STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265247	A. Building B. Wing	12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kirksville Manor Care Center	1705 East Laharpe Kirksville, MO 63501

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30813 Based on interview and record review, the facility failed to accurately assess and timely report changes in condition to the resident's physician for one resident (Resident #2), who was admitted to the facility following a fall, in a review of six sampled residents. The day following his/her admission, the resident developed blisters, edema, pain and bruising to his/her left knee. Staff did not consistently assess the resident's skin and his/her condition as the resident continued to have pain requiring a narcotic pain medication and received antibiotic therapy, and did not timely notify the physician of the changes in the resident's condition. The resident requested to see his/her physician (11 days after admission) and was admitted to the hospital with significant swelling from his/her knee to his/her toes, severe pain, and a wound on his/her knee. The facility census was 63. Review of the facility's policy, Resident Examination and Assessment, revised February 2014, showed the following: -The purpose of this procedure is to examine and assess the resident for any abnormalities in health status; -Skin: intactness, moisture, color, texture, presence of bruises, pressure sores, redness, edema and rashes; -All assessment data obtained during the procedure should be recorded in the resident's medical record; -Notify the physician of any abnormalities such as, but not limited to: -Wounds or rashes on the resident's skin; -Worsening pain, as reported by the resident; -Report other information in accordance with facility policy and professional standards of practice. Review of the facility's policy, Change in Resident's Condition or Status, revised May 2017, showed the following: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Actual harm Residents Affected - Few	-Our facility shall promptly notify the resident, his/her attending physician, and representative of changes in the resident's medical/mental condition and/or status; -The nurse will notify the resident's attending physician or physician on-call when there has been a(an): -Discovery of injuries of an unknown source; -Significant change in the resident's physical/emotional/mental condition; -Need to alter the resident's medical treatment significantly; -Need to transfer the resident to a hospital/treatment center; -Specific instruction to notify the physician of changes in the resident's condition; -Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider; -Except in medical emergencies, notifications will be made within 24 hours of a change occurring in the resident's medical/mental condition or status; -The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. 1. Review of Resident #2's Physician Order Sheet (POS), dated November 2023, showed the resident's diagnoses included Alzheimer's disease and history of falls. Review of the resident's face sheet showed he/she was his/her own responsible party and was admitted to the facility on [DATE]. Review of the resident's nurses' notes dated 11/17/23, showed the resident was admitted to the facility from home after a fall on 11/16/23. The resident complained of left knee pain. Physician C was here this evening and reviewed orders. Review of the resident's medical record showed no documentation staff completed a skin assessment of the resident's left knee upon his/her admission to the facility on [DATE]. Review of the resident's nurses notes showed the following: -On 11/18/23 at 6:39 A.M., skin warm to touch, bruises noted to left side of left knee. diagnosed with contusion (bruise) to left knee due to fall; -On 11/18/23 at 9:42 P.M., Licensed Practical Nurse (LPN) F documented he/she faxed Physician C about the resident's knee. Fluid filled blisters, edema, heat, pain and bruising; (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	-On 11/19/23 at 12:07 P.M., LPN I documented the resident's left knee was swollen, bruised and had several pus pockets surrounding the knee. Physician was notified 11/17/23 via email per charting (previous note showed physician was notified by fax on 11/18/23). Review of the resident's Medication Administration Record (MAR), dated November 2023, showed the following: -On 11/19/23 at 12:34 P.M., the resident rated his/her pain a five (on a scale of one to 10 with 10 being the most pain). Staff administered hydrocodone-acetaminophen (a narcotic pain medication) 5-325 milligrams (mg) as needed (PRN) for pain related to contusion of left knee; -On 11/20/23 at 12:31 A.M., the resident rated his/her pain a six (on a scale of one to 10). Staff administered hydrocodone-acetaminophen 5-325 mg PRN for pain related to contusion of left knee. Review of the resident's baseline care plan, dated 11/20/23, showed the following: -Partial/moderate assistance for toileting, dressing, transfers, bed mobility; -Used walker and wheelchair for mobility; -The resident had a fall in the last month prior to admission; -Current skin integrity issues left blank; -Baseline care plan did not address swelling or bruising of the resident's left knee. Review of the resident's nurses notes, dated 11/20/23 at 1:32 P.M., showed LPN A documented the resident's skin was warm and dry, skin color within normal limits (WNL) and turgor is normal. No skin issues. (Review showed no evidence LPN A documented an assessment of the condition of the resident's knee.) Review of the resident's medical record showed no evidence the facility received a response or followed up with the resident's physician on 11/19/23 or 11/20/23 regarding the swelling, fluid filled blisters, heat and pain identified on 11/18/23. The resident continued to have pain in his/her left knee which required administration of PRN narcotic pain medication. Review of email correspondence between LPN A and Physician C, dated 11/21/23, showed Physician C noted per discussion with staff, we are going to start Bactrim DS (an antibiotic) twice daily for seven days. If knee gets worse by tomorrow, resident to go to hospital for evaluation by orthopedics urgently. Review of the resident's POS, dated November 2023, showed no documentation of the order to give Bactrim DS twice daily for seven days or if the knee gets worse by tomorrow to go to the hospital for evaluation by orthopedics urgently (as documented on the email correspondence received from the physician on 11/21/23). Review of the resident's nurses' notes showed the following: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	-On 11/21/23 at 2:01 P.M., LPN A documented he/she received call from Physician C to start resident on Bactrim DS one tablet by mouth twice daily for seven days for possible infection to left knee. Further instructed to monitor, and if fever or signs/symptoms of sepsis (blood infection), to call the office; -On 11/21/23 at 2:27 P.M., LPN A documented the resident's skin warm and dry, skin color WNL and turgor is normal. No skin issues. (Review showed no evidence LPN A documented an assessment of the condition of the resident's knee.) Review of the resident's MAR, dated 11/21/23, showed the resident rated his/her pain a nine (on a scale of one to 10) on the evening and night shifts. (Review of the resident's nurses notes showed no documentation related to the resident's pain on these shifts.) Review of the resident's MAR, dated 11/22/23 at 1:00 A.M., showed the resident rated his/her pain a nine (on a scale of one to 10). Staff administered hydrocodone-acetaminophen 5-325 mg PRN for pain related to contusion of left knee. Review of the resident's nurses note, dated 11/22/23 at 1:37 P.M., showed LPN B documented the resident continues on Bactrim DS for left knee infection. Review of the resident's wound evaluation completed by LPN D/wound nurse, dated 11/22/23, showed the following: -Blister left front knee measured 12 centimeters (cm) by 11.2 cm; -Suspected infection; -Wound presents with multiple blisters that are rupturing. Peri-wound has edema and color is black and blue. Warm to the touch. The physician has been notified. Will continue current medications and treatment. During interviews on 12/13/23 at 11:50 A.M., Physician C said he/she received a fax from the facility on 11/22/23 stating the resident's blisters were the same. He/She sent a fax back to the facility asking if there was any improvement and did not receive a reply back from the facility. Review of the resident's medical record showed no documentation of the fax the facility sent to the physician on 11/22/23 and no documentation to show the facility notified the physician of the resident's pain, swelling, and bruising. Review of the resident's MAR, dated 11/22/23 at 4:41 P.M., showed the resident rated his/her pain a nine. Staff administered hydrocodone-acetaminophen 5-325 mg PRN for pain related to contusion of left knee. (Review of the resident's nurses notes showed no documentation related to the resident's pain on this shift.) Review of the resident's nurses' notes showed the following: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-On 11/23/23 at 2:19 P.M., the Director of Nurses (DON) documented the resident continues on Bactrim DS for infection to the left knee. Site is noted to be warm to touch, with fluid filled blisters, redness and edema. The resident complains of pain to touch but refuses pain medication. (Reviewed showed no documentation the facility staff notified the resident's physician of the condition of the resident's knee on 11/23/23); -On 11/24/23 at 1:13 P.M., skin warm and dry, skin color WNL and turgor is normal. Currently taking Bactrim DS until 11/28/23. Infection noted to left knee. The resident had pain in his/her left knee; pain rated at a 3. The pain was aching, dull, cramping, non-radiating and worse with movement. Review of the resident's MAR, dated 11/24/23, showed the resident rated his/her pain a 10 (on a scale of one to 10) on the evening shift. Staff administered hydrocodone-acetaminophen 5-325 mg PRN for pain related to contusion of left knee at 7:01 P.M. (Review of the resident's nurses notes showed no documentation related to the resident's pain on this shift.) Review of the resident's medical record showed no evidence staff assessed the resident's skin on 11/25/23. Review of the resident's MAR, dated 11/25/23 at 12:15 P.M., showed the resident rated his/her pain a 10 (on a scale of one to 10). Staff administered Tylenol (pain reliever) 325 mg, two tabs PRN for pain related to contusion of the left knee. (Review of the resident's nurses notes showed no documentation related to the resident's pain on this shift.) Review of the resident's nurses' notes showed the following: -On 11/26/23 at 3:53 P.M., LPN G documented the resident continues on antibiotic for left knee wound infection. (No documentation staff completed a skin assessment of the resident's knee); -On 11/27/23 at 7:55 A.M., LPN H documented the resident continues on antibiotic due to blisters left knee. Voices no complaints of pain or discomfort. Wound open to air. (No documentation staff completed a skin assessment of the resident's knee). Review of the resident's MAR, dated 11/27/23 at 8:54 A.M., showed the resident rated his/her pain a 10. Staff administered hydrocodone-acetaminophen 5-325 mg PRN for pain related to contusion of the left knee. Review of the resident's medical record showed no evidence the facility assessed the resident's knee on 11/24/23 through 11/27/23 to identify an improvement or decline in the resident's condition. The resident continued to have pain in his/her left knee which required administration of PRN narcotic pain medication. During interview on 12/12/23 at 12:01 P.M., LPN D/wound nurse said the resident wanted to see his/her original primary care physician (PCP D) so that appointment was made (for 11/28/23). Review of the resident's nurses notes showed the following: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-On 11/28/23 at 1:21 P.M., LPN B documented the resident's skin warm and dry, skin color WNL and turgor is normal. Currently taking skin antibiotics. Skin infection noted to left knee. (No documentation staff completed a skin assessment of the resident's knee); -On 11/28/23 at 10:35 P.M., the resident had an appointment with his/her primary care physician (PCP) D outside the facility and was referred to the emergency room for urgent evaluation of the left knee swelling and hematoma. The resident was admitted to the hospital. Review of the resident's emergency department physician documentation, dated 11/28/23, showed the following: -The resident presented to the emergency department for left leg swelling and tenderness. He/She was seen in this hospital on 11/16 after a fall at home. The resident said he/he was unable to bear weight on his/her left knee and family had him/her placed in the nursing facility on 11/17/23 for assistance with activities of daily living while he/she recovered. Since then, the resident's knee has continued to swell and has developed a large open area with granulation tissue (connective tissue in a wound). At this time, the resident has significant swelling from the proximal knee all the way down to his/her toes on his/her left foot. The resident endorses significant pain upon standing and also significant pain to light palpitation. He/She went to the physician today to be evaluated and the physician sent him/her to the emergency department for further evaluation; -Exam: The resident reports decreased sensation in the affective extremity. The resident experiences severe pain on palpitation or the affected extremity. Swelling and tenderness in left leg. Large wound on medial left knee with swelling going all the way to to the left foot. 2+ pitting edema (swelling) that is extremely painful to light palpitation. -Possible compartment syndrome (an increase in pressure inside a muscle, which restricts blood flow and causes pain). Surgical consult suspects a closed degloving injury (closed degloving soft tissue injury, caused by abrupt separation of skin and subcutaneous tissue from the underlying fascia). Review of the resident's computed tomography (CT) scan angiogram (efficient and accurate in the evaluation of lower extremity arterial injuries after trauma. Specific CTA signs of vascular injury can be readily detected, and additional information regarding osseous and soft-tissue injuries can also be routinely obtained), dated 11/28/23, showed the following: -Large medial (midline) and anterior (front) superficial (on the surface) fascia (a thin casing of connective tissue that surrounds and holds every organ, blood vessel, bone, nerve fiber and muscle in place) thigh hematoma (happens when an injury causes blood to collect and pool under the skin) measuring 12.3 centimeters (cm) by 4.9 cm by 17.3 cm; -Extensive cutaneous (relating to the skin) and subcutaneous (under the skin) superficial fascia cellulitis (a deep bacterial infection of the skin). Review of the hospital general surgery procedure notes, dated 12/1/23, showed the following: -Pre-operative diagnosis: infected hematoma left lower extremity; -Procedure: Excisional debridement (surgical removal of tissue) of left lower extremity hematoma; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Swelling and eschar (dead tissue) was located to the left knee. The 4 cm by 5 cm eschar over the region of swelling was removed which exposed a large amount of old blood clot and fluid. The clot was debrided and the wound found to undermine approximately 11 cm at 7:00 position, 3 cm at 9:00 position, and 9 cm at 11:00 position. The wound extended to the muscle. A wound vac (a mechanical device used to gently pull fluid from a wound over time) was placed. During interview on 12/12/23 at 11:44 A.M., 12/13/23 at 11:39 A.M., and 12/19/23 at 11:04 A.M., LPN B (who documented in the resident's nurses notes on 11/22 and 11/28) said the following: -He/She saw the resident's knee on 11/22/23 (the day after the resident started on antibiotics) but he/she did not remember being told to send the resident to the emergency room if the knee was worse. This was the first time he/she saw the resident's knee and thought the knee was getting better; -The resident had cellulitis of the left knee. It was red and had a few blisters; -Staff should document when the resident had blisters; -The resident went out for an appointment (on 11/28/23) and was sent to the hospital. During interview on 12/12/23 at 12:01 P.M., LPN D/wound nurse said the following: -The admitting nurse was responsible for the initial skin assessment. -The resident did not have any open wounds when he/she was admitted (on Saturday, 11/17/23); -The next week the resident's friend alerted him/her that the resident had blisters on his/her left knee. The physician was notified and LPN A sent a picture of the knee to the physician. The physician ordered an antibiotic for cellulitis (on 11/21/23); -He/She completed the resident's skin assessment on 11/22/23. During interviews on 12/12/23 at 1:09 P.M.,12/13/23 at 11:48 A.M., and 12/19/23 at 11:00 A.M., LPN A said the following: -The resident's left knee was swollen, red and blistered. He/She sent a fax and called Physician C. He/She also sent Physician C a picture of the resident's knee and received orders for an antibiotic (on 11/21/23); -He/She remembered the order to send the resident to the emergency room if the resident's knee was worse. He/She thought he/she verbally told the next shift nurse about this order. If he/she didn't pass it on verbally, then he/she would have written it in the report book; -He/She couldn't remember seeing the resident's knee on 11/23/23, the next time he/she worked, to know if the knee was the same or worse; -If there was a change in the wounds, then staff should notify the physician; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-He/She supposed staff should have documented daily on the blisters and bruising on the resident's knee; -He/She usually faxed the physician with any concerns; -He/She would follow-up on faxed concerns in a couple days. During interviews on 12/12/23 at 2:10 P.M.,on 12/13/23 at 11:27 A.M., and 12/19/23 at 10:56 A.M., the Director of Nursing (DON) said the following: -The wound nurse completed weekly skin assessments (for residents with wounds), and the charge nurses completed weekly skin assessments on the residents' shower days; -If staff see anything new or a decline in an area, they were to let the wound nurse know so he/she would get orders; -The resident had some skin changes including swelling and blisters. One blister popped and scabbed over. She passed it on in report on 11/20/23 or 11/21/23 (she couldn't remember which day for sure) that the physician needed to be notified of the swelling and blisters; -She expected staff to follow-up on a fax to the physician with a phone call within 24 hours to see if the physician's office received the fax and for any new orders; -She was not aware of the order to send the resident to the emergency room for evaluation if the resident's knee worsened (order received on 11/21/23); -She would have expected staff to respond to the physician's fax (sent 11/22/23 per the physician interview) asking if there were any improvements in the blisters; -She would expect staff to document on bruising and blisters in the resident's daily assessment, and to assess and document accurate descriptions of wounds. During interviews on 12/13/23 at 11:50 A.M. and on 12/19/23 at 4:42 P.M., Physician C said the following: -He/She saw the resident in the facility on admission. The resident's left knee was swollen and had bruising around the thigh on the anterior aspect (front part). There were no blisters at that time; -He/She would have expected the facility to notify/follow-up with him/her regarding the fax they sent on 11/18/23 before staff sent him/her the pictures of the resident's knee on 11/21/23; -A little while after admission, staff sent a picture of the resident's left knee in an email. He/She called the facility and ordered Bactrim DS for seven days for suspected cellulitis, and if the knee worsened, to send the resident to the emergency room for urgent orthopedic evaluation (ordered received 11/21/23); -He/She received a fax from the facility on 11/22/23 stating the blisters were the same. He/She sent back a fax asking if there was any improvement and did not receive a reply back from the facility; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-He/She would have expected staff to notify him/her after 11/21/23 when the resident continued to have pain, swelling and blisters. During interview on 12/20/23 at 9:25 A.M., the administrator said he expected staff to follow-up on a fax to the resident's physician by the end of the staff's shift. If that staff did not get a response from the physician, then he would expect staff to pass this information along in report so the next shift could follow-up. He expected staff to document skin assessments accurately on initial assessment and when there was a change in the skin condition. He expected staff to pass along information to the next shift if a resident had an order to send to the hospital if not improved and he would expect staff to follow physician orders.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30813 Based on observation, interview, and record review, the facility failed to consistently evaluate, implement, and modify interventions, in accordance with current standards of practice and as necessary to reduce the risk of falls, for one resident (Resident #20), in a review of three sampled residents. The facility also failed to safely secure the resident (Resident #20) in the facility van during a transport from the hospital where the resident was evaluated for injuries from a fall. The resident slid out of his/her wheelchair and onto the floor of the facility van. The facility staff did not report, evaluate, or modify interventions to prevent further falls during transportation in the facility van. The resident sustained multiple bruises over his/her face and arms in addition to skin tears with reported pain from his/her falls. The facility census was 63. Review of the facility policy, Falls Clinical Protocol, last revised March 2018, showed the following: -The physician will help identify individuals with a history of falls and risk factors for falling. -The nurse shall assess and document/report the following: vital signs, recent injury, musculoskeletal function, observing for change in normal range of motion, weight bearing, change in cognition or level of consciousness, neurological status, pain, frequency and number of falls since last physician visit, precipitating factors, details on how fall occurred, current medications, especially those associated with dizziness or lethargy, and active diagnoses. -The staff and practitioner will review each resident's risk factors for falling and document in the medical record; -The physician will identify medical conditions affecting fall risk and the risk for significant complications of falls. -Falls often have medical causes; they are not just a nursing issue. -The staff will evaluate, and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the events, etc.; -Falls should also be identified a witnessed or unwitnessed events. -For an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall. -Often, multiple factors contribute to a falling problem. -If the cause of a fall is unclear, or if the individual continues to fall despite attempted interventions, a physician will review the situation and help further identify causes and contributing factors. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or is not correctable. -Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. -If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation (for example, if the individual continues to try to get up and walk without waiting for assistance). -The staff, with the physician's guidance, will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved. -The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. -Frail elderly individuals are often at greater risk for serious adverse consequences of falls. -Risks of serious adverse consequences can sometimes be minimized even if falls cannot be prevented. -If interventions have been successful in fall prevention, the staff will continue with current approaches and will discuss periodically with the physician whether these measures are still needed; for example, if the problem that required the intervention has resolved by addressing the underlying cause. -If the individual continues to fall. the staff and physician will re-evaluate the situation and reconsider possible reasons for the resident's falling (instead of, or in addition to those that have already been identified) and also reconsider the current interventions. Review of the facility's policy, Falls Risk Assessment, revised March 2018, showed the following: -The nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information. -Upon admission, the nursing staff and the physician will review a resident's record for a history of falls, especially falls in the last 90 days and recurrent or periodic bouts of falling over time. -The nursing staff will ask the resident and/or his/her family about any history of the resident falling. (continued on next page)

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	265247	A. Building B. Wing	12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kirksville Manor Care Center	1705 East Laharpe Kirksville, MO 63501

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-The nursing staff, attending physician, and consultant pharmacist will review for medications or medication combinations that could relate to falls or fall risk, such as those that have side effects of dizziness, ataxia, or hypotension (low blood pressure); -The staff will look for evidence of a possible link between the onset of falling (or an increase in falling episodes) and recent changes in the current medication regimen. -The attending physician and nursing staff will evaluate the resident's vital signs, assess the resident for medical conditions (such as those that cause dizziness or vertigo) or sensory impairments (such as decreased vision and peripheral neuropathy) that may predispose to falls. -Assessment data shall be used to identify underlying medical conditions that may increase the risk of injury from falls (such as osteoporosis). -The staff, with the support of the attending physician, will evaluate functional and psychological factors that may increase fall risk, including ambulation, mobility, gait, balance, excessive motor activity, activities of daily living (ADL) capabilities, activity tolerance, continence, and cognition. -The staff will seek to identify environmental factors that may contribute to falling, such as lighting and room layout. -The staff and attending physician will collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable. During an interview on 2/8/24, at 1:45 P.M., the Director of Nursing (DON) said the facility did not have a policy for securing a resident for transport in the facility vehicle. 1. Review of Resident #20's undated face showed his/her diagnoses included altered mental status, muscle weakness, unsteadiness on feet, need for assistance with personal care, lack of coordination, reduced mobility, dizziness, restlessness and agitation, abnormal gait and mobility, and a history of falls. Review of the resident's care plan, dated 5/17/23, showed it did not contain information regarding the resident's fall risk, or interventions to prevent falls. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 5/24/23, showed the following: -admitted to the facility on [DATE]; -Moderate cognitive impairment; -Diagnosis include metabolic encephalopathy (problem in the brain caused by chemistry issues in the blood), non-traumatic brain dysfunction, altered mental state, history of falling, unsteady on feet, abnormal gait, and restlessness and agitation. -Moderate hearing difficulty; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Usually understands and is usually understood; -Verbal behaviors directed towards others; -Uses wheelchair and dependent on staff for transfers; -Requires staff to provide more than half of the effort for wheelchair mobility/locomotion; -Fall in the month prior to admission to the facility and two to six months prior to admission; -One fall with no injury since admission to the facility -Section V: fall care area triggered for falls and staff documented falls will be addressed in the resident's care plan. Review of the resident's quarterly MDS, dated [DATE], showed the resident had two or more falls with no injury since last assessment. Review of the resident's care plan did not address fall risk or history of falls. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -No behaviors or rejection of care. Review of the resident's care plan, updated 11/21/23, showed it did not contain information regarding the resident's fall risk, or interventions to prevent falls. Review of the resident's care plan, updated 1/3/24, showed it did not contain information regarding the resident's fall risk, or interventions to prevent falls. Review of the resident's nurse's notes, dated 1/19/24, at 2:27 A.M., showed the following: -Entry for fall on 1/18/2024 at 7:15 P.M.; -Resident found on floor sitting cross legged when staff entered room; -Resident stated he/she was going to climb the wall and take a shower; -Alert and oriented to person, facility and year; -At approximately 9:30 P.M. staff witnessed resident sliding from wheelchair to floor, no injuries noted. Review of the resident's nurses notes dated 1/23/24, at 8:50 P.M., showed the following: -Certified Nurse Assistant (CNA) was called to resident room by another resident across the hall; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Resident was lying on his/her back on the floor mat by his/her bed; -Neurological checks initiated; -Resident alert and oriented times one and mumbling at times, which was the same as prior to fall. Review of the resident's post fall evaluation, dated 1/23/24, 9:01 P.M. showed the following: -Fall occurred in the resident's room and was not witnessed; -Resident was lying on floor mat by bed; -Wearing glasses, socks on his/her feet; -Resident was not wearing oxygen as prescribed at time of fall; -Incontinent at time of fall; -Contributing factors include confusion, delusions, restlessness, and incontinence;. -Skin note: older bruises noted to left posterior hand and open scratches to left lower extremity that are not new; -Resident has had a change in mental status, behaviors and hospitalization in last six months. Review of the resident's nurse's notes, dated 1/30/24, at 8:24 A.M., showed the following: -Resident on the floor in dining room; -Witness to the fall said the resident was attempting to stand up, and went face first onto the floor; -Bridge of nose cut open and swollen; -Left pinky finger with skin tear approximately 4 centimeter (cm) in length; -Resident complained of right shoulder/rib pain; -911 called and family notified; -Resident transported by emergency services to the hospital; -The resident returned to the facility Review of the resident's record showed no documentation staff completed any root cause analysis of the falls, initiation of fall interventions, a post fall evaluation after the fall on 1/30/24, or evidence of neurological checks. The resident's care plan did not show the resident as a fall risk or any evidence or reevaluation of the resident's care plan to address falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's nurse's notes, dated 2/5/24, at 1:21 A.M., showed the following: -Resident observed sitting up with legs crossed on bedside mat, bed in low position; -Residents pants were wet with urine. Review of the resident's record showed no documentation the resident's physician or family were notified of the fall, a fall evaluation was completed, reevaluation of any interventions to prevent falls was completed after the fall on 2/5/24 1:21 A.M. fall. The resident's medical record did not contain a post fall evaluation. The resident's care plan did not contain fall risk or any evidence or reevaluation of the resident's care plan for falls. Review of the resident's nurse's notes, dated 2/5/24, at 3:39 A.M., showed the resident was found lying across his/her floor mat sideways, with his/her head off on the floor. The staff did not document evidence of physician notification, family notification, evaluation of fall, or re-evaluation of fall interventions after the 2/5/24 3:39 A.M. fall. The resident's care plan did not contain fall risk or any evidence or reevaluation of interventions to prevent future falls. Review of the resident's nurse's notes, dated 2/5/24, at 9:35 A.M., showed the following: -Witnessed as resident went headfirst out of his/her wheelchair onto his/her knees on the floor in dining room; -Resident did not hit his/her head; -Resident did bump his/her elbow and reopened an old skin tear to right elbow. The staff did not document evidence of physician notification, family notification, evaluation of fall, or re-evaluation of fall interventions after the 2/5/24 9:35 A.M. fall. The resident's care plan did not contain fall risk or any evidence or reevaluation of interventions to prevent future falls. Review of the resident's nurse's notes, dated 2/5/24, at 10:13 P.M., showed the following: -At 5:45 P.M. another resident informed writer that resident was on the floor; -Resident was lying on the floor mat by his/her bed; -Resident was trying to sit up but had poor trunk control; -Resident had a 2 cm x 0.1 cm skin tear superior to right antecubital (elbow) area; -Resident continues to hallucinate; -The resident speaks, he/she has word salad (mixture of words that do not make sense) and garbled speech noted which is not new; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Resident admits to hitting his/her head; -Neurological checks initiated; -Physician notified and orders received to transport the resident to the emergency room for evaluation and treatment. The staff did not document evidence of continued neurological checks, evaluation of the fall, or re-evaluation of fall interventions after the 2/5/24 10:13 P.M. fall. The resident's care plan did not contain fall risk or any evidence or reevaluation of interventions to prevent future falls. Review of the resident's nurse's notes, dated 2/6/24, at 4:33 A.M., showed the following: -Transport driver called at 3:55 AM and asked for someone to meet the facility vehicle outside when they arrived at the building; -The resident was on the floor of the bus, he/she slid out of his/her wheelchair; -The resident did not have injuries; -Resident returned to his/her room and in bed; -Bandage on right upper arm with red drainage, bandage on left lower arm, bruise's on both right and left arms; -Pupils slow to react; -Blood pressure 95/44, heart rate 58 (normal ranges for heart rate is 60-80 beats per minute, blood pressure: 90-120/60-80); -Resident returned from the emergency room with a diagnosis of vascular dementia, unspecified severity, with other behavioral disturbance. During an interview on 2/8/24, at 1:42 PM., Transportation Staff #34 said the following: -He/She and staff member Certified Medication Technician (CMT) #35 went to the hospital to pick the resident up and transport him/her back to the facility on [DATE]; -When the staff arrived at the emergency room the hospital staff brought the resident out to the facility vehicle; -The resident was flipping and flopping, and carrying on; -CMT #35 didn't know what to do; -He/She told the CMT, we will just have to strap him/her the best we can and go; -The resident slid out of the chair while they were driving to the facility; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Observation on 2/8/24, at 1:15 P.M., showed the resident in his/her room. The resident had dark purple bruising around both eyes and on the right cheek. Both of the resident's arms were covered in bruises with the majority of his/her forearms dark purple. The resident has a large uncovered scabbed area approximately 2.5 cm long on his/her right arm above the elbow. During an interview on 2/8/24, at 1:28 P.M., Nurse Aide (NA) #11 said the resident falls a lot. He/She is not sure what was in place to prevent the resident from falling. The resident has a lot of bruises from the falls. The resident has slept the last two days. During an interview on 2/8/24, at 1:20 P.M., the resident's family member said the resident has fallen a lot. This week he/she has fallen, some of the staff say 2 falls and some say 3. Staff said the resident's blood pressure has been low. During an interview on 2/8/24, at 1:42 PM., the DON said the following: -Staff are expected to assess a resident for injuries after a fall, if a resident hit their head or if the fall was unwitnessed staff do neurological checks for 72 hours; -Staff are expected to report the fall to nursing management, the physician, and the resident's family; -The staff are expected to do a post fall evaluation, and the MDS coordinator is expected to update the care plan after re-evaluating the interventions; -Staff should have taken the resident back into the hospital if he/she could not be secured safely in the facility vehicle; -It is not a safe transport if the resident slid out of the wheelchair to the floor of the vehicle, the resident could have had worse injuries. During an interview on 3/13/24, at 8:15 A.M., the Administration said the following: She expected staff to follow up with falls to put measures in place to prevent future falls; -Staff are expected to only transport residents that are safe to transport; combative residents are not safe to transport; -Staff should not accepted the resident from the emergency room if he/she was combative because they could not safely transport a combative resident; -Staff are expected to call their department head or the administrator if there is something they are not sure how to handle a situation.