified R1 had diagnosis that included, neuropathy (nerve damage that numbness in extremities), vascular dementia, urinary retention, weakness, unsteadiness on feet, muscle wasting and atrophy (wasting or thinning of muscle mass). R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 had moderate cognitive impairment. R1 had no falls in the past six months. R1 required supervision/touch assist for sit to stand, chair to bed, bed to chair, walking, toileting, and toileting hygiene. R1 required intermittent catheterization and had not done a toileting program. R1's MDS did not identify falls prior to residing at the facility. R1's Fall Risk assessment dated [DATE], identified R1 did not have a history of falls in the past six months, occasional incontinence, required hands on assistance to move from place to place, and used an assistive device. Summary identified that R1 had a score of 16 which placed R1 at a high fall risk, family reported no falls in the last six months and R1 used a walker and assist of one for all transfers with intermittent confusion noted. R1's care plan dated 1/11/24, identified R1 had a risk of falls related to (r/t) dementia, history of falls, and noted self-transferring. Goals included R1 would not experience falls and would be free of injury through review date. R1's care plan dated 1/11/24, identified R1 had altered self-care performance, limited physical mobility r/t dementia, pain, weakness and need for assist. Interventions included: -one-person physical assist with toileting and transferring on/off toilet, use four wheeled walker (4WW). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-assistance with adjusting clothing, incontinence care, applying incontinence product, wiping self, and pericare. -encourage to use call light for assistance. Ensure call light is within reach. -one-person physical assist with bed mobility. -one-person assist with transfers and ambulation using gait belt and 4WW. R1's bladder evaluation dated 1/18/24, identified R1 had a history of urinary incontinence and urinary tract infections (UTI). R1 was frequently incontinent. Conditions impacting urinary status included pain, edema, diabetes, and urinary disorders. Voiding status identified R1 had the perception of needing to void, dribbled after void, and urinary retention. R1's usual elimination was upon rising, after breakfast, after lunch, after dinner, at bedtime, during the night, and intermittent cath after voiding. Evaluation for bladder program potential left blank. R1's care plan dated 1/11/24, identified R1 had altered urinary pattern related to functional incontinence, history of urinary tract infection, stress incontinence, urinary retention, neurogenic bladder, and straight cath use. Goals included R1 will show no signs/symptoms of urinary infection, and decrease frequency of urinary incontinence. Interventions included: -catheterize twice per day by staff and as needed (PRN), monitor urine outputs (voided and post cath) -attempt to identify residents individual toileting habits/voiding pattern through observation and interview staff/family Although R1's comprehensive bladder assessment dated [DATE] identified R1's usual toileting routine was prior to facility admission, R1's care plan did not address R1's toileting routine according to the assessment. The falls are identified as follows: R1's progress noted dated 1/12/24 at 4:11 a.m., identified R1 self-transferred into bed from recliner chair and was reminded again to use the call light. At 4:49 a.m., R1 was found taking self back from bathroom without walker and did not use the call light. R1's progress note dated 1/13/24 at 5:26 a.m., identified R1 self-transferred twice to the bathroom, once using his call light and once not using it. R1's Incident Report dated 1/19/24, identified that R1's call light went off around 11:15 p.m. R1 was found laying on the left side by the recliner. Call light was underneath resident and pulled out from wall. R1 stated that his legs gave out on him twice-once in the bathroom and once on his way back from the bathroom. Predisposing factors included R1 did not use the call light consistently, call light in reach, improper footwear, and ambulated without assistance. Intervention included call light clipped to R1's shirt and ice packs applied to back/hip and left side of head, and gripper socks applied. R1's care plan was revised on 1/19/24, to include ensure gripper socks are on. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's progress note dated 1/20/24 at 9:45 p.m., identified R1 had been self-transferring all afternoon and not using the call light. R1 had been reminded throughout the evening to use the call light and was shown multiple times how to. R1's Incident Report dated 1/21/24, identified R1's call light went off around 2:30 a.m. R1 was found kneeling on floor next to bed holding on to side rail. R1 stated he was coming back from the bathroom and his legs gave out. Added a double touch call light with one call light clipped to R1 and the other call light on outer edge of bed. Predisposing factors included incontinence, gait imbalance, impaired memory, does not use call light consistently, ambulating without assist, used wheeled walker, and call light in reach. Interventions included call light clipped to shirt and gripper socks on. R1's care plan was revised on 1/21/24 to include ensure double touch call light in place, with one call light clipped to shirt and one on outer edge of bed. R1's Fall Risk assessment dated [DATE], identified R1 had a recent fall history of 1-2 times in the past six months, occasional incontinence, required hands on assistance to move from place to place, exhibits loss of balance while standing, uses short discontinuous steps and/or shuffling gait, and used assistive device. Documented date of recent falls on 1/19/24, and 1/21/24. Summary identified R1 now had a score of 20 and placed him at a high fall risk, used walker and assist of 1 for all transfers and R1 noted to often self-transfer despite education and intermittent confusion noted and to see care plan for interventions. R1's care plan was revised on 1/24/24 to include ensure bed alarm is on at all times when resident is in bed. R1's Physical Therapy (PT) discharge date d 1/29/24, identified that R1 required partial to moderate assist with transfers, ambulation, and bed mobility. R1's Occupational Therapy (OT) discharge date d 1/29/24, identified R1 required touching assist with toileting tasks, toilet transfer, and dressing. R1's progress notes reviewed between 1/30/24 to 2/15/24 identified R1 had been found by staff self-transferring 21 times. Thirteen (13) of R1's self-transfers were toileting related and of those 13 self transfers, 10 were between 8:56 p.m. and 6:30 a.m. (the other three did not identify reason for self-transfer) The record identified the self transfers occurred on 1/30/24, 1/31/24, 2/1/24, 2/2/24, 2/4/24, 2/5/24, 2/8/24, 2/9/24, 2/11/24, 2/14/24 and 2/15/24. There was no indications a comprehensive assessment and/or care plan revision was completed that addressed the mitigation of falls related to R1's self transfers to the bathroom. R1's progress note dated 2/15/24 at 12:15 a.m., identified R1 self-transferred throughout shift. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Incident Report dated 2/15/24 at 2:40 a.m., identified R1 yelled for help and staff found him resting his head on the foot pedals of the scooter with legs in the doorway of the bathroom and he was lying on his back. R1 was continent, bed alarm was on and blinking but did not go over staff pagers, gripper socks were on. R1 stated he used his walker, and did not use the call light. R1 stated he lost his balance and hit the wall and slid down to the floor because his knees also gave out. Identified an abrasion to upper-mid back, left lower back and bruising to left elbow, right elbow, and left inner wrist. Predisposing factors included drowsy, gait imbalance, impaired memory, weakness/fainted, ambulating without assist, call light in reach, does not use call light consistently, bed alarm, used wheeled walker. Interventions included education to R1 to use his call light, and to sit on the toilet instead of standing in front of it. No revision to the care plan was evident. R1's Fall Risk assessment dated [DATE], identified a score of 22 and placed him at a high fall risk. Risk factors included occasional incontinence, exhibits loss of balance while standing, uses short discontinuous steps and/or shuffling gait, and used assistive device. R1 used walker and assist of 1 for all transfers and R1 noted to often self-transfer despite education and intermittent confusion noted. See care plan for interventions. R1's progress note dated 2/21/24 at 4:16 a.m., identified R1 toileted self. At 8:09 p.m., R1 toileted self. R1's progress note dated 2/23/24 at 2:52 a.m., identified R1 took self to the bathroom. Again, at 3:04 a.m., R1 took self to the toilet. R1's progress note dated 2/26/24 at 3:28 a.m., identified R1 toileted self. At 10:32 p.m., R1 toileted self. R1's progress note dated 2/27/24 at 4:39 a.m., R1 toileted self. R1's progress note dated 2/28/24 at 5:31 a.m., identified R1 toileted self. R1's Incident Report dated 3/1/24 at 10:00 p.m., identified R1 was found lying on his stomach with his head at the end of his bed and feet facing towards his room door. R1 stated he hit the left side of his forehead on the bed, and that his back, head, and ribs hurt and rated the pain 5/10. Staff identified no injuries at this time. R1 stated he was trying to get a shirt out of the closet and his legs slipped. Predisposing factors included gait imbalance, impaired memory, weakness/fainted, ambulating without assist, call light in reach, and does not use call light consistently. Intervention was hourly safety checks. The care plan was revised on 3/1/24 to include the hourly safety checks. R1's Point of Care (POC) hourly safety checks dated 3/12/24 through 4/12/24 identified the hourly safety checks were not consistently completed; checks occurred anywhere between one hour and seven hours apart. R1's Fall Risk assessment dated [DATE], identified a score of 22 and placed him at a high fall risk. There was no change from the previous assessment dated [DATE]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Incident Report dated 3/4/24 at 3:15 a.m., identified R1's bed alarm went off and when staff entered R1's room the walker was seen by the bathroom entrance and R1 was found sitting on buttocks on the floor next to the sink and the wall. Urine was noted to be on the floor next to the toilet and gripper socks were wet with urine. R1 stated he was trying to go to the bathroom and his legs gave out. Predisposing factors included water/urine on floor, gait imbalance, does not use call light consistently, ambulating without assist, using bed alarm, using wheeled walker, and call light within reach. Intervention was R1 was reminded to use the call light and wait for staff to assist. R1's Fall Risk assessment dated [DATE], identified a score of 22 and placed him at a high fall risk and see care plan for interventions. There was no change from the previous assessment dated [DATE]. R1's Incident Report dated 3/11/24 at 11:38 p.m., identified R1 was found laying on the R) side next to the recliner chair. Recliner chair was in sitting position and cushion noted to be moved slightly forward. R1 stated he slid out of the recliner chair and legs wouldn't hold him up/keep him from sliding. Predisposing factors included impaired memory, call light in reach, does not use call light consistently and during transfer. Intervention was to put dysum under and on top of recliner cushion. The care plan was revised on 3/11/24 to include ensure dysum in recliner chair. One under cushion and one on top of cushion. R1's Fall Risk assessment dated [DATE], identified a score of 22 and placed him at a high fall risk and see care plan for interventions. There was no change from the previous assessment dated [DATE]. R1's Incident Report dated 3/27/24, at 11:30 p.m. identified R1 was found sitting on he floor in his bathroom, calling for help. R1's legs were out in front of him with feet under the sink and his back was facing the bathroom door. [NAME] was next to the toilet. R1 did not have grip socks on and had not used his call light to go to the bathroom. R1 stated I was washing my hands and my knees gave out and I went onto my butt. R1 complained of buttock and lower back pain. R1 was transferred to bed via mechanical lift and reminded to use his call light to use the bathroom. Predisposing factors included confused, drowsy, current UTI, gait imbalance, impaired memory, weakness, ambulating without assist, does not use call light consistently, using a bed alarm, using walker. It was not evident the care plan was revised after the fall for new interventions. R1's Incident Report dated 3/28/24 at 3:40 a.m., identified R1 was found lying on the floor next to his bed. Bed alarm was on and R1 had used his walker and had gripper socks on. R1's head was near the side of the bed and legs were stretched out on the floor. R1 stated he was coming back from the bathroom and was going to sit on the bed but wasn't close enough and missed the bed. R1 stated if it takes me longer to get up then maybe you can get here before I start moving. Predisposing factors included confused, drowsy, incontinent, recent illness, current urinary tract infection (UTI), gait imbalance, impaired memory, weakness/fainted, recent change in medications/new, ambulating without assist, call light within reach, does not use call light consistently, side rails up, and using bed alarm. Interventions included staff educated R1 to use the call light and wait for staff, and staff put R1's bed in a lower position. It was not evident the care plan was revised with new interventions. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Incident Report dated 3/28/24 at 7:19 p.m., identified R1 was found on the floor laying on the right side with back to the closet door and head towards the room door. R1 stated he was leaving the bathroom and just fell . R1 complained of pain in the right hip and had an abrasion to the right ear with pain rated 2/10 and farther in the report it stated pain was 10/10.Predisposing factors included incontinent, current UTI, gait imbalance, impaired memory, weakness/fainted, ambulating without assist, call light within reach, does not use call light consistently, and used wheeled walker. The bed alarm had been used in the recliner and did not alarm over staff pagers. Intervention included range of motion to hip and ice. On 3/29/24 the report noted that R1 had a right hip fracture. It was not evident new fall interventions were developed and implemented. R1's Hospital summary dated 4/3/24, identified R1 had admitted on [DATE], after sustaining a fall with right hip pain. R1 had multiple falls since moving to Oak Hills Living Center. Computed tomography showed right hip fracture. Right hip surgery completed 4/1/24. The summary further identified R1 had a history of re-current urinary tract infection (UTI); at the time of admission R1 had UTI that was treated with intravenous antibiotics. R1 also had chronic urinary retention and is to be self-cathing. Assessment and plan identified chronic urinary retention a Foley indwelling catheter was placed to decrease risk of recurrent UTI due to inappropriate self-cath due to dementia and no weight baring on the right leg. R1's Fall Risk assessment dated [DATE], identified for a readmission that R1 had multiple falls with documented dates of falls. The assessment identified R1 to be continent with complete control, nothing marked under gait analysis. Summary included a score of 17 that placed R1 at a high risk for falls. R1 was currently a full body mechanical lift and assist of two for all transfers. Intermittent confusion noted and see care plan for interventions. R1's progress note dated 4/9/24 at 9:18 p.m., identified R1's family member called and stated R1 kept calling her and saying he was going to get up and walk. Staff went into R1's room and his legs were hanging out of bed. During an observation and interview on 4/10/24 at 9:11 a.m., R1 was laying in bed, gripper socks on feet. After skin inspection and dressing from OT-A and Registered Nurse (RN)-B, R1 dangled left leg over the edge of the bed. R1 was able to use trapeze to pull himself up in bed. R1 stated I don't know how my hip is, I haven't used it yet. OT-A educated R1 on hip precautions. OT-A placed call light around trapeze above R1's head and lowered bed. OT-A did not attach a call light to R1's shirt or place one on the side of the bed. R1's split call light was attached on the right side of the recliner out of reach of R1 and not in accordance to the care plan. During an observation and interview on 4/10/24 at 10:40 a.m., with NA-A and NA-B, NA-A stated before R1's fall he was pretty mobile. NA-A explained R1 would self-transfer at night they (staff) knew if the bed alarm went off, R1 was up in the bathroom toileting, we would know when he was trying to do things he wasn't supposed to NA-B stated staff knew the fall interventions through staff report and by looking at the Kardex (abbreviated care plan). NA-A and NA-B reviewed the fall preventions in place from the Kardex. At 10:56 a.m. , NA-A went to R1's room and moved the call light from the trapeze and clipped it to R1's shirt and moved the call light from the recliner to the side of the bed. During an observation and interview on 4/10/24 at 11:55 a.m., R1 was laying in bed and stated I don't like to stay in bed all the time. I got problems right now that I can't get up. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with R1 and family member (FM)-A on 4/10/24 at 2:04 p.m., R1 was laying in bed. FM-A stated neuropathy was what caused R1's legs to just give out unexpectedly. R1 was falling at home too and required neighbors or emergency services to help him get off the floor. R1 stated he could feel his legs giving out more. R1 talked about wanting to go outside. From his window he could see residents and staff outside. FM-A stated he had to wait for therapy to ok him leaving the bed. During an interview on 4/10/24 at 2:53 p.m., RN-A reviewed R1's falls, RN-A stated the intervention for the double touch call light should probably be worded differently after verification that it was not correctly placed this morning. RN-A stated R1 has not really been in his recliner since hospital return and that intervention should be changed. The fall on 2/15/24, RN-A indicated there was no added intervention and R1 would not go for sitting down to urinate, so staff just gave reminders. Since R1 returned they have not done anything additional for fall prevention. RN-A stated I think if his hip didn't hurt he would be on the move. During an observation on 4/11/24 at 8:20 a.m., R1 was in sleeping in bed. Call light was clipped to the bed by R1's elbow and the other portion of the call light was hanging off the side rail on the outside portion of the bed. R1 would not be able to reach the light. Alarm for recliner was hanging on a lamp by his recliner. During an observation on 4/11/24 at 10:59 a.m., R1 was in the recliner. Call light was hanging off the side table and the other half was hanging on the side rail. R1 was unable to reach the call light on the side rail. Dysum (non-slip rubber-like plastic material used to stabilize surfaces) that would be under his buttocks was on his left arm rest and chair alarm was hanging over his lamp and not underneath his buttocks. During an interview on 4/11/24 at 11:03 a.m., RN-A verified the staff had not put put the call light, Dysum, and chair alarm in place and should have. During an interview on 4/11/24 at 11:44 a.m., R1 was in the recliner. R1 stated his catheter burned. Dysum remained on left arm of recliner and chair alarm hung from the lamp. During an observation on 4/11/24 at 1:27 p.m., R1 was in bed. Call light was clipped to a blanket around groin area and other portion of call light was hanging off the side rail where R1 could not reach it. During an interview on 4/11/24 at 1:15 p.m., RN-B stated [R1] used the toilet whenever. Nursing was to straight cath (intermittently catheterizing to remove urine) in the morning and at bedtime and FM-A would cath R1 during the day. R1 was not good at putting the call light on for toileting, he would sneak in there himself. I hope they keep the cath in because he will end up with UTI's. During an interview on 4/11/24 at 1:24 p.m., NA-D stated prior to R1's right hip fracture they would catch R1 taking himself to the toilet a few times a shift. NA-D thought R1 had a toileting plan from therapy. NA-D stated the nurses monitored output. (continued on next page)

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	245490	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/11/24 at 2:22 p.m., with social worker (SW), RN-A, and Director of Nursing (DON) RN-A stated R1 did not have an individualized toileting plan and did not have an answer for why there was not one in place. When R1 was in the hospital an indwelling catheter was placed. RN-A did not believe a toileting program would have prevented the fall. R1 just used the toilet when he wanted to. His right hip pain was the only thing preventing him from moving at the moment. We are going to do a low bed as a prevention, he has a catheter, and maybe start a tracking sheet to track his restlessness. SW stated that one fall intervention in place was the indwelling catheter. During an interview on 4/11/24 at 2:45 p.m., DON did not identify R1's fall pattern; DON stated the team felt satisfied with the interventions in place as they were happening and at the time we felt the interventions were appropriate. Because of his frequenct of falls he will be one of our projects in our new focused risk management meetings. Our expectation was for everyone to be screened for a toileting program. During an observation and interview on 4/11/24 at 3:45 p.m., NA-E was in R1's room. R1 was in bed and sliding toward the end of the bed. R1 stated I had to go to the bathroom, it was burning down there. R1 had pulled on the catheter and again stated it burns. Call light was hanging over the side table and the other one attached to bedding instead of one portion being connected to R1's shirt according to the care plan. NA-E did not acknowledge R1 stating that the catheter burned, instead NA-E explained to R1 that urine went through the tubing to the urinary collection bag. During an interview on 4/11/24 at 3:52 p.m., NA-E indicated he went to R1's room a little bit ago. R1 was not on the floor, he was in bed. R1 had asked to have his catheter checked. NA-E put the call light by his hip side like he wanted and other call light he wanted dangling and he could not reach it. During an observation on 4/12/24 at 8:59 a.m., R1 was in bed wearing grippy socks. NA-F and NA-G were assisting R1 with morning cares. R1 was able to get both legs off the edge of the bed and attempted to get to a seated position. R1 stated his legs hurt like hell. NA-F and NA-G used a full body mechanical lift to transfer R1 from his bed to his recliner. R1's bed alarm did not sound. Pressure chair alarm was hanging over the lamp. The NA's left the room and shortly thereafter a certified occupational therapy assistant (COTA) came into the room and verified the alarm was not under R1. COTA and NA-G put the pressure alarm under R1. During a continuous observation on 4/12/24 that began at 9:55 a.m. and ended at 11:43 a.m. R1 demonstrated restlessness with multiple attempts of self-transfer. -9:55 a.m., R1 was in the recliner with the door 3/4 of the way closed. R1 was leaning forward in the recliner and then sat back several times, in a rocking motion. A visitor entered his room. -10:22 a.m., R1 had attempted to stand up from recliner. An unidentified staff saw R1 from across the hall, walked quickly into the room and redirected R1. -10:24 a.m., R1 shifted his legs to get ready to stand and asked his visitor to help him sit up in the recliner. Visitor gave R1 his hand to support with standing, but then removed his hand and informed R1 he was not supposed to stand. R1 remained seated in the chair. Visitor did not turn on the call light or ask sfaff to assist. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-10:28 a.m., R1 was sitting forward in the recliner and continuously shifting his position. -10:46 a.m., unidentified staff answered R1's call light. -10:51 a.m., R1 sat forward in the recliner as he raised the chair up and down; visitor remained in the room. -11:03 a.m., R1 was attempting to stand up, unidentified staff entered the room, R1 denied help. -11:04 a.m., Staff exited room, and R1 had the recliner partially raised and was leaning forward. Staff entered room again with a mug. -11:05 a.m., Staff member exited room and left the door half closed. R1 leaned forward and pointed to the bin with catheter in it. -11:09 a.m., R1 leaned forward and reached down to the floor and pulled on catheter tubing and then fell backwards in the chair, then leaned forward again and back. -11:17 a.m., R1's visitor exited the room, visitor reminded R1 not to get up. -11:19 a.m., R1 leaned forward; staff responded to the activated chair alarm. -11:22 a.m., R1 leaned forward and back in his chair. -11:43 a.m., SW went to room to begin 1:1 observation of R1. During an interview on 4/12/24 at 11:15 a.m. DON was made aware R1 was restless, intermittently trying to stand-up, and pulling at his catheter tubing. DON indicated she would provide 1:1 supervision until a comprehensive causal analysis be completed and appropriate interventions were implemented. DON further indicated she would have nursing assess the issue with the catheter. The immediate jeopardy for R1 was removed 4/12/2024, at 5:22 p.m., when it was verified the facility developed and implemented the following: -Reviewed falls policy and implemented a new process for data collection/analysis. -R1 was provided with 1:1 supervision -Completed comprehensive fall analysis/assessments, reviewed/revised/implemented R1's care plan with appropriate interventions. -Identified like residents who were high risk for falls with falls. Completed a comprehensive analysis and reviewed/revised care plans for appropriate interventions. -All staff were provided education with competency testing on fall program policy and following care plans as it pertained to their scope of practice. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R3's MDS dated [DATE], identified an admitted ,d+[DATE]. Severe cognitive impairment, required extensive staff assistance. Diagnoses included dementia, abnormalities of gait and mobility, muscle weakness, and difficulty in walking. R3's care plan dated 4/11/24, identified altered self care performance. Goals included maintaining current level of function. Interventions included: -1 person toileting assistance and a high rise toilet seat, prompt/assist with toileting every two hours and PRN during waking hours and once during the night -encourage resident to use call light and that it was within reach -required sit to stand mechanical lift for transfers R3's care plan dated 4/11/24, identified a focus for risk of falls r/t deconditioning, dementia, incontinence, psychoactive drug use, and unaware of safety needs. Goals included R3 would experience no falls and be free of injury. Interventions included: -ensure dysum is underneath allegra in recliner for residents safety 2/22/23 -ensure floor mat is down when resident in recliner chair 2/16/24 -keep bed in lowest position when resident in bed 3/12/24 -place floor mats when resident in bed 3/12/24 R3's fall incident report dated 1/13/24 at 1:15 a.m., identified R3 calling loudly from room. R3 was sitting on the cushion in front of the recliner. R3 stated I was scooting because my butt hurt. Noted incontinence brief was shredded and pulled apart. Predisposing factors included confused, drowsy, incontinent, recent illness, impaired memory, weakness/fainted, call light within reach, does not use call light consistently, and has a foot rest in front of recliner. R3 had intermittent confusion, frequently incontinent, confined to a chair and oriented. Summary score of 19 on the assessment which placed R3 at a high fall risk. Required EZ stand for all transfers and was alert with intermittent confusion. Call light within reach. Dysum in wheelchair. In review of R3's record no new fall interventions were developed or implemented. R3's fall incident report dated 2/16/24 at 3:30 a.m., identified R3 was found laying on right side on floor in front of recliner chair. Incontinence pad had been picked apart by R3 and was all over the floor. R3 did not know she was on the floor or how she got there. R3 had a skin abrasion on right elbow. Predisposing factors included confused, incontinent, impaired memory, call light within reach, and does not use call light properly. R3 scored a 22 on the assessment and was a high fall risk. EZ stand for transfers and alert with intermittent confusion. Call light in place. Intervention was a floor mat. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R3's fall incident dated 3/9/24 at 12:50 a.m., identified R3 was on the floor in front of the recliner with half on her foot cushion and the other half on the floor. Asked how she fell and R3 stated I was trying to get these damn things off., pointing to ready wraps that were half off at the time. Predisposing factors included confused, impaired memory, weakness/fainted, call light within reach, does not use call light consistently, using floor mat, and soft foot stool in front of recliner. Frequent safety checks initiated for the remainder of the night. Although R3 had three falls from the recliner, in review of R3's record it was not evident a comprehensive analysis was completed and no new interventions were developed or implemented to prevent or mitigate the risk of re-current falls from recliner. R3's fall incident dated 3/10/24 at 5:30 a.m., identified R3 sitting on the floor in front of the recliner sitting on the floor mat with foot stool under her legs and head leaning up against front of recliner. R3 stated her buttocks hurt from sitting. Noted R3's ready wraps were half off and R3 had started ripping the brief tabs off. Noted that recliner was rocking forward and R3 was leaning forward in it constantly due to the chair leaning. Put in maintenance slip to check over. Predisposing factors included furniture, drowsy, incontinent, impaired memory, weakness/fainted, call light within reach, does not use call light consistently, and using floor mat. During care conference with family discussed sleeping in bed instead of recliner and family to bring in pajama pants as she has been pulling brief apart. R3's care plan was not revised to include R3 to sleep in the bed instead of the recliner. During an interview on 4/1/024 at 1:58 p.m., FM-B stated R3 did fall a couple of times out of the recliner and now they lower the bed to the floor and put a mat on the side of it. R3 slept in the bed no [TRUNCATED

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F 0690 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49616 Based on observation, interview, and document review the facility failed to implement an individualized toileting program based on the comprehensive assessment and failed to ensure intermittent catheterization physician orders for urinary retention were consistently followed to prevent or mitigate the risk of urinary tract infections (UTI) for 1 of 1 residents (R1) reviewed for incontinence. Findings include R1's face sheet identified R1 had diagnoses that included included fracture of right femur, vascular dementia, retention of urine, and neuromuscular dysfunction of bladder R1's significant change Minimum Data Set (MDS) dated [DATE], identified an admitted ,d+[DATE]. R1 had moderate cognitive impairment. R1 required limited assist for toilet use, and transfers. R1 was frequently incontinent of urine. A toileting program was not in place to manage urinary incontinence. R1's bladder evaluation dated 2/6/24, identified R1 had a history of urinary incontinence and urinary tract infections (UTI). R1 was frequently incontinent. Conditions impacting urinary status included pain, edema, diabetes, and urinary disorders. Physical functioning status listed one person physical assist for bed mobility, transfer, walking, toileting, and personal hygiene. Voiding status identified R1 had the perception of needing to void, dribbled after void, urinary retention, and fills bladder/voids large amounts. R1's usual elimination was upon rising, after breakfast, after lunch, after dinner, at bedtime, during the night, and intermittent cath after voiding. Post-voiding perception and residual urine evaluation left blank, residual urine marked yes and amount emptied was unknown with intermittent cath after voiding. Evaluation for bladder program potential was left blank. Summary of frequency plan identified schedule bathroom use per schedule listed in 'other' category per resident request. R1's bowel and bladder care plan dated 2/6/24, identified altered urinary pattern related to functional incontinence, history of UTI, stress incontinence, urinary retention, neurogenic bladder, and straight catheter use. Goal was that R1 would show no signs or symptoms of urinary infection. Interventions included: -attempt to identify individual toileting habits/voiding pattern through observation & interview with resident/family/caregivers. 1/11/24 -14 french catheter 1/16/24 -straight cath orders: cath twice daily per staff and as needed. Monitor urine outputs (voided and post cath per doctor) 1/23/24 R1's care plan did not identify the individualized usual toileting schedule as per the assessments dated 2/6/24. R1's physicians for the urinary catheter included the following: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Monitor urine output/retention every day and evening shift post voided (cath) (start date 1/23/24 and stop date 3/19/24) -Nurses: straight cath resident after first and last void of the day. Ensure to stay with resident and document amount every morning and at bedtime *[family member (FM)] to assist with 12:00 and 4:00 p.m. straight catheter (start date 2/20/24 and stop date 3/22/24) -Nurses: straight cath resident after first and last void of the day. Ensure to stay with resident and document amount every morning and at bedtime **[family member (FM)] to assist with 12:00 and 4:00 p.m. straight catheter (start date 3/22/24 and stop date 4/3/24) In review of R1's March treatment administration record (TAR) in combination with progress notes identified no consistent documentation of urinary output prior to catheterization and was not evident the catheterization was performed after R1 voided. Additionally, R1 was not consistently catheterized according to physician orders. Furthermore, not evident FM had been provided with education of the catheterization procedure. Additionally, when the family member performed catheterization it could not be determined if the FM followed the physician order to catheterize after void, nor evident of the amount of urine obtained from catheterizing. R1's TAR indicated R1 was not catheterized and/or refused 13 times without further assessment or intervention. The TAR identified the following amounts collected during the day and evening shift; the TAR did not include the collection times of 12:00 p.m. and 4:00 p.m. -3/1/24 day 300cc eve 250cc -3/2/24 day 325cc eve 250cc -3/3/24 day 150cc -3/4/24 day 225cc eve 100cc -3/5/24 eve 300cc -3/6/24 day 300cc eve 150cc -3/7/24 day 250cc eve 450cc -3/9/34 eve 175cc -3/10/24 eve 450cc -3/11/24 day 125cc eve 225cc -3/12/24 day 350cc eve 200cc -3/13/24 day 275cc -3/14/24 day 250cc (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3/15/24 day 200cc -3/16/24 day 175cc -3/17/24 day 100cc -3/18/24 day 275cc eve 300cc R1's Hospital summary dated 4/3/24, identified R1 had admitted on [DATE], after sustaining a fall with right hip pain. R1 had multiple falls since moving to Oak Hills Living Center. Computed tomography showed right hip fracture. Right hip surgery completed 4/1/24. The summary further identified R1 had a history of re-current urinary tract infection (UTI); at the time of admission R1 had UTI that was treated with intravenous antibiotics. R1 also had chronic urinary retention and is to be self-cathing, but with his bad memory he often says he has self-cathed when he has not. A 16 french indwelling Foley catheter placed 3/29/24 at 12:15 p.m. Assessment and plan identified chronic urinary retention that a Foley was recommended ongoing to decrease risk of recurrent UTI due to inappropriate self-cath due to dementia and no weight baring on the right leg. The summary directed for R1 to have a follow-up urology appointment on 4/17/24. R1's care plan updated 4/3/24, identified new interventions that included: -catheter placed during hospitalization -observe for complications related to catheter use: blockage, pain/discomfort, etc. -conduct bladder/urinary assessment admission, quarterly, annually, and with significant change -check catheter tubing for leaks -change catheter per MD orders or facility protocol During an observation on 4/10/24 at 9:11 a.m., R1 was laying in bed, the urine collection bag was on the floor in a gray rectangle wash basin. At 9:25 a.m., registered nurse (RN)-B moved catheter to left side of bed. Catheter was full of yellow urine. RN-B filled three graduates to empty the catheter with 2300cc's of urine removed from the drainage bag. RN-B stated I've never seen so much before. Catheter system was placed on right side of bed. During an observation and interview on 4/11/24 at 11:44 a.m., R1 was in his recliner with his pants off. R1 stated his catheter burns. During an observation and interview on 4/11/24 at 3:45 p.m., R1 was in bed. R1 stated I had to go to the bathroom because it was burning down there. R1 pulled at catheter and again stated it burns. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 4/12/24 at 8:59 a.m., R1 was in his recliner and stated I have to go to the bathroom, does it go in the tube? Certified occupational therapy assistant (COTA) explained to R1 the urine came out through the tube and drained into a bag but was glad R1 had a sensation to void. At 9:55 a.m. , R1 put his hand down his pants. At 11:05 a.m., R1 had leaned over the recliner and pointed to the bin with the catheter bag in it. At 11:06 a.m., R1 began moving the catheter tubing in his pants. At 11:09 a.m., R1 attempted to reach down to the floor and pull on the catheter tubing. At 11:22 a.m., R1 again put his hand down his pants to move his catheter tube. During an interview on 4/10/24 at 2:53 p.m., RN-A stated she would expect staff to follow the interventions in the care plan and sign off on them when completed for urinary output. RN-A stated it was hard to tell what his normal output was prior to the catheter being placed. Staff would usually get 300-400cc's from the straight cath and then he would take himself to the bathroom, staff were supposed to take him. We would usually empty the catheter at least once a shift. Reviewed that R1 had an output of 2300cc on 4/10/24 at 9:11 a.m., from his foley catheter. RN-A stated yes, that is a lot. I would have to see who was working, that definitely would require education. During an interview on 4/11/24 at 1:24 p.m., nursing assistant (NA)-D indicated prior to R1's Foley catheter placement NA-D R1 had not been on a toileting schedule and was unaware of any specific toileting times. Before the Foley, most of the time staff would just catch R1 in the bathroom toileting himself. NA-D stated that nurses would monitor and document R1's urine output. During an interview on 4/11/24 at 1:15 p.m., RN-B indicated prior to the indwelling catheter placement R1 was not on a toileting program and R1 would go to the bathroom whenever. We would cath him in the morning and at night, he [R1] wasn't good for putting on his light for toileting. R1 was supposed to be cathed after he voided. RN-B explained R1 would tell the staff he used the toilet in the morning or the nursing assistants would inform nurses R1 was ready to be cathed. RN-B would cath R1 without assessing R1 for bladder fullness even though the facility had a bladder scanner to check for post void residual. RN-B would cath R1 while he was sitting on the toilet and did not use the graduate to measure the urine. RN-B stated she would always get 300-400 cc's of urine out. R1 would also sometimes cath himself without telling staff he did it. When R1 took himself to the toilet, he did not always get the urine into the collection hat. During an interview on 4/11/24 at 2:22 p.m., RN-A indicated prior to the indwelling catheter placement R1 did not have an individualized toileting plan and she was not sure why. R1 was hard to monitor outputs because R1 would have already used the toilet or refused the nurses cathing. We had a graduate and R1 would urinate around it so staff were not able to get the measurement. During an interview on 4/11/24 at 2:41 p.m., COTA stated R1 had four times a day straight cath. COTA indicated when R1 was first admitted to the facility he started the self cath, however that did not go well so staff took over twice a day and FM-A completed the catheterization the other two times a day. R1 constantly had to go to the bathroom and was not sure why the indwelling catheter was left in. During an interview on 4/12/24 at 1:28 p.m., licensed practical nurse (LPN)-A stated there was no formal documentation for FM-A straight cathing R1. FM-A would just tell staff the amount. LPN-A was uncertain if FM-A had training in the procedure. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/11/24 at 2:45 p.m., DON stated that she was unsure if R1 would even be appropriate with toilet retraining and would want to discuss it with COTA. DON went on to say that it is the facility expectation that all residents are to be screened for the toileting program. A policy for straight catheterization was not provided. The facility policy titled Urinary Catheter Care review date 11/20/23, identified to review and document the clinical indications for catheter use prior to inserting. Nursing and interdisciplinary team should assess and document the ongoing need for a catheter that is in place. Remove the catheter as soon as it is not longer needed. Observe for complications associated with catheters such as if the resident indicates the bladder is full or that they need to void, if the resident complains of burning, tenderness, or pain in the urethral area.