STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265656	A. Building B. Wing	04/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Strafford Care Center	505 West Evergreen Strafford, MO 65757

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41559 Based on interview and record review, the facility failed to ensure residents were treated with dignity and respect at all times when one staff (Certified Nurses Assistant (CNA) B) was spoke in a rude, loud, and disrespectful manner to one resident (Resident #1). The facility had a census of 69. Review of the facility's Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Resident Property Policy, not dated and provided as the facility's dignity/respect policy, showed the following guidance: -Any employee or volunteer who becomes aware of abuse, mistreatment, neglect, exploitation, or misappropriation shall immediately report to the nursing home administrator. (The policy did not address treating residents in a dignified manner.) 1. Review of Resident #1's face sheet (basic information sheet) showed the following: -admitted [DATE]; -Diagnoses included Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors) and dementia (a group of thinking and social symptoms that interferes with daily functioning). Review of the resident's Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 01/28/24, showed the resident was cognitively intact. Review of the resident's care plan, current as of 04/07/24, showed the following: -The resident required one staff assistance with transfers; -The resident has behaviors including being rude to other residents, roommates, and their families. During an interview on 04/07/24, at 10:45 A.M., the resident said the following: -He/She typically goes to bed around 7:30 P.M., to 8:00 P.M.; (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: 265656	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/07/2024
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 04/06/24, sometime during the second shift he/she put his/her call light on because he/she was wet; -He/She yelled down the hall to CNA B who was at the nurses' station; -The resident said the CNA B appeared frustrated and was not happy about helping the resident to bed; -He/She and CNA B, got into it with each other; -The resident became increasingly upset when asked about the interaction between him/her and CNA B; -The resident appeared reserved with his/her body language and fidgeted with his/her hands frequently (rubbing hands) while avoiding eye contact often looking at the floor when discussing the incident. During an interview on 04/07/24, at 2:56 P.M., the resident reiterated her statements from the earlier interview and said him/her and CNA B had words. The resident exhibited similar body language when asked about the interaction between the resident and CNA B. Review of the resident's nurses' notes, dated 04/06/24 to 04/07/24, showed staff did not document related to the interaction between CNA B and the resident. Review of CNA B's written statement showed the following: -On 04/06/24, at 7:30 A.M., he/she was at the desk trying to calm another resident; -Resident #1 was outside his/her room and started yelling, CNA B, I want to get in bed; -He/She responded, I'm busy helping someone else right now, I'll help you when I'm done; -When he/she pushed the resident's wheelchair into the bathroom and was getting the resident ready for bed the resident started yelling, Why were you standing at the desk with the other resident; -He/She told the resident, I was trying to calm the other resident; -The resident responded, Well, I wanted to get in bed; -He/She told the resident, Resident #1, other people need help too, you cant always be first; -Resident #1 then started yelling about putting his/her undergarments in a trash bag in his/her drawer; -He/She told the resident, Resident #1, you can ask nicely. You don't have to be so demanding. During an interview on 04/07/24, at 1:50 P.M., CNA B said the following: -He/She was at the nurses' station calming another resident; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident started yelling at him/her stating he/she wanted to go to bed; -He/She told the resident he/she would return to assist after putting the other resident to bed; -He/She assisted the resident to the toilet and the resident started yelling at him/her because the resident wanted his/her clothes put in his/her bag instead of the bag the CNA was using; -He/She told the resident, You could be nice to us, you don't have to be demanding all the time. CNA B said he/she told this to the resident in a normal manner. Review of CNA F's typed statement, dated 04/07/24, showed the following: -The resident was sitting in his/her doorway; -He/She asked the resident what he/she needed; -The resident said his/her roommate was yelling; -He/She entered the room and noted the roommate had vomited; -He/She left and gathered items to address the vomit and care for the roommate and returned; -The resident said he/she was ready for bed; -CNA B entered the room to assist the resident; -The resident was assisted to the bathroom by CNA B; -The resident began yelling at CNA B stating he/she noticed CNA B standing at the nurses' station doing nothing when he/she wanted to go to bed; -CNA B told the resident he/she was assisting another resident and came to assist him/her when he/she was available; -He/She reports CNA B was appropriate in tone, stance, and mannerism. During an interview on 04/07/24, at 11:18 A.M., Certified Medication Technician (CMT) A said the following: -He/She was working the second shift (2:00 P.M., to 10:00 P.M) on 04/06/24; -He/She witnessed CNA B being loud, rude, and disrespectful to the resident in the hallway outside the resident's room; -The resident asked CNA B for assistance to go to bed; -CNA B responded to the resident by stating, Don't you see I'm busy, in a rude and disrespectful tone; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident mumbled in response; -CNA B said to the resident, What did you say? in a rude and disrespectful tone; -The resident replied, nothing; -CNA B said to the resident, That's what I thought, in a rude and disrespectful tone; -CNA B was loud, rude, and disrespectful when talking to the resident; -The resident appeared upset with how CNA B was speaking to him/her; -He/She reported this to Registered Nurse (RN) E around 7:35 P.M.; -RN E acknowledged the report stating CNA B's attitude was too much; -RN E did not do anything to address CNA B's behavior; -He/She did not report his/her concerns to anyone else; -He/She has reported concerns of CNA B's behavior to administrative staff in the past. During an interview on 04/07/24, at 2:01 P.M., CMT C said the following: -He/She works the second shift; -He/She was working on a different hall than CNA B on 04/06/24; -During the shift CNA D reported to him/her that he/she walked into the resident's room and observed CNA B and the resident yelling at each other; -CNA D reported CNA B told the resident, You yelled at me first; -He/she has witnessed CNA B yelling at residents in a rude and disrespectful manner in the past; -CNA B has told residents, Okay, Stop hitting your call light, in a rude and disrespectful tone; -He/She reported concerns regarding CNA B's behavior about one month ago to administrative staff; -Staff should be respectful towards residents at all times. During an interview on 04/07/24, at 2:21 P.M., CNA D said the following: -He/She works the second shift; -He/She was working on the memory unit on 04/06/24; -He/She usually assists the resident to bed around 8:00 P.M., to 8:30 P.M.; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She left the memory unit and went to the resident's room; -He/She entered the room and observed CNA B tell the resident in a rude and disrespectful manner, Well, you were yelling at me first; -The resident was obviously upset; -He/She left the room quickly following observing this interaction and returned to the memory unit; -CMT A reported the concerns of CNA B's behavior to RN E; -He/She did not report her concerns to anyone because CMT A had reported to RN E; -CNA B is unprofessional; -He/She has seen CNA B be disrespectful and rude to residents in the past and it has been reported to administration; -CNA B told staff (unsure date or time) while he/she was present that, If there were an emergency he/she would just shut the resident in his/her room and leave him/her there; -Staff should be respectful to residents at all times; -Concerns regarding staff behavior should be reported to the charge nurse. During an interview on 04/07/24, at 2:42 P.M., RN E said the following: -He/She was the charge nurse on 04/06/24 for the second shift; -He/She was unaware of any reports of CNA B having inappropriate behavior toward a resident; -He/She denied any reports of CNA B being rude or disrespectful toward any residents on 04/06/24; -He/She would have removed CNA B from the floor pending investigation if reported; -Staff are to be respectful to residents at all times; -Any concerns of staff behavior should be reported immediately to the charge nurse or Assistant Director of Nursing (ADON). During an interview on 04/07/24, at 2:55 P.M., the ADON said the following: -There have not been any reports of inappropriate behavior from CNA B toward residents he/she is aware of; -He/She has not seen any inappropriate behavior from CNA B toward any residents; -Staff are to be polite and respectful to residents at all times; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Any concerns should be reported immediately to administrative staff after ensuring resident safety. During an interview on 04/07/24, at 3:11 P.M., the Director of Nursing (DON) said the following: -He/She has not received any reports of inappropriate behavior from CNA B toward any residents; -He/She has not seen any inappropriate behavior from CNA B; -Staff should be respectful to residents at all times; -If there are concerns of staff behavior the residents safety should be ensured first and then the concerns should be reported to the charge nurse. During an interview on 04/07/24, at 3:31 P.M., the Administrator said the following: -Staff are to be professional and treat residents with respect; -He had not received any report of concerns of staff behavior; -Concerns of staff behavior should be reported immediately to the charge nurse and the Administrator for appropriate action. MO00234299

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41559 Based on observation, interview, and record review, the facility failed notify the physician and resident representative of a fall with injury in a timely fashion for one resident (Resident #1). The facility census was 70. Review of the facility policy titled, Fall Champion Program, not dated, showed the following information: -Staff are to notify the Medical Director, Fall Champion, and Administrator of falls; -Staff are to notify the resident's physician and family/responsible party and document the notification in the fall event. 1. Review of Resident #1's face sheet (basic information sheet) showed the following information: -admitted [DATE]; -Diagnoses included dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) without behavioral disturbance, adult failure to thrive, reduced mobility, chronic pain, encounter for adjustment and management of a vascular access device, and an irregular heart beat; -The resident had an designated responsible party. Review of the resident's Minimum Data Sheet (MDS - a federally mandated assessment tool completed by facility staff), dated 03/21/24, showed the following: -Severe cognitive impairment; -History of falls; -Utilized a walker and wheelchair for mobility assistance; -Required supervision for walking; -Required partial to moderate assistance with mobility. Review of the resident's care plan for falls, last reviewed/revised 05/01/24, showed the following: -The resident was at risk for falling related to poor vision; -The resident had no-injury falls noted for 02/14/24, 03/30/24, 04/03/24, and 04/27/24; (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had a fall on 04/30/24 with an abrasion noted to the left forehead, left arm, and left wrist. Review of the resident's progress note dated 04/30/24, at 3:00 A.M., showed Licensed Practical Nurse (LPN) A documented the resident was sitting in his/her wheelchair refusing to go to his/her room or sit in his/her recliner. The LPN and another staff heard a thud. The resident was observed lying on the floor face down. The resident had one arm above his/her head and was holding his/her head with the other arm. Staff went to get the resident off the floor and observed a small amount of blood on the floor. The resident had a bump with a laceration on the left side of his/her forehead. The resident had a skin tear on his/her left wrist and upper arm. The areas were cleaned and dressed. The resident was able to move his/her upper and lower extremities, had strong and equal grips, and eyes were reactive to light. The resident's clothes were changed and he/she was assisted to bed. (Staff did not document notification of the resident's physician or representative of the fall with injury.) Review of the resident's progress note dated 04/30/24, at 10:34 A.M., showed LPN B documented a fall follow-up for the resident. The resident had a fall in the morning with an abrasion to his/her forehead with no complaints of pain or discomfort noted. The resident was able to move all extremities without distress. The resident's vital signs were within normal limits and he/she was up in his/her wheelchair at the time of the note. (Staff did not document notification of the resident's physician or representative of the fall with injury.) Review of the resident's fall event report, dated 04/30/24 and closed on 05/03/24, showed the following information: -LPN A documented the resident fell on [DATE] at 3:00 A.M.; -The fall was unwitnessed; -The resident had a bump, laceration, and skin tear noted; -Staff did not document physician notification; -Staff did not document responsible party notification. Review of the resident's progress note dated 05/02/24, at 1:16 P.M., showed LPN C documented a late entry progress note for 04/30/24, at 11:10 A.M. LPN C documented at 10:30 A.M., the resident had complaints of left leg pain. The resident stated he/she had shooting pain down his/her leg that worsened when touched and with any movement. LPN C reported the assessment to the Nurse Practitioner (NP) D who was on-call for the resident's physician. The NP gave orders to x-ray the resident's left pelvis/hip, femur (thighbone), knee, tibia (shin bone), and fibula (calf bone). LPN C contacted the x-ray company and ordered images over the phone and documented the orders in the medical record. (Staff did not document notification of the resident's responsible party.) During an interview on 05/22/24, at 10:00 A.M., NP D said the following: -He/She spoke to someone at the facility on 04/30/24 around 10:30 A.M., regarding reported left hip pain for the resident; (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She noted the resident lost balance on 04/27/24 and had complaints of left hip pain. He/She ordered an x-ray; -He/She did not have any note regarding a fall occurring on 04/30/24 at 3:00 A.M.; -The physician's office should be notified regarding falls. During an interview on 05/22/24, at 8:41 A.M., NP F said the following: -On 04/30/24, at 10:30 A.M., LPN C contacted the NP on-call who noted the resident had complaints of hip and leg pain following the resident losing his/her balance and falling on 04/27/24; -The physician's office has no note regarding a fall on 04/30/24 at 3:00 A.M.; -They are usually contacted immediately following falls. During an interview on 05/22/24, at 2:18 P.M., the resident's Physician said the following: -He was unaware of any notification the resident had a fall on 04/30/24 at 3:00 A.M.; -He should be notified by facility staff regarding any fall quickly; -The resident's family was also upset due to not being notified regarding the fall. During an interview on 05/22/24, at 11:51 A.M., LPN A said the following: -He/She was the charge nurse during the 10:00 P.M. to 6:00 A.M. shift on 04/30/24; -On 04/30/24, around 3:00 A.M. to 3:30 A.M., the resident fell in the area next to the day room and dining room near the nurses' station; -He/She looked away from the resident and heard a thud; -When he/she looked back the resident was on the floor; -He/She assessed the resident for injuries while on the floor; -The resident had a small raised abrasion on the left side of his/her forehead; -The resident was able to move his/her arms and legs without issues or complaints of pain; -The resident's vital signs were normal; -Staff got the resident up from the floor and placed in his/her wheelchair without issue; -Staff took the resident to his/her room and put him/her in bed. The resident had no complaints of pain; (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She could not recall if he/she contacted the physician or family following the fall; -If a fall occurs overnight and there are no immediate concerns staff usually wait to contact the physician and family until the following morning. During an interview on 05/22/24, at 9:01 A.M., LPN B said the following: -He/She was the charge nurse for the 6:00 A.M. to 2:00 P.M., shift for 04/30/24; -He/She received report from the off-going charge nurse (LPN A) at 6:00 A.M.; -LPN A reported the resident fell during his/her shift; -LPN A did not report if he/she had contacted the physician or family; -The physician and family/responsible party should be contacted immediately following falls. During an interview on 05/21/24, at 3:15 P.M., LPN C said the following: -He/She was the Assistant Director of Nursing (ADON) on 04/30/24; -He/She thought the injury may have been related to a previous non-injury fall that occurred on 04/27/24; -The physician and family/responsible party should be notified as soon as possible following the fall and the notification should be documented in the progress notes. During an interview on 05/21/24, at 3:45 P.M., Registered Nurse (RN) E said the following: -He/She was the charge nurse for the 2:00 P.M. to 10:00 P.M. shift on 04/30/24; -He/She called the physician and family; -The NP seemed surprised and the family was not aware of the fall; -The physician and family/responsible party should be notified immediately following a fall. During an interview on 05/21/24, at 1:33 P.M., the MDS Coordinator said the following: -LPN A was the nurse working on 04/30/24, at 3:00 A.M., when the resident fell ; -The fall should be reported to the physician and family/responsible party as soon as possible once the resident is stable; -Any notifications made should be documented in the nursing notes or fall event. During an interview on 05/22/24, at 12:23 P.M., the Interim Director of Nursing (DON) said he following: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The physician should be contacted immediately following the fall for any orders or monitoring needed followed by contact to the family or responsible party; -The notifications should be documented in the fall event in the medical record. During an interview on 05/22/24, at 1:15 P.M., the Administrator said the following: -He/She was not made aware of the resident's fall or x-ray orders on 04/30/24, at 3:00 A.M., until after the resident was sent to the hospital; -The physician, family or responsible party, DON, and Administrator should be notified immediately following a fall; -Notification of the physician and family or responsible party should be documented in the progress notes by the nurse. MO00235482

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F 0684 Level of Harm - Minimal harm or potential for 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** 41559 Based on observation, interview, and record review, the facility failed to provide care per standards of practice when the facility failed to complete/document neurological checks (a series of tests that assess mental status, reflexes, and movements) timely after a fall with a head injury, failed to ensure all nursing staff were aware of the fall with injury and fall monitoring, and failed to timely address x-rays results showing a fracture after fall for one resident (Resident #1). The facility also failed to provide care per standards of practice when staff failed to complete an ordered urinalysis (UA) timely and when failed to administer medications to treat a urinary tract infection (UTI) as ordered for one resident (Resident #2). The facility census was 70. 1. Review of the facility policy titled, Fall Champion Program, not dated, showed the following information: -The facility is to appoint a Fall Champion to assist in the oversight and monitoring of the fall prevention program; -Staff are to stay with the resident; -Emergency care is to be provided as needed; -Staff are to take vital signs and assess condition of the resident; -If the fall is not witnessed or the resident hits their head neurological checks are to be implemented immediately; -Staff are to notify the Medical Director, Fall Champion, and Administrator; -Staff are to document a fall event in the medical record; -Staff are to notify the resident's physician and family/responsible party and document the notification in the fall event; -Staff are to complete post fall follow-up for 72 hours including assessment, documentation of the resident's condition in progress notes, and neurological checks; -The charge nurse is to initiate preventative fall interventions immediately. Review showed the facility did not provide a policy regarding neurological checks. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Saunder's Medical-Surgical Nursing, 4th edition, 2002, showed that neurological assessments (neuro checks) can detect early signs of central nervous system (brain) deterioration and are commonly done after a person sustains a head injury to detect complications. One of the most serious types of head injuries is a subdural hematoma (which consists of a collection of blood on the surface of the brain) and is an emergency condition. The purpose of performing neurological assessments is to establish a baseline upon which subsequent assessments can be compared and changes in neurological status can be determined. Review of Resident #1's face sheet (basic information sheet) showed the following information: -admitted [DATE]; -Diagnoses included dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) without behavioral disturbance, adult failure to thrive, reduced mobility, chronic pain, encounter for adjustment and management of a vascular access device, and an irregular heart beat; -The resident had an designated responsible party. Review of the resident's Minimum Data Sheet (MDS - a federally mandated assessment tool completed by facility staff), dated 03/21/24, showed the following: -Severe cognitive impairment; -History of falls; -Utilized a walker and wheelchair for mobility assistance; -Required supervision for walking; -Required partial to moderate assistance with mobility. Review of the resident's care plan for falls, last reviewed/revised 05/01/24, showed the following: -The resident was at risk for falling related to poor vision; -The resident had no-injury falls noted for 02/14/24, 03/30/24, 04/03/24, and 04/27/24; -The resident had a fall on 04/30/24 with an abrasion noted to the left forehead, left arm, and left wrist. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Strafford Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 505 West Evergreen Strafford, MO 65757	

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's progress note dated 04/30/24, at 3:00 A.M., showed Licensed Practical Nurse (LPN) A documented the resident was sitting in his/her wheelchair refusing to go to his/her room or sit in his/her recliner. The LPN and another staff heard a thud. The resident was observed lying on the floor face down. The resident had one arm above his/her head and was holding his/her head with the other arm. Staff went to get the resident off the floor and observed a small amount of blood on the floor. The resident had a bump with a laceration on the left side of his/her forehead. The resident had a skin tear on his/her left wrist and upper arm. The areas were cleaned and dressed. The resident was able to move his/her upper and lower extremities, had strong and equal grips, and eyes were reactive to light. The resident's clothes were changed and he/she was assisted to bed. Staff initiated neurological checks and vital signs were in a normal range. Review of the resident's Observation Detail List Report, dated 04/30/24, showed the following information: -Instructions showed neurological checks were required to be completed every fifteen (15) minutes for the first hour, every thirty (30) minutes for the second hour, every hour for the next two hours, and every shift for the next 72 hours; -On 04/30/24, at 3:00 A.M., a 15-minute interval neurological assessment was documented by LPN A. The resident was noted to have a lethargic/drowsy level of consciousness and sluggish pupil response, strong motor function, and no signs or symptoms of pain; -On 04/30/24, at 3:15 A.M., a 15-minute interval neurological assessment was documented by LPN A. The resident was noted to be alert with pupils equal and reactive to light, strong motor function, and no signs or symptoms of pain; -On 04/30/24, at 3:30 A.M., a 15-minute interval neurological assessment was documented by LPN A. The resident was noted to be alert with pupils equal and reactive to light, strong and weak motor function marked for the left lower extremity, and no signs or symptoms of pain; -Staff did not document completion of the fourth 15-minute neurological assessment scheduled for 04/30/24 at 3:45 A.M.; -Staff did not document completion of the two sets of 30-minute neurological assessments for the second hour following the fall on 04/30/24; -Staff did not document completion of the two sets of required hourly neurological assessments for the third and fourth hour following the fall on 04/30/24. Review of the resident's progress note dated 04/30/24, at 10:34 A.M., showed LPN B documented a fall follow-up for the resident. The resident had a fall in the morning with an abrasion to his/her forehead with no complaints of pain or discomfort noted. The resident was able to move all extremities without distress. The resident's vital signs were within normal limits and he/she was up in his/her wheelchair at the time of the note. (continued on next page)

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Strafford Care Center	505 West Evergreen Strafford, MO 65757

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's progress note dated 05/02/24, at 1:16 P.M., showed LPN C documented a late entry progress note for 04/30/24, at 11:10 A.M. LPN C documented at 10:30 A.M., the resident had complaints of left leg pain. The resident stated he/she had shooting pain down his/her leg that worsened when touched and with any movement. LPN C reported the assessment to the Nurse Practitioner (NP) D who was on-call for the resident's physician. The NP gave orders to X-ray the resident's left pelvis/hip, femur (thighbone), knee, tibia (shin bone), and fibula (calf bone). LPN C contacted the X-ray company and ordered images over the phone and documented the orders in the medical record. Review of the resident's physician's orders, dated 04/01/24 to 05/01/24, showed an order dated 04/30/24, at 10:30 A.M., for x-ray of the left femur (thigh bone), hip, and knee for diagnoses of reduced mobility. Review of the resident's progress note dated 04/30/24, at 4:15 P.M., showed Registered Nurse (RN) E documented the resident had an unwitnessed fall in the early morning on 04/30/24. The resident had an abrasion to his/her forehead and the nurse cleansed the wound with wound cleanser, patted dry, applied antibiotic ointment to the wound, and covered with a band aid. The resident denied any pain or discomfort. The RN documented he/she assessed the resident and no other injuries were noted. The RN documented staff will continue resident on fall follow-up with neurological checks through 05/03/24. Review of the resident's x-ray report, dated 04/30/24, showed the following: -An X-ray was completed on 04/30/24 for an indication of left hip and lower extremity pain from a recent fall; -Findings showed an acute high impacted fracture (fracture where the broken ends of the bone are jammed together by the force of the injury) of the neck of the left femur; -The findings were electronically signed by a physician on 04/30/24, at 4:28 P.M. Review of the resident's Observation Detail List Report, dated 04/30/24, showed on 04/30/24, at 4:38 P.M., a per shift neurological assessment was documented by RN E. The resident was noted to be alert with pupils equal and reactive to light, strong motor function, and no signs or symptoms of pain. During an interview on 05/22/24, at 9:49 A.M., an X-ray Company Staff said the following: -The resident's X-ray results were faxed to the facility on [DATE] at 4:45 P.M.; -A follow-up call regarding the report was placed on 05/01/24 at 1:00 A.M.; -The call follow-up was received by LPN A. Review of the resident's hospital record, dated 04/30/24 to 05/02/24, showed the following: -Emergency Medical Services (EMS) received a call on 04/30/24, at 10:34 P.M., for report of a hip fracture; -EMS was dispatched to the facility on [DATE] at 10:37 P.M.; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-EMS arrived to the facility on [DATE] at 10:51 P.M.; -EMS assessed the resident on 04/30/24 at 11:03 P.M.; -The resident was transported by EMS to the hospital on 04/30/24 at 11:09 P.M. Review of the resident's fall event report, dated 04/30/24 and closed on 05/03/24, showed the following information: -LPN A documented the resident fell on [DATE] at 3:00 A.M.; -The fall was unwitnessed; -The 72 hour neurological checks are to be completed and documented appropriately; -The fall occurred in the day room; -The resident was sitting in his/her wheelchair prior to the fall; -The resident had a bump, laceration, and skin tear noted; -The resident had full range of motion to all four extremities without pain, rotation, deformity, or shortening noted; -The resident was alert with agitation, anxiety, and restlessness noted; -The notifications section showed staff did not document notification of the attending physician; -The notifications section showed staff did not document notification of the responsible party. During an interview on 05/22/24, at 11:51 A.M., LPN A said the following: -He/She was the charge nurse during the 10:00 P.M. to 6:00 A.M. shift on 04/30/24; -On 04/30/24, around 3:00 A.M. to 3:30 A.M., the resident fell in the area next to the day room and dining room near the nurses' station; -He/She looked away from the resident and heard a thud; -When he/she looked back the resident was on the floor; -He/She assessed the resident for injuries while on the floor; -The resident had a small raised abrasion on the left side of his/her forehead; -The resident was able to move his/her arms and legs without issues or complaints of pain; -A neurological assessment was completed at that time with no identified concerns; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident's vital signs were normal; -Staff got the resident up from the floor and placed in his/her wheelchair without issue; -Staff took the resident to his/her room and put him/her in bed. The resident had no complaints of pain; -He/She completed neurological assessments throughout his/her shift and no issues were noted; -He/She writes neurological assessments on paper and transfers them to the electronic medical record later; -He/She believes the written checks were not saved; -He/She reported the fall details and need for neurological assessments to the on-coming nurse; -He/She could not recall who the on-coming nurse was; -Neurological assessments should be completed every 15 minutes for the first hour, every 30 minutes for the second hour, hourly for the next two hours, and every shift for the next 72 hours. During an interview on 05/22/24, at 10:23 A.M., Restorative Aide (RA) G said the following: -He/She worked the 6:00 A.M. to 2:00 P.M. shift on 04/30/24; -At 7:00 A.M., Certified Nurses Assistant (CNA) H asked for his/her assistance with the resident; -He/She entered the resident's room and observed he/she had an open area on his/her head and was bleeding on his/her pillow; -He/She reported immediately to LPN B; -LPN B entered the room and cleaned the resident up and placed a bandage on his/her head; -He/She and CNA H stood the resident up to fix his clothing after LPN B left the room; -When the resident stood up the resident said, Ow, that hurts and grabbed his/her left hip; -The resident had facial grimacing related to the pain; -He/She immediately reported to LPN B regarding the report of pain; -LPN B pulled the residents pants down and looked at the resident's left side; -The LPN said the area was not red and left the room; -The LPN only visually looked at the resident; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She reported his/her concerns regarding the assessment of the resident to the former Director of Nursing (DON) around 8:00 A.M. During an interview on 05/22/24, at 10:35 A.M., CNA H said the following: -He/She worked the 6:00 A.M. to 2:00 P.M., shift on 04/30/24; -Sometime before breakfast he/she walked into the resident's room and observed the resident bleeding from his head; -He/She told RA G who came into the room to assist; -He/She was not aware of the resident having a fall during the prior shift; -LPN B was informed and came to the room to assess the resident; -The resident voiced complaints of pain in his/her left hip when he/she stood up; -LPN B visually looked at the resident's hip area and said it was not red; -RA G reported the concerns regarding the assessment from LPN B to the former DON. During an interview on 05/22/24, at 9:01 A.M., LPN B said the following: -He/She was the charge nurse for the 6:00 A.M. to 2:00 P.M., shift for 04/30/24; -He/She received report from the off-going charge nurse (LPN A) at 6:00 A.M.; -LPN A reported the resident fell during his/her shift and was on neurological checks and had a scrape on his/her forehead; -LPN A also reported the resident had been stating he/she was in pain; -The resident said he/she was in pain frequently; -The resident complained his/her hip hurt sometime during the shift and he/she assessed the resident; -The resident had no apparent injury, redness, or swelling, and had no inversion or rotation; -The resident was laid down in bed and voiced no further complaints of pain; -He/She checked on the resident several times throughout the shift, but failed to complete some of the neurological assessments; -He/She usually documented the neurological assessments on paper and then entered them in the computer later; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Neurological assessments should be completed every 15 minutes for the first hour, every 30 minutes for the second hour, hourly for the next two hours, and every shift for the next 72 hours; -The resident appeared normal throughout his/her shift and did not voice complaints of pain; -He/She was unaware LPN C also assessed the resident for a report of pain; -He/She was unaware of an order for an x-ray for the resident until the end of his/her shift; -He/She reported the resident's fall, neurological check protocol, and the x-ray orders to RN E at the 2:00 P. M. shift change; -All nursing staff should be communicating frequently regarding resident care, changes, and orders; -There was a communication breakdown between nursing staff regarding the resident assessments for pain during his/her shift; -Faxed results for labs and x-rays typically print to the medication room fax machine; -All staff are responsible for checking for faxes and giving to relevant staff; -For critical faxes the x-ray or lab company typically gives a follow-up call; -No calls regarding the resident's X-ray were received during his/her shift. During an interview on 05/21/24, at 3:15 P.M., LPN C said the following: -He/She was the Assistant Director of Nursing (ADON) on 04/30/24; -On 04/30/24, at 10:30 A.M., he/she assessed the resident for complaints of pain in his/her left leg; -The resident said his/her whole leg hurt and he/she had facial grimacing when moving his/her leg; -He/She immediately reported the concern to NP D; -His/Her shift ended at 2:00 P.M., prior to the x-ray company arriving to the facility; -He/She did not know what time the x-ray was completed; -He/She told RN E regarding the pending x-ray prior to leaving; -RN E received the x-ray results on 04/30/24, around 10:00 P.M., and sent the resident to the hospital; -He/She was not aware the resident had fallen on 04/30/24, at 3:00 A.M.; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She thought the injury may have been related to a previous non-injury fall that occurred on 04/27/24; -He/She did not see the resident's forehead laceration since the resident was wearing a hat; -He/She completed a targeted assessment related to the residents leg pain since he/she did not know about the fall at 3:00 A.M.; -The charge nurse should immediately assess the resident for any injuries following a fall; -Any unwitnessed fall or fall where the resident hits their head requires initiation of neurological checks; -Neurological assessments should be completed every 15 minutes for the first hour, every 30 minutes for the second hour, hourly for the next two hours, and every shift for the next 72 hours. During an interview on 05/22/24, at 10:00 A.M., NP D said the following: -He/She spoke to someone at the facility on 04/30/24 around 10:30 A.M., regarding reported left hip pain for the resident; -He/She noted the resident lost balance on 04/27/24 and had complaints of left hip pain. He/She ordered an x-ray; -He/She did not have any note regarding a fall occurring on 04/30/24 at 3:00 A.M. During an interview on 05/22/24, at 8:41 A.M., NP F said the following: -On 04/30/24, at 10:30 A.M., LPN C contacted the NP on-call who noted the resident had complaints of hip and leg pain following the resident losing his/her balance and falling on 04/27/24; -The physician's office had no note regarding a fall on 04/30/24 at 3:00 A.M.; -They are usually contacted immediately following falls; -If a resident has an unwitnessed fall neurological checks should be implemented; -The resident was a high fall risk related to blindness; -If the resident had any changes following the fall the physician should be contacted by the facility. During an interview on 05/21/24, at 3:13 P.M., Nurses Assistant (NA) I said the following: -He/She remembered the resident had a fall during third shift prior to her shift from 2:00 P.M. to 10:00 P.M.; -He/She could not recall the date of the fall; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Information regarding falls and measures implemented should be shared between nurses during shift change. During an interview on 05/21/24, at 1:33 P.M., the MDS Coordinator said the following: -LPN A was the nurse working on 04/30/24, at 3:00 A.M., when the resident fell ; -The charge nurse is to complete an initial assessment for injuries immediately following a fall; -Neurological assessments should be implemented for any fall that is unwitnessed or the resident hits their head; -Neurological assessments should be completed every 15 minutes for the first hour, every 30 minutes for the second hour, hourly for the next two hours, and every shift for the next 72 hours; -Neurological assessments are documented in the electronic medical record in the indicated neurological assessment area; -Any changes noted during neurological assessments should be reported immediately to the physician; -Information regarding a fall and measures implemented is to be exchanged between charge nurses at shift change; -The charge nurse is responsible for fall documentation, neurological assessment documentation, and any notifications made. During an interview on 05/22/24, at 12:23 P.M., the Interim DON said he following: -An initial assessment should be completed for all falls to determine if there are any injuries or impairments; -If the fall is unwitnessed or the resident hits their head neurological assessments should be implemented; -Neurological assessments should be completed every 15 minutes for the first hour, every 30 minutes for the second hour, hourly for the next two hours, and every shift for the next 72 hours; -Any changes observed should be reported immediately to the physician; -The physician should be contacted immediately following the fall for any orders or monitoring needed followed by contact to the family or responsible party; -Reports of pain should be assessed by the charge nurse immediately and the physician should be contacted for any orders; -Information regarding falls, neurological assessments, and any injuries or monitoring should be passed along at shift change between nurses and as needed as changes occur; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Faxed lab or x-ray results are received to the fax machine in the medication room or machine in the front of the facility; -The fax machine should be checked regularly at least per shift to ensure there are not any errors; -Faxes received should be given to the relevant staff as quickly as possible. During an interview on 05/22/24, at 1:15 P.M., the Administrator said the following: -He/She was not made aware of the resident's fall or x-ray orders on 04/30/24, at 3:00 A.M., until after the resident was sent to the hospital; -The resident was sent to the hospital on 04/30/24 for a broken hip (unsure time); -The charge nurse is to assess the resident immediately following a fall for any injury; -If the fall is unwitnessed or the resident hits their head neurological assessments should be implemented; -Neurological assessments should be completed every 15 minutes for the first hour, every 30 minutes for the second hour, hourly for the next two hours, and every shift for the next 72 hours; -Any changes noted should be reported immediately to the ADON or DON for immediate follow-up; -Fall information, neurological assessments status, any orders or concerns, should be reported between nurses at shift change; -The on-coming charge nurse should inform care staff regarding information from shift report; -Faxes are received to the main office or medication room fax machines; -The fax machines should be checked twice per shift (once at the beginning and once at the end of shift); -Faxes received should be given to relevant staff as soon as possible once noted; -Every morning there is a department head meeting between the ADON, DON, and Administrator to discuss any events that may have occurred during the overnight shift. 2. Review of the facility's policy titled Physician Orders, undated, showed medication orders should specify the type, route, dosage, frequency, and strength of the medication ordered. Review of the facility's policy titled Medication, Administration Guidelines, undated, showed the following: -Medications are given to benefit a resident's health as ordered by the physician; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If there is doubt concerning the administering of medications, the physician's order must be verified before the medication administered. Review of Resident #2's face sheet showed the following: -admitted [DATE]; -Diagnoses included dementia (loss of memory), anxiety disorder (persistent and excessive worry that interferes with daily activities), chronic kidney disease (loss of kidney function), depressive episodes (feelings of sadness), and osteoporosis (thinning of the bone mass due to depletion of calcium and bone protein). Review of the resident's quarterly MDS, dated [DATE], showed the following: -Memory problems, severally impaired; -Dependent upon staff for eating, toileting hygiene, showers, dressing and personal hygiene; -Frequently incontinent of bladder and bowels. Review of the resident's care plan, last reviewed 04/29/24, showed the following: -Needs assistance with adult daily living skills (ADLs - dressing, grooming, bathing, eating, and toileting); -Staff will give resident's medications as directed. Review of the resident's April 2024 progress notes showed the following: -On 04/10/24, at 7:57 P.M., nurse was notified by staff that the resident had a temperature of 101.3 degrees Fahrenheit (F) (normal is 98.7 degrees F) with facial grimacing noted upon assessment. Resident had an as needed order for pain that could not be administered at that time due to his/her scheduled medication that had been administered. Staff notified the resident's provider of the existing condition. This nurse will wait for phone call back with further instructions. Staff will continue to monitor; -On 04/10/24, at 8:48 P.M., stat (as soon as possible) order received to obtain UA with CNS (culture and sensitivity) if indicated. The lab at facility to draw labs. The nurse will attempt to straight cath (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) of resident and send urine off with lab. Review of the resident's Physician Order Report, dated 04/01/24 to 04/30/24, showed staff did not document an order for the ordered UA. Review of the resident's nurse Medication Administration Record (MAR) Flowsheet, dated 04/01/24 to 04/03/24, showed an order, dated 04/10/24, for stat UA with CNS. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265656	A. Building B. Wing	04/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Strafford Care Center	505 West Evergreen Strafford, MO 65757

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility document, with date of service 04/11/24, from the resident's provider showed the provider was notified on 04/10/24 that the resident was febrile (has symptoms of a fever) with temp of 101.3 F. Provider instructed nursing staff to administer as needed Tylenol and obtain blood work, UA with CNS, and chest x-ray. No lab results available at this time. Review of the resident's April 2024 progress notes showed staff did not document regarding the resident's condition, if an UA was obtained and sent off, or UA results. Review of the resident's April 2024 progress notes dated 04/13/24, at 8:00 A.M., showed staff noted resident had a condition change. The resident was weak and using wheelchair for mobility. He/she was hard of hearing and having difficulty with comprehension. His/her appetite had decreased and required more assist with ADLs. Staff will continue to monitor. Review of the resident's medical record and facility documents showed no documentation of completion or results of the ordered urinalysis on 04/10/24. Review of the resident's progress notes showed the following: -On 05/03/24, at 2:27 P.M., family present for visit and concerned with resident's increased pain and restlessness. Family would like a UA if able. Staff placed call to hospice and received new order for UA with CNS via straight cath stat; -On 05/03/24, at 3:16 P.M., UA obtained via straight cath. Resident tolerated well. Staff called for lab to pick up; -On 05/03/24, at 6:28 P.M., staff called resident's provider and received new orders for Cipro (anti--infective medication) for five days for UTI until culture comes back. Resident in pain and staff administered medication to address. Review of the resident's Physician Order Report, dated 05/01/24 to 05/31/24, showed the following: -An order, dated 05/03/24, for stat UA with culture; -An order, dated 5/03/24, for Cipro (antibiotic), 250 milligrams (mg) twice a day for UTI,. Review of the resident's May 2024 Medication Administration Record (MAR) showed the following: -On 05/03/24, staff administered the first dose of Cipro at 7:00 P.M., -On 05/04/24, staff administered Cipro two times as ordered; -On 05/05/24, staff did not administer the 7:00 A.M. dose and indicated the medication was unavailable. Staff did administer the 7:00 P.M. dose. Review of the resident's Physician Order Report, dated 05/01/24 to 05/31/24, showed an order, dated 05/06/24, for Cipro 250 mg one tablet twice per day for urinary tract infection (UTI). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Strafford Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 505 West Evergreen Strafford, MO 65757	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's urine sample taken on 05/03/24 showed positive for streptococcus bovis (species of gram positive bacteria associated with urinary tract infections) and recommended therapeutic agent as penicillin (an anti-infective medication). Review of the resident's May 2024 MAR showed the following: -On 05/06/24, staff administered Cipro twice a day as ordered; -On 05/07/24, staff administered Cipro twice a day as ordered. Review of the resident's progress note dated 05/08/24, at 1:14 P.M., showed staff received call from doctor and new orders received to extend Cipro for UTI for 10 days total (05/13/24). Charge nurse informed; Review of the resident's Physician Order Report, dated 05/01/24 to 05/31/24, showed an order, dated 05/08/24, for Cipro 250 mg, one tablet twice per day for UTI. Review of the resident's May 2024 MAR showed the following: -On 05/08/24, staff administered the Cipro at 7:00 A.M., but did not administer the 7:00 P.M. dose and did not provide a reason; -On 05/09/24, staff administered Cipro twice as ordered; -On 05/10/24, staff did not administer the 7:00 A.M. dose and noted medication unavailable. Staff did administer the 7:00 P.M. dose; -On 05/11/24, staff did not administer Cipro and noted the medication was discontinued. Review of the resident's Physician Order Report, dated 05/01/24 to 05/31/24, showed the order, dated 05/08/24, for Cipro 250 mg, one tablet twice per day for UTI, was discontinued on 05/11/24. Review of the resident's progress notes showed the following: -On 05/31/24, resident appeared to be in pain while urinating. Family present and voiced concerns. Staff notified nurse practitioner and received order for UA with CNS; -On 05/31/24, at 4:06 P.M., a RN from hospice called and gave orders via telephone to start cefdinir (an anti-infective medication) 250 mg for five days per doctor; -On 05/31/24, at 7:04 P.M., resident UA[TRUNCATED]

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41559 Based on observation, interview, and record review, the facility failed to ensure all records were complete and accurate when staff failed to document regarding x-ray results and transport to the hospital for one resident (Resident #1) following a fall with injury. The facility census was 70. Review of the facility policy titled, Fall Champion Program, not dated, showed the following information: -Emergency care is to be provided as needed after a fall; -Staff are to take vital signs and assess condition of the resident; -Staff are to complete post fall follow-up for 72 hours including assessment, documentation of the resident's condition in progress notes, and neurological checks (a series of tests that assess mental status, reflexes, and movements). 1. Review of Resident #1's face sheet (basic information sheet) showed the following information: -admitted [DATE]; -A discharge date of [DATE]; -Diagnoses included dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) without behavioral disturbance, adult failure to thrive, reduced mobility, chronic pain, encounter for adjustment and management of a vascular access device, and an irregular heart beat. Review of the resident's Minimum Data Sheet (MDS - a federally mandated assessment tool completed by facility staff), dated 03/21/24, showed the following: -Severe cognitive impairment; -History of falls; -Utilized a walker and wheelchair for mobility assistance; -Required supervision for walking; -Required partial to moderate assistance with mobility. Review of the resident's care plan for falls, last reviewed/revised 05/01/24, showed the following: -The resident was at risk for falling related to poor vision; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had no-injury falls noted for 02/14/24, 03/30/24, 04/03/24, and 04/27/24; -The resident had a fall on 04/30/24 with an abrasion noted to the left forehead, left arm, and left wrist. Review of the resident's progress note dated 04/30/24, at 3:00 A.M., showed Licensed Practical Nurse (LPN) A documented the resident was sitting in his/her wheelchair refusing to go to his/her room or sit in his/her recliner. The LPN and another staff heard a thud. The resident was observed lying on the floor face down. The resident had one arm above his/her head and was holding his/her head with the other arm. Staff went to get the resident off the floor and observed a small amount of blood on the floor. The resident had a bump with a laceration on the left side of his/her forehead. The resident had a skin tear on his/her left wrist and upper arm. The areas were cleaned and dressed. The resident was able to move his/her upper and lower extremities, had strong and equal grips, and eyes were reactive to light. The resident's clothes were changed and he/she was assisted to bed. Review of the resident's progress note dated 04/30/24, at 10:34 A.M., showed LPN B documented a fall follow-up for the resident. The resident had a fall in the morning with an abrasion to his/her forehead with no complaints of pain or discomfort noted. The resident was able to move all extremities without distress. The resident's vital signs were within normal limits and he/she was up in his/her wheelchair at the time of the note. Review of the resident's progress note dated 05/02/24, at 1:16 P.M., showed LPN C documented a late entry progress note for 04/30/24, at 11:10 A.M. LPN C documented at 10:30 A.M., the resident had complaints of left leg pain. The resident stated he/she had shooting pain down his/her leg that worsened when touched and with any movement. LPN C reported the assessment to the Nurse Practitioner (NP) D who was on-call for the resident's physician. The NP gave orders to X-ray the resident's left pelvis/hip, femur (thighbone), knee, tibia (shin bone), and fibula (calf bone). LPN C contacted the X-ray company and ordered images over the phone and documented the orders in the medical record. Review of the resident's physician's orders, dated 04/01/24 to 05/01/24, showed an order dated 04/30/24, at 10:30 A.M., for x-ray of the left femur (thigh bone), hip, and knee for diagnoses of reduced mobility. Review of the resident's progress note dated 04/30/24, at 4:15 P.M., showed Registered Nurse (RN) E documented the resident had an unwitnessed fall in the early morning on 04/30/24. The resident had an abrasion to his/her forehead and the nurse cleansed the wound with wound cleanser, patted dry, applied antibiotic ointment to the wound, and covered with a band aid. The resident denied any pain or discomfort. The RN documented he/she assessed the resident and no other injuries were noted. Review of the resident's x-ray report, dated 04/30/24, showed the following: -An x-ray was completed on 04/30/24 for an indication of left hip and lower extremity pain from a recent fall; -Findings showed an acute high impacted fracture (fracture where the broken ends of the bone are jammed together by the force of the injury) of the neck of the left femur; -The findings were electronically signed by a physician on 04/30/24, at 4:28 P.M. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility census report showed the resident discharged from the facility on 04/30/24 at 11:00 P. M. The report did not note the reason for discharge. Review of the resident's progress notes showed staff did not document after 04/30/24, at 4:15 P.M., regarding the fall earlier that day, regarding the x-ray results or actions taken following receipt of x-ray results, or the discharge of the resident. During an interview on 05/22/24, at 11:51 A.M., LPN A said the following: -He/She was the charge nurse during the 10:00 P.M. to 6:00 A.M. shift on 04/30/24; -On 04/30/24, around 3:00 A.M. to 3:30 A.M., the resident fell in the area next to the day room and dining room near the nurses' station; -He/She looked away from the resident and heard a thud; -When he/she looked back the resident was on the floor; -He/She assessed the resident for injuries while on the floor; -The resident had a small raised abrasion on the left side of his/her forehead; -The resident was able to move his/her arms and legs without issues or complaints of pain; -The resident's vital signs were normal; -Staff got the resident up from the floor and placed in his/her wheelchair without issue; -Staff took the resident to his/her room and put him/her in bed. The resident had no complaints of pain; -Assessments related to falls should be documented in the nursing notes or fall event by the charge nurse. During an interview on 05/22/24, at 9:01 A.M., LPN B said the following: -He/She was the charge nurse for the 6:00 A.M. to 2:00 P.M., shift for 04/30/24; -He/She received report from the off-going charge nurse (LPN A) at 6:00 A.M.; -LPN A reported the resident fell during his/her shift and was on neurological checks and had a scrape on his/her forehead; -LPN A also reported the resident had been stating he/she was in pain; -He/She was unaware of an order for an x-ray for the resident until the end of his/her shift; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Assessments, neurological checks, and notifications made should be documented in the resident medical record; -The charge nurse is responsible for documentation. During an interview on 05/21/24, at 3:15 P.M., LPN C said the following: -He/She was the Assistant Director of Nursing (ADON) on 04/30/24; -His/Her shift ended at 2:00 P.M., prior to the x-ray company arriving to the facility; -Assessments and follow-up related to falls should be documented in the medical record; -The charge nurse is responsible for ensuring documentation is completed. During an interview on 05/21/24, at 3:45 P.M., Registered Nurse (RN) E said the following: -He/She was the charge nurse for the 2:00 P.M. to 10:00 P.M. shift on 04/30/24; -He/She received shift report at 2:00 P.M., from the off going nurse LPN B; -LPN B reported the resident fell prior to his/her shift, but did not provide any additional details regarding the fall; -He/She was unaware of orders for an x-ray until he/she saw a fax on 04/30/24 around 9:30 P.M. to 10:00 P. M.; -He/She reviewed the x-ray report and it indicated the resident had a fractured femur; -Assessments, follow-up, and notifications should be documented in the fall event or nurses notes; -The charge nurse is responsible for documentation. During an interview on 05/21/24, at 1:33 P.M., the MDS Coordinator said the charge nurse is responsible for fall documentation, neurological assessment documentation, and any notifications made. During an interview on 05/22/24, at 12:23 P.M., the Interim DON said the charge nurse is responsible for documentation related to falls, changes, and notifications. During an interview on 05/22/24, at 1:15 P.M., the Administrator said the charge nurse is responsible for documenting fall assessments including neurological assessments and any changes. MO00235482