STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265392	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delhaven Manor	5460 Delmar Blvd Saint Louis, MO 63112

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46970 Based on observation, interview and record review, the facility failed to provide reasonable accommodation of needs and preferences for one resident when staff failed to assist him/her out of bed when he/she requested (Resident #1). The sample size was 3.The census was 60. Review of the facility's Activities of Daily Living (ADLs) Supporting policy, last reviewed by the facility 2/6/24, showed: -Policy Statement: Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living; -Policy Interpretation and Implementation: -Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: -Mobility (transfer and ambulation, including walking); -Care and services to prevent and/or minimize functional decline will include appropriate pain management, as well as treatment for depression and symptoms of depression; -Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals, and recognized standards of practice; -The resident's response to interventions will be monitored, evaluated and revised as appropriate. Review of the facility's Resident's Rights Policy Statement, revised February 2021 and reviewed 2/21/24, showed: -Policy Statement: Employees shall treat all residents with kindness, respect, and dignity; -Policy Interpretation and Implementations: -Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: (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: 265392	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/23/2024
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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A dignified existence; -Be treated with respect, kindness, and dignity; -Self-determination; -Exercise his or her rights as a resident of the facility and as a resident or citizen of the United States; -Be supported by the facility in exercising his or her rights; -Exercise his or her rights without interference, coercion, discrimination or reprisal from the facility. Review of Resident #1's admission nursing evaluation, dated 7/4/23, showed: -Bed mobility - dependent, assistance required, one person; -Transfer - Assistance required, two person. Review of the resident's activity evaluation, dated 7/5/23, showed: Psychosocial well-being: very interested in life/activities. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 1/23/24, showed: -Cognitively intact; -Functional limitation in range of motion, impairment on both upper and lower extremity; -Chair/bed-to-chair transfer was blank, not addressed; -Diagnosis included traumatic spinal cord dysfunction (damage to any part of the spinal cord or nerves at the end of the spinal canal), quadriplegia (affected by or relating to paralysis of all four limbs). Review of the resident's progress note, showed: -On 2/6/24 at 10:14 A.M., Resident was found on the floor. The resident stated that the bed remote was behind his/her right shoulder and head of bed began to elevate. The resident stated that he/she slid out of bed. The resident is alert and oriented times three, complains of neck pain and headache. There was a one centimeter (cm) laceration observed to the right lateral side of his/her head. A pressure dressing was applied. This writer and two Certified Nurse Assistants (CNA) assisted with transferring the resident back to bed via mechanical lift. A call was placed to Emergency Medical Service (EMS). Awaited arrival of EMS; (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 2/6/24 at 11:02 A.M., staff received report from hospital emergency department that the resident has a fracture C-2, and he/she was coming back to the facility. The resident to always remain in his/her cervical collar (C-collar, a medical device used to support and immobilize a person's neck) and has a follow-up medical appointment in two weeks; -On 2/7/24 at 12:50 A.M., Addendum, diagnoses closed nondisplaced fracture (the bone cracks or breaks but retains its proper alignment) of second cervical vertebra unspecified fracture morphology; -On 2/10/24 at 3:03 P.M., caregiver responded to the resident's call light and alerted this writer that the resident was on the floor at bedside. This writer asked the resident if he/she could explain what happened, resident stated that he/she had a muscle spasm in bilateral lower extremities and slid out of the bed. Bed was in the safest position and mat was in place. Resident denied pain. Call was placed to 911; -On 2/20/24, this writer was informed by the CNA the resident was found on the floor laying on mat in bedroom. This writer asked the resident what happened, he/she stated, I rolled out of the bed, rolled over twice on the mat. This writer observed the resident laying on mat facing the wall. The CNA stated that the resident was also laying in the bed facing the wall when he/she checked on him/her earlier. This writer and two caregivers and therapy assisted the resident back to bed. Resident denied being in pain. Resident back in bed. Bed in safest position with call light within reach. Skin assessed underneath C-collar. Skin dry and intact; -On 2/20/24 at 7:13 P.M., the resident was found on the floor this morning unable to tell how it happened. Resident denied any pain or discomfort. Review of the resident's care plan, dated 2/22/24, showed staff did not address the resident's need for staff assistance with transfers. Review of the resident's medical record, showed no new physicain orders the resident could not get out of bed. Observation and an interview on 2/21/24 at 2:50 P.M., showed the resident was in bed. The resident said staff told him/her it would take four people to get him/her out of bed. He/She believed that was an excuse not to get him/her up. The resident said staff told him/her every day if he/she did not get up that day, he/she would get up on the next day. However, staff never got him/her up out of bed. The resident said he/she felt isolated, sad, and like he/she was in jail. He/She had not participated in activities such as dominoes, bingo or going outside since his/her fall. Before the fall, he/she participated in activities but couldn't now. During an interview on 2/21/24 at 3:32 P.M., Certified Medication Technician (CMT) C said he/she knew the resident, but didn't work with him/her regularly. The resident was total care, quadriplegic and used a mechanical lift for transfers. He/She saw the resident outside smoking before, but not lately. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 2/22/24 at 3:11 P.M., showed the resident was in bed. He/She wanted to get up today, but no one got him/her up. He/She thought staff didn't want to get him/her up. The resident said staff told him/her therapy had to check on him/her before he/she could get into his/her motorized wheelchair. The resident thought staff were just telling him/her that. He/She didn't think he/she would get up tomorrow either. The resident said he/she felt like a hostage. During an interview on 2/23/24 at 9:37 A.M., Social Worker G said the resident had been up all the time and attended activities before his/her fall. He/She thought the resident had been a little depressed because the resident wanted to get up but staff had not gotten him/her up out of bed. Social Worker G said he/she understood. The resident required total care, had two falls, and was wearing a neck collar. The resident had not gotten up because of a pressure sore (areas of damage to the skin and the underlying tissue caused by constant pressure or friction) on his/her bottom. The resident wouldn't get back into bed when the staff would ask him/her to. Social Worker G said staff would get him/her up provided the resident would agree to go back to bed. Social Worker G expected staff to get the resident up to his/her chair, if he/she had a pressure relieving cushion in it. Social Worker G said the resident had a pressure relieving cushion for his/her chair. During an interview on 2/23/24 at 10:36 A.M., Therapist D said he/she thought the resident had not been out of bed because he/she was waiting on a follow-up appointment with a physician. He/She didn't know for sure why the resident hadn't gotten out of bed. During an interview on 2/23/24 at 11:28 A.M., CNA E said the resident used to get up every day before his/her fall. The resident could not get out of bed until he/she saw the doctor. Staff would then know if they could get the resident up out of bed. During an interview on 2/23/24 at 2 P.M., Activity Assistant H said before the resident's fall, he/she would come down for activities but after the fall, the resident didn't come down because staff didn't get him/her up. During an interview on 2/23/24 at 2:57 P.M., CMT F said the resident got out of bed every day and participated in activities before he/she fell on [DATE]. He/She said the resident still wanted to participate and was ready to get back rolling like he/she had been. During an interview on 2/23/24 at 2:55 P.M., the Director of Nursing expected staff to get the resident up out of bed if there were not any documented reasons for him/her not to get up. MO00231477 MO00232048

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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 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. 46970 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive care plan to address the resident's specific needs, which included fall interventions. The staff failed to conduct fall investigations to determine fall causes and interventions for 3 of 3 falls. In addition, the faclity failed to revise the resident's care plan to address his/her change in mood and access to socialization (Resident #1). The sample size was 3. The census was 60. Review of the facility's Care Plans, Comprehensive Person-Centered, revised 3/2022, showed: -Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident; -Policy Interpretation and Implementation: -The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident; -The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment; -Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to receive the services and/or items included in the plan of care; -The comprehensive, person-centered care plan: -Includes measurable objectives and timeframes; -Describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; -Includes the resident's stated goals upon admission and desired outcomes; -Builds on the resident's strengths; -Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making; -When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition changes; -The IDT reviews and updates the care plan: -When there has been a significant change in the resident's condition; -When the desired outcome is not met. Review of the facility's Resident's Rights Policy, revised 2/2021, showed: -Policy statement: Employees shall treat all residents with kindness, respect, and dignity; -Policy Interpretation and Implementation: Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: -Be notified of his or her medical condition and of any changes in his or her condition; -Be informed of, and participate in, his or her care planning and treatment; -Be informed of safety or clinical restriction. Review of the facility's Falls-Clinical Protocol, revised 3/2018, showed: -Assessment and recognition: -The physician will help identify individuals with a history of falls and risk factors for falling; -The staff and physician will document in the medical record a history of one or more recent falls; -While many falls are isolated individual incidents, a few individuals fall repeatedly. Those individuals often have an identifiable underlying cause; -In addition, the nurse shall assess and document/report the following: -Recent injury, especially fracture or head injury; -Frequency and number of falls since last physician visit; -The staff and practitioner will review each resident's risk factors for falling and document in the medical record; -The staff will evaluate, and document falls that occur while the individual is in the facility; for example, when and where they happen, any observation of the events, etc; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Fall categorization included circumstances such as sliding out of a chair or rolling from a low bed to the floor; -For an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall; -If the cause of a fall is unclear, or if a fall may have a significant medical cause such as a stroke or an adverse drug reaction (ADR), or if the individual continues to fall despite attempted interventions, a physician will review the situation and help further identify causes and contributing factors; -Based on 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; -Monitoring and Follow-Up: -The staff, with the physician's guidance, will follow up on any fall with associated injury until the resident is stable and delayed complication's 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; -Risks of serious adverse consequences can sometimes be minimized even if falls cannot be prevented; -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 reconsider the current interventions. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated, 1/23/24, showed: -Cognitively intact; -Motorized wheelchair; -Functional limitation in range of motion, impairment on both upper and lower extremity; -Chair/bed-to-chair transfer was blank, not addressed; -Diagnosis included traumatic spinal cord dysfunction (damage to any part of the spinal cord or nerves at the end of the spinal canal) and quadriplegia (affected by or relating to paralysis of all four limbs). (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's progress note, showed: -On 2/6/24 at 10:14 A.M., Resident was found on the floor. The resident stated that the bed remote was behind his/her right shoulder and head of bed began to elevate. The resident stated that he/she slid out of bed. The resident is alert and oriented times three (to person, place and time), complains of neck pain and headache. There was a one centimeter (cm) laceration observed to the right lateral side of his/her head. A pressure dressing was applied. This writer and two Certified Nurse Assistants (CNA) assisted with transferring the resident back to bed via mechanical lift. A call was placed to Emergency Medical Service (EMS). Awaited arrival of EMS; -On 2/6/24 at 11:02 A.M., staff received report from hospital emergency department that the resident has a fracture C-2, and he/she was coming back to the facility. The resident to always remain in his/her cervical collar (C-collar, a medical device used to support and immobilize a person's neck) and has a follow-up medical appointment in two weeks. Review of the resident's after visit hospital summary, dated 2/6/24, showed, reason for visit - fall; Diagnoses: fall, initial encounter, closed nondisplaced fracture of second cervical vertebra, unspecified fracture morphology. Done today: inpatient consult to orthopedic surgery and skin glue. Review of the resident's progress notes, dated 2/7/24 at 7:06 A.M., showed the resident's family inquired about bed siderails Review of the resident's progress note, dated 2/8/24 at 4:06 P.M., showed care plan meeting today with IDT members. The resident unable to attend but family in attendance. The family addressed concerns related to having a 1/2 rail due to the resident falling out of bed. Continue with current care plan. Review of the resident's progress notes, showed: -On 2/10/24, caregiver responded to the resident's call light and alerted this writer that the resident was on the floor at bedside. This writer asked the resident if he/she could explain what happened, resident stated that he/she had a muscle spasm in bilateral lower extremities and slid out of the bed. Bed was in the safest position and mat was in place. Resident denied pain. Call was placed to 911; -No additional documentation regarding this fall. Review of the resident's progress notes, showed: -On 2/20/24, this writer was informed by the CNA that the resident was found on the floor laying on mat in bedroom. This writer asked the resident what happened, he/she stated, I rolled out of the bed, rolled over twice on the mat. This writer observed the resident laying on mat facing the wall. The CNA stated that the resident was also laying in the bed facing the wall when he/she checked on him/her earlier. This writer and two caregivers and therapy assisted the resident back to bed. Resident denied being in pain. Resident back in bed. Bed in safest position with call light within reach. Skin assessed underneath C-collar. Skin dry and intact; (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 2/20/24 at 7:13 P.M., resident was found on the floor this morning unable to tell how it happened. Resident denied any pain or discomfort. Review of the resident's medical record, including the care plan, showed no documentation staff completed fall investigations or any determination if new interventions should have been implemented. Review of the resident's care plan, dated 2/22/24, showed: -Care plan description: The resident is at risk for fall related injury due to history of falling related to poor safety awareness, quadriplegia, and dependent on staff for assistance. The resident wears a cervical collar and has fall mats in place, touch call light in reach at all times. 2/6/24 observed on floor, fracture C-2, 2/10/24 observed on the floor, no injury, 2/20/24, found on the floor, no injury; -Care plan goal: Control of falls to the extent practicable; -Interventions: Refer to physical therapy for evaluation, start date 2/8/24. refer to restorative nursing program, start date 2/8/24. Need call light on to help see at night, start 2/8/24. Monitor for changes in condition that may warrant increased supervision/assistance and notify the physician, start 2/8/24; -No transfer assistance level of care documented; -No new interventions care planned related to falls on 2/10/24 and 2/20/24; -No Social Service documentation related to the resident's change in mood; -No Social Service documentation related to social/mental assessment or interventions; -No interventions related to the resident's ability to attend activities. During an interview on 2/23/24 at 10:36 A.M., Therapy Manager D said she knew the resident's fall on 2/6/24 caused an injury and the resident now wore a C-collar. She assisted with getting the resident back in bed on 2/20/24 from a fall. Therapy Manager D said the resident said his/her pillow slid from underneath his/her head but when he/she was found, the pillow was on the floor and the resident's head was still on the pillow. She said when a resident falls, therapy was responsible to complete a fall screening. She didn't know anything about a bedrail assessment, physical therapy, or the restorative nursing program requests being made at the care plan meeting by the resident's family. Review of the resident's medical record, showed no fall screening documentation. Review of the resident's Social Services progress note, showed: -No documentation related to the resident's change in mood because he/she was not able to get out of bed; -No interventions implemented by Social Services related to the resident's inability to get out of bed or participate in activities. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/23/24 at 9:37 A.M., Social Worker G said the resident required total care, had two falls, and wore a neck collar. He/She thought the resident had been a little depressed because he/she wanted to get up and Social Worker G said he/she understood. The resident had not gotten up because of a pressure sore (areas of damage to the skin and the underlying tissue caused by constant pressure or friction) on his/her bottom. Staff would get him/her up, provided the resident agreed to go back to bed He/She said the resident had been up all the time and attended activities previous to the fall. He/She said the facility had a 1:1 activity program for residents who were in bed or didn't want to come out from their rooms. He/She did not know if the resident was offered those services, but would like to think the resident was offered activities since he/she had been in his/her room. Observation on 2/21/24 at 2:50 P.M., showed the resident was in bed with a scabbed over sore above his/her left eye and on the right side of the back of his/her head. The resident's bed was in its lowest position. During an interview on 2/22/24 at 11:54 A.M., Licensed Practical Nurse (LPN) J said he/she could get care information about residents from his/her care plan and shift report. During an interview on 2/23/24 at 11:28 A.M., CNA E said he/she knew how to care for residents by shift report, looking at the residents, and by the care plan. During an interview on 2/23/24 at 2:50 P.M., the Director of Nursing (DON) said the resident's level of care was dependent. The DON said the first fall was isolated, the second fall was related to a muscle spasm and she was unsure what happened with the third fall. She said investigations had been completed for the falls and a facility post fall tool had been used. She expected a fall investigation to have been completed. She said she didn't know about the family's request for bedrails, physical therapy or restorative nursing program at the care plan meeting. The DON and Administrator both expected the assessments to have been completed, all falls to have been care planned, and the care plan information to have been accurate. She said LPN K (who is also the MDS Coordinator) was responsible for care plan information. At the time of exit on 2/23/24, no documentation for fall investigations, post fall tools, fall assessments or any other assessments were provided. MO00231477 MO00232048

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F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

46970

Based on observation, interview and record review, the facility failed to identify potential safety hazards for one resident's environment, who staff assessed as being unable to move while in bed, when the staff left the bed remote control under the resident's back (Resident #1). The resident's back applied pressure to the bed remote control and caused it to elevate to the highest position. This resulted in a one centimeter laceration of the head and a C-2 (a break in the second vertebra of the neck) neck fracture. In the two weeks following this fall with injury, the resident had two additional falls. The facility failed to investigate and implement additional safety interventions after each fall. The sample size was 7. The census was 60.

Review of the facility's Falls-Clinical Protocol, revised 3/2018, showed:

-Assessment and recognition:

-The physician will help identify individuals with a history of falls and risk factors for falling;

-The staff and physician will document in the medical record a history of one or more recent falls;

-While many falls are isolated individual incidents, a few individuals fall repeatedly. Those individuals often have an identifiable underlying cause;

-In addition, the nurse shall assess and document/report the following:

-Recent injury, especially fracture or head injury;

-Frequency and number of falls since last physician visit;

-Cause Identification:

-For an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall;

-If the cause of a fall is unclear, or if a fall may have a significant medical cause such as a stroke or an adverse drug reaction (ADR), or if the individual continues to fall despite attempted interventions, a physician will review the situation and help further identify causes and contributing factors;

-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;

-Treatment/Management:

(continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Delhaven Manor		STREET ADDRESS, CITY, STATE, ZIP CODE: 5460 Delmar Blvd Saint Louis, MO 63112	

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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 - Minimal harm or potential for actual harm Residents Affected - Few	-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; -Monitoring and Follow-Up: -The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling; -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 reconsider the current interventions; -As needed, and after an appropriately thorough review, the physician will document any uncorrectable risk factors and underlying causes. Review of the facility's Repositioning Level II Policy, revised 5/2013, showed: -Purpose: The purpose of this procedure is to provide guidelines for the evaluation of resident repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort for all bed-or chair-bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents; -Lower the bed into lowest position and place the side rails in the appropriate position as indicated in the resident's care plan; -Place the call light within easy reach of the resident. Review of the facility's Resident's Rights Policy, revised 2/2021, showed: -Policy statement: Employees shall treat all residents with kindness, respect, and dignity; -Policy Interpretation and Implementation: Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: Be informed of safety or clinical restriction. Review of Resident #1's evaluation for use of bed rails, dated 12/9/23, included: -Identify all that contribute to the resident's need to use bed rail(s): weakness and unable to support trunk in upright position; -Will the bed rail(s) assist the resident in: Bed mobility -no; Transfer-no; Other: avoiding rolling out of bed and providing a sense of security-no; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Recommendation: Bedrails are not needed; -Comment: The resident is totally dependent of staff to turn and reposition. He/She is quadriplegic and does not make any movement in bed and is dependent on staff to turn and reposition him/her; Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated, 1/23/24, showed: -Cognitively intact; -Motorized wheelchair; -Diagnosis included traumatic spinal cord dysfunction (damage to any part of the spinal cord or nerves at the end of the spinal canal), quadriplegia (affected by or relating to paralysis of all four limbs). Review of the resident's progress note, showed: -On 2/6/24 at 10:14 A.M., Resident was found on the floor. The resident stated that the bed remote was behind his/her right shoulder and head of bed began to elevate. The resident stated that he/she slid out of bed. The resident is alert and oriented times three (to self, place and time), complains of neck pain and headache. There was a one centimeter (cm) laceration observed to the right lateral side of his/her head. A pressure dressing was applied. This writer and two Certified Nurse Assistants (CNA) assisted with transferring the resident back to bed via mechanical lift. A call was placed to Emergency Medical Service (EMS). Awaited arrival of EMS; -On 2/6/24 at 11:02 A.M., staff received report from hospital emergency department that the resident has a fracture C-2, and he/she was coming back to the facility. The resident to always remain in his/her cervical collar (C-collar, a medical device used to support and immobilize a person's neck) and has a follow-up medical appointment in two weeks; -On 2/7/24 at 12:50 A.M., Addendum, diagnoses closed nondisplaced fracture (the bone cracks or breaks but retains its proper alignment) of second cervical vertebra unspecified fracture morphology. Review of the resident's after visit hospital summary, dated 2/6/24, showed, reason for visit - fall; Diagnoses: fall, initial encounter, closed nondisplaced fracture of second cervical vertebra, unspecified fracture morphology. Done today: inpatient consult to orthopedic surgery and skin glue. Review of the resident's progress note, dated 2/7/24 at 7:06 A.M., showed the resident's family inquired about bed siderails. Review of the resident's progress note, dated 2/8/24 at 4:06 P.M., care plan meeting today with interdisciplinary team (IDT) members. The resident unable to attend but family in attendance. The family addressed concerns related to having a 1/2 rail due to the resident falling out of bed. Continue with current care plan. Review of the resident's progress note, dated 2/10/24, showed: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Caregiver responded to the resident's call light and alerted this writer that the resident was on the floor at bedside. This writer asked the resident if he/she could explain what happened, resident stated that he/she had a muscle spasm in bilateral lower extremities and slid out of the bed. Bed was in the safest position and mat was in place. Resident denied pain. Call was placed to 911; -On 2/20/24, this writer was informed by the CNA the resident was found on the floor laying on mat in bedroom. This writer asked the resident what happened, he/she stated, I rolled out of the bed, rolled over twice on the mat. This writer observed the resident laying on mat facing the wall. The CNA stated that the resident was also laying in the bed facing the wall when he/she checked on him/her earlier. This writer and two caregivers and therapy assisted the resident back to bed. Resident denied being in pain. Resident back in bed. Bed in safest position with call light within reach. Skin assessed underneath C-collar. Skin dry and intact; -On 2/20/24 at 7:13 P.M., the resident was found on the floor this morning unable to tell how it happened. Resident denied any pain or discomfort. Review of the resident's medical record, showed no documentation for fall investigations, post fall tools or fall assessments. Review of the resident's care plan dated 2/22/24, showed: -Care plan description: The resident is at risk for fall related injury due to history of falling related to poor safety awareness, quadriplegia, and dependent on staff for assistance. The resident wears a cervical collar and has fall mats in place; touch call light in reach at all times. 2/6/24 observed on floor, fracture C-2, 2/10/24 observed on the floor, no injury, 2/20/24, found on the floor, no injury; -Care plan goal: Control of falls to the extent practicable; -Intervention: Refer to physical therapy for evaluation. Refer to restorative nursing program. Monitor for changes in condition that may warrant increased supervision/assistance and notify the physician; -The care plan did not address if new interventions were put in place after each fall and what, if any, steps staff should take or implement to ensure safety. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 2/21/24 at 2:50 P.M., showed a scabbed over sore, above the resident's left eye and on the right side of the back of the resident's head. During an interview, the resident said he/she fell out of bed because there was no bedrail on his/her bed. He/She was in bed so the Wound Nurse could check his/her wounds. After the wound care was completed, staff put his/her legs in the middle of the bed, with a pillow behind his/her legs so his/her legs wouldn't move. After the staff left, the bed started to lift, and the head of bed lifted. His/Her legs always face to the right, so that was the direction he/she fell . The bed was up high and when he/she fell out of bed. When he/she fell out of bed, he/she hoped nothing bad would happen. The resident said he/she called for staff, but no one came, and he/she couldn't reach the call light. When staff finally came and saw him/her, he/she was bleeding. Staff told him/her not to move and called the ambulance. The resident said he/she was hurting, and the fall was nothing nice. His/Her legs were leaned toward the right and the momentum just took his/her whole body that way. He/She couldn't brace or catch himself/herself because the resident's hands were contracted (a permanent tightening of the muscles, tendons, skin that causes the joints to shorten and become very stiff) and unable to open. He/She is afraid to be turned away from the wall because there is no bedrail and thinks he/she will fall out of the bed again. The resident said he/she fell again yesterday . He/She was repositioned in bed and at some point, the pillow started to slide towards the left, with his/her head on the pillow. The resident said he/she was trying to reposition himself/herself and the more he/she moved, the more the pillow moved, until he/she fell to the floor. The resident said he/she fell out of bed, landing on the pillow but he/she wasn't hurt. Even though the bed was low, it hurt his/her neck. During an interview on 2/23/24 at 10:36 A.M., Therapy Manager D said she knew one fall caused the injury and that the resident was wearing a C-collar. She assisted with getting the resident back in bead on 2/20/24 from a fall. Therapy Manager D said the resident said his/her pillow slid from underneath his/her head but when he/she was found, the pillow was on the floor and the resident's head was still on the pillow. She said when a resident falls, therapy is responsible to complete a fall screening. She didn't know anything about the care plan meeting bedrail assessment request. Review of the resident's medical record, showed no fall screening documentation in the progress note or medical chart. During an interview on 2/23/24 at 11:28 A.M., CNA E said the resident fell on his/her call light on 2/6/24. When he/she went to answer the call light is when he/she saw the resident on the floor. He/She stood at the resident's door and hollered for the nurse. He/She said they didn't move the resident because he/she had complained that his/her neck was hurting. The resident was lying on the floor on his/her left side. He/She had blood coming out of his/her head on the left side. That was the first time the resident fell . He/She didn't have bedrails. The resident said he/she was lying on the bed remote, and the bed kept raising up and that's when he/she fell out. The bed was all the way up in its highest position when the resident fell . CNA E said he/she didn't know how the bed remote got underneath the resident's back. As far as he/she knew, the resident's head was the only thing hurt but when the resident came back to the facility, he/she had a neck brace on. CNA E said the second time the resident fell out of bed, he/she had a muscle spasm. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/23/24 at 2:50 P.M., the Director of Nursing (DON) said the resident's level of care was dependent (total care) and she didn't know about the care plan meeting bedrail assessment request. The DON said the first fall was isolated, the second fall was related to a muscle spasm, and she was unsure what happened with the third fall. She said investigations had been completed for the falls and a facility post fall tool had been used. She expected a fall investigation to have been completed and fall precautions to have been in place at the time of admission. The DON said if nursing did an assessment and thought it was safe to move the resident, after he/she complained of neck and headache, then it was safe to do so. At the time of exit on 2/23/24 no documentation for fall investigations, post fall tools, fall assessments or screenings had been provided. MO00231477 MO00232048

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46970 Based on observation, interview, and record review, the facility failed to provide services to promote one of seven sampled resident's highest possible level of well-being, to assure the emotional and social needs of the resident were met/maintained. The facility also failed to address the resident's mental and psychosocial needs thoroughly, which negatively impacted him/her, causing feelings of isolation and sadness (Resident #1). The sample was 7. The census was 60. Review of the facility's Social Service Designee documentation policy, dated 2003, showed: -The primary purpose of your job position is to assist in planning, developing, organizing, implementing, evaluating, and directing our facility's social service programs in accordance with current existing federal, state, and local standards, as well as our established policies and procedures, to assure that the medically related emotional and social needs of the resident are met/maintained on an individual basis; -Administrative functions: -Record and maintain regular social service progress notes indicating response to the treatment plan; -Coordinate social service activities with other departments as necessary; -Make routine visits to residents and perform services as necessary; -Work with emotional problems including assist resident/family with anxieties and stress caused by illness and admission to the facility, difficulties in coping with residual physical disabilities, fears related to helplessness and death, and the need for institutional and specialized care; -Assist in providing solutions for social and practical environmental problems; -Assist in interpreting social, psychological, and emotional needs of the resident/family to the medical staff, attending physician, and other resident care team members; -Assist in obtaining resources from community social, health and welfare agencies to meet the needs of the resident; -Provide consultation to members of our staff, community agencies, etc., in efforts to solve the needs and problems of the resident through the development of social service programs. Review of the facility's Activities of Daily Living (ADLs) Supporting policy, last reviewed by the facility 2/6/24, showed: -Policy Statement: Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living; (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Policy Interpretation and Implementation: -Care and services to prevent and/or minimize functional decline will include appropriate pain management, as well as treatment for depression and symptoms of depression; -Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals, and recognized standards of practice. Review of the facility's Resident's Rights Policy Statement, revised February 2021 and reviewed 2/21/24, showed: -Policy Statement: Employees shall treat all residents with kindness, respect, and dignity; -Policy Interpretation and Implementations: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: -A dignified existence; -Be treated with respect, kindness, and dignity; -Self-determination; -Communication with and access to people and services, both inside and outside the facility. Review of Resident #1's activity evaluation, dated 7/5/23, showed: Psychosocial well-being: very interested in life/activities. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated, 1/23/24, showed: -Cognitively intact; -Rarely felt lonely or isolated; -Motorized wheelchair; -Diagnosis included traumatic spinal cord dysfunction (damage to any part of the spinal cord or nerves at the endo of the spinal canal), quadriplegia (affected by or relating to paralysis of all four limbs). (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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's progress note, dated 2/6/24 at 10:14 A.M., showed the resident was found on the floor. The resident stated that the bed remote was behind his/her right shoulder and head of bed began to elevate. The resident stated that he/she slid out of bed. The resident is alert and oriented times three, complains of neck pain and headache. There was a one centimeter (cm) laceration observed to the right lateral side of his/her head. A pressure dressing was applied. This writer and two Certified Nurse Aides (CNAs) assisted with transferring the resident back to bed via mechanical lift. A call was placed to Emergency Medical Services (EMS). Awaited arrival of EMS. Observation and interview on 2/21/24 at 2:50 P.M., showed the the resident in bed. During an interview, he/she said he/she had no activities available to him/her. Before the fall, he/she had participated in activities but couldn't now. He/She felt isolated, sad, and like he/she was in jail. He/She was told by staff that it would take four people to get him/her out of bed, but he/she believed that was an excuse not to get him/her up. The resident said staff told him/her every day if he/she did not get up that day, he/she would get up on the next day. However, staff never got him/her up out of bed. The resident said he/she had not participated in activities, such as dominoes, bingo, or going outside since his/her fall. During an interview on 2/21/24 at 3:32 P.M., Certified Medication Technician (CMT) C said he/she knew the resident but didn't work with him/her regularly. The resident was total care, quadriplegic, and used a mechanical lift for transfers. He/She saw the resident outside smoking before but not lately. Observation and interview on 2/22/24 at 3:11 P.M., showed the resident in bed. The resident said he/she wanted to get up, but no one got him/her up. He/She thought staff didn't want to get him/her up. The resident said staff told him/her therapy had to check on him/her before he/she could get into his/her motorized wheelchair. The resident thought staff was just telling him/her that and didn't think he/she would get up tomorrow either. The resident said he/she felt like a hostage. During an interview on 2/23/24 at 10:36 A.M., Therapist D said he/she thought the resident had not been out of bed because he/she was waiting on a follow-up appointment with a physician. He/She was not aware of any evaluation or assessment request for getting the resident out of bed. During an interview on 2/23/24 at 11:28 A.M., CNA E said the resident used to get up everyday before his/her fall. He/She said the resident wasn't getting out of bed now until he/she would see the doctor. Then staff would know then if they could get the resident up out of bed. During an interview on 2/23/24 at 2 P.M., Activity Assistant H said before the resident's fall, he/she would come down for activities but after the fall, the resident didn't come down. Staff didn't get him/her up or he/she couldn't get up, was as much as he/she knew. If residents didn't come downstairs for activities, activity staff would go to the resident rooms to see if they wanted activities in their room. He/She didn't know if the Activity Director went to the resident's room to see if he/she wanted activities or not. During an interview on 2/23/24 at 2:57 P.M., CMT F said the resident got out of bed every day and participated in activities before he/she fell on [DATE]. He/She said the resident still wanted to participate and was ready to get back rolling like he/she had been doing. Review of the resident's care plan, dated 2/22/24, showed: (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No activity interventions in place; -No social service documentation related to the resident's change in mood; -No social service documentation related to an assessment or interventions. Review of the resident's Social Services progress note, showed: -No documentation related to the resident's change in mood because he/she was not able to get out of bed; -No interventions implemented by Social Services related to the resident's sudden inability to get out of bed or participate in activities. During an interview on 2/23/24 at 9:37 A.M., Social Worker G said the resident required total care, had two falls, and was wore a neck collar. He/She thought the resident had been a little depressed because he/she wanted to get up and Social Worker G said he/she understood. The resident had not gotten up because of a pressure sore (areas of damage to the skin and the underlying tissue caused by constant pressure or friction) on his/her bottom. The resident didn't want to get back into bed when the staff would ask him/her to. Staff would get him/her up, provided the resident agreed to go back to bed. Social Worker G expected staff to get the resident up to his/her chair, if he/she had a pressure relieving cushion in it. Social Worker G said the resident had a pressure relieving cushion for his/her chair. He/She said the resident had been up all the time and attended activities previous to the fall. He/She said the facility had a 1:1 activity program for residents who were in bed or didn't want to come out from their rooms. He/She did not know if the resident was offered those services, but would like to think the resident was offered activities since he/she had been in his/her room. He/She would check on the resident and make sure he/she had activities. During an interview at 11:02 A.M., Social Worker G said he/she spoke with the Activity Director to have the resident put on the 1:1 activity program roster today and would get a radio for his/her room. Observation on 2/23/24 at 1:52 P.M., showed the resident up in his/her wheelchair in the dining room parked alongside the dining room table. The resident was playing bingo and socializing with other residents. During an interview at 2:20 P.M., the resident said he/she was happy to be out of bed. Observation on 2/23/24 at 3:20 P.M., showed the resident outside the facility in his/her motorized wheelchair. He/She was smiling. He/She was talking and laughing with other residents who were outside at the time. During an interview on 2/23/24 at 2:55 P.M., the Director of Nursing (DON) said he/she expected Social Services to address the resident's feelings of depression, related to being in his/her room and unable to get up. The DON expected the Activity Director to provide activities to the resident while he/she had been in his/her room. MO00231477 (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MO00232048