STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265727	A. Building B. Wing	02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carmel Hills Wellness & Rehabilitation	810 East Walnut Independence, MO 64050

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** 37608 Based on interview and record review, the facility failed to ensure one of six sampled residents (Resident #1) received timely assistance in obtaining a hearing device for communication. The facility census was 154 residents. Review of Resident #1's Admission Record showed: -Was admitted to the facility on [DATE] with the following diagnosis; -Cognitive Communication Deficit (having trouble reasoning and making decisions while communicating, remembering their conversations and experiences and trouble responding in an appropriate or socially acceptable manner). Review of the resident's Care Plan, revised on 3/24/23, showed: -Focus: --Had a communication problem related to hearing deficit. -Goal: --Will be able to make basic needs known on a daily basis through the review date of 12/6/23. -Interventions: --Anticipate and meet needs. --Allow adequate time to respond, repeat as necessary, do not rush, and request clarification from the resident to ensure understanding. --Face when speaking, make eye contact, turn off television/radio to reduce environmental noise, ask yes/no questions if appropriate, use simple brief, consistent words/cues and use alternative communication tools as needed. --Discuss with resident/family concerns of feelings regarding communication difficulty. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--Ensure hearing aids are placed in both ears. --Speak on an adult level, speaking clearly and slower than normal. --Validate resident's messages by repeating aloud. Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment tool used by facilities for care planning), dated 12/6/23, showed: -He/she was cognitively intact. -Was able to make self understood and understand others. -Hearing adequate with hearing aids. Review of the resident's Order Summary Report dated 1/1/24 to 1/31/24, showed the night nurse must ensure resident's hearing aids are taken from the resident and stored in their box in the top drawer of the nurse's cart. The A.M. nurse must put hearing aids in the resident's ears every A.M. Found in a box in the top drawer of the nurse's cart, every morning and at bedtime for loss prevention. Review of the resident's Treatment Administration Record (TAR), dated 1/1/24, showed the following: -No hearing aids were applied the mornings of 1/1/24 & 1/6/24; -1/2/24 - 1/5/24 showed code 9 (see progress note), but no progress notes were documented in medical record. -At bedtime the TAR showed 1/1/24 - 1/5/24 no hearing aids were removed and on 1/6/24 showed staff documented yes (resident was in the hospital at this time). During an interview on 1/16/24 at 4:46 P.M., the Administrator said: -The resident was sent to the hospital in November 2023 and the resident only returned with the blue hearing aid. -The red hearing aid was missing. -The hospital was contacted to see if the red hearing aid had been found. It was not found. -The blue hearing aid was cracked and did not work. -The family was notified of the missing and broken hearing aids. -Family picked up the broken hearing aid to get it fixed. Not sure of the date. -Contact had been made with the family about the hearing aids and when the facility could expect to get the hearing aids for the resident. No time frame was given. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/30/24 at 2:01 P.M., Licensed Practical Nurse (LPN) B said: -The resident's hearing was not good and used hearing aids to hear. -The red hearing aid was lost at the hospital the last time the resident was sent to the hospital (November 2023) and the blue hearing aid was broken. -The blue hearing aid was given to the resident's son. -The resident had not had hearing aids for a while. -The family was working on getting the resident new hearing aids. -The resident was able to notify staff if he/she was in pain or needed assistance. -Sometimes the resident would yell for help and would just stare or say he/she forgot what he/she needed. During an interview on 1/30/24 at 2:25 P.M., Certified Nurse Aide (CNA) F said the resident could hear when his/her hearing aids were in place, but if no hearing aids, staff would have to talk into the resident's left ear for him/her to hear what was being said. The resident had not had hearing aids for a while, but did not give time frame. During an interview on 1/30/24 at 3:26 P.M., the Assistant Director of Nursing said: -The family took the blue hearing aid to get it fixed and had to order a new red hearing aid. -The facility was waiting for the hearing aids to arrive at the facility. During an interview on 1/17/24 at 12:53 P. M., the Nurse Practitioner said the resident was not able to hear without his/her hearing aids. The hearing aids should have been fixed as soon as possible, but could not make the family get the hearing aids fixed any faster. During an interview on 2/26/24 at 8:24 A.M.,the resident's family member said: -The facility was to be taking care of getting the hearing aids fixed. -He/she was paying a monthly payment to an outside company for servicing the hearing aids. -The facility would not use this company, because they had a company they used as the facility. -The resident went without hearing aids for at least eight months. -The family paid a private company to care for the hearing aids. -He/she was constantly in the social service office trying to get the hearing aids fixed. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The day the resident was discharge from the hospital to a new facility the hearing aids arrived at this facility. -He/she picked up the hearing aids and took them to the new facility. -Social service employee who was to take care of this is no longer at the facility.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37608 Based on observation, interview, and record review, the facility failed to ensure residents were free from accidents for two sampled residents (Resident #1 and #3) out of six sampled residents. On 1/5/24 about 10:15 P.M., Certified Nurse Assistant (CNA) A transferred Resident #1 without using the Hoyer lift (a mechanical means to transfer a resident) from the wheelchair to the bed. During the transfer CNA A realized it was not safe to continue and lowered the resident to the floor. CNA A and CNA B then transferred the resident from the floor to bed by placing their arms under the resident's arms, one on each side and lifting the resident up. They did not use a gait belt or mechanical lift to transfer the resident back to his/her bed. Facility staff did not report the fall or assess the resident after the fall. The resident had an increase in yelling behavior throughout the night and was noted as not very responsive to questions being asked, pale in color, and yelling out in pain when turned from side to side during changing the next morning. The resident was also found to have bruising on their left upper arm and chest. The resident was sent to the hospital for further assessment. It was found the resident had extensive swelling in the left knee, left ankle, left posterior thigh and right hamstring, and multiple fractures in the left knee/femur. The hamstring bruising was a source of blood loss. The resident had a hemoglobin (the protein contained in red blood cells that is responsible for delivery of oxygen to the tissue) of 6 and required 5 units packed red blood cells and surgical intervention. The facility also failed to ensure they knew the location and status of one resident (Resident #3) and to coordinate safe transportation when on 1/9/24 the resident was left sitting in the hospital lobby all night after a dialysis appointment. The facility census was 154 residents. The Administrator was notified on 1/31/24 at 1:50 P.M., of an Immediate Jeopardy (IJ) which began on 1/5/24. The IJ was removed on 1/7/24, as confirmed by surveyor onsite verification. Review of the facility's Transfer Policy, dated 6/1/2020, showed: -To provide the form of transfer best suited to the residents' needs and to maintain resident safety during the transfer. -A licensed nurse and/or Director of Rehabilitation Services assess and determine lifting and transfer requirements and the procedure used for each resident. -The procedure is recorded in the resident's Care Plan. -Residents must be lifted or transferred according to the determined procedure. -Residents who require assistance in transferring will be transferred using a gait/transfer belt or with a lift. -Nursing staff are trained to use good body mechanics, knowing the proper procedure, and properly operating assistive devices. -Mechanical lift procedures are used on any resident unable to independently pivot or transfer. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's Fall Policy, dated 8/1/2020, showed: -To ensure that the resident's environment remains as free of accident hazards as is possible, and that each resident receives adequate supervision and assistance to prevent accidents. -A fall is defined as a sudden, uncontrolled, unintentional, downward displacement of the body to the ground. -Upon a fall, stay with the resident and send another staff member to notify a licensed nurse. -The resident should not be moved until the licensed nurse has assessed the resident's condition. -The assessment should include level of consciousness, position, possible injuries, pain, vital signs, swelling, bruising, alignment, and range of motion. -The resident's physician and responsible party will be notified. -After each fall a licensed nurse will complete a Post-Fall Assessment & Investigation and document in a detailed progress note. -Document all falls on the 24-hour report, notification of physician and responsible party. 1. Review of Resident #1's Admission Record showed he/she was admitted to the facility on [DATE] with the following diagnoses: -Cognitive Communication Deficit (having trouble reasoning and making decisions while communicating, remembering their conversations and experiences and trouble responding in an appropriate or socially acceptable manner). -Parkinson's disease (a chronic disease characterized by a fine slowly spreading tremor, muscle weakness, muscle stiffness and a peculiar gait). -Dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain). -Contractures (an abnormal usually permanent condition of a joint, characterized by flexion and fixation) of left & right ankles and left & right knees. -Osteoarthritis (a degenerative disease of the bone and Joint) of knee, unspecified. Review of the resident's Care Plan, revised on 3/24/23, showed: -Focus: --Had self-care performance deficit related to post-polio syndrome, Parkinson's disease, and stroke. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Interventions: --He/she was dependent assist by two staff for bed mobility, transfers, dressing and bathing. -Focus: --He/she uses opioid pain medication related to chronic pain. -Goal: --Will be free of any discomfort or adverse side effects from pain medication. -Interventions: --Administer pain medications as ordered by physician. --Monitor/document side effects and effectiveness every shift. --Monitor for increased falls. -Focus: --He/she was at risk for alterations in comfort related to chronic pain and decreased mobility. -Interventions: --Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. --Monitor/document for side effects of pain medications. --Monitor/record/report to nurse any signs or symptoms of non-verbal pain, changes in breathing, vocalization (grunting, moaning, yelling out or silence), mood/behavior changes (more irritable, restless, aggressive,squirmy, or constant motion), eyes (wide open/narrow, slits/shut, glazed, tearing, or no focus), Face (sad, crying, worried, scared, clenched teeth or grimacing), and body (tense, rigid, rocking, curled up, or thrashing). --Provide the resident with reassurance that pain is time limited. --Encourage to try different pain relieving methods (positioning, relaxation therapy, progressive relaxation, bathing, heat and cold application, muscle stimulation, ultra-sound). -The care plan did not identify the resident need or use of a Hoyer lift. Review of the resident's undated Card-X (a resource for care staff that gives a brief overview of each resident and updated as needed) that was generated by the care plan showed: -He/she was dependent for transfer via Hoyer lift by two staff. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Bed mobility was extensive assist by two staff. Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment tool used by facilities for care planning), dated 12/6/23, showed: -He/she was cognitively intact. -Was able to make self understood and understand others. -His/her lower extremities were impaired on both sides. -He/she used a mechanical lift for transfers. -Dependent on staff for sit to lying, lying to sitting, chair/bed to chair and cannot sit to stand. -No pain frequency assessed. -Had as needed pain medication. -No non-medical interventions for pain received. -No opiods given for pain. Review of the resident's Order Summary Report dated 1/1/24 to 1/31/24, showed: -No physician order for the use of a Hoyer lift for transfers. -Pain monitoring every shift for pain. -Hydrocodone-Acetaminophen Oral Tablet 5-325 milligrams (mg), give one tablet by mouth every 4 hours as needed for moderate to severe pain, started 5/9/23. -Tylenol (Acetaminophen) Tablet, give 650 mg by mouth every 4 hours as needed for pain related to pain in left knee, not to exceed three grams (gms) of Acetaminophen in 24 hours, started 9/26/22. -Voltaren External Gel 1% (Diciofenac Sodium) Topical, apply to both knees topically two times a day for pain, Apply 4 gms, not to exceed 16 gms per knee or 32 gms in 24 hours. Review of the resident's Skilled Evaluation Note, dated 1/4/24 at 9:50 A.M., showed: -He/she was alert and oriented to person and place. -He/she had impaired balance. -He/she had paralysis. Review of the resident's Behavior Note, dated 1/7/24 at 00:07 A.M., showed: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On 1/5/24 the resident sat by the nurse's station in his/her wheelchair and requested pain medication for his/her chronic right knee pain. -No new issues with the resident's knee noted at 9:30 P.M. on 1/5/24. -At 10:15 P.M. on 1/5/24 the resident verbalized pain medication was effective. -Resident was transferred to bed by CNA A at 10:30 P.M. on 1/5/24. -Resident had increased yelling after getting into bed which is a behavior that is related to the resident's dementia. -Upon entering his/her room to check on him/her, he/she would just stare at Licensed Practical Nurse (LPN) A and stopped yelling. -When asked what the problem was, he/she would not respond. -No signs or symptoms of pain or discomfort noted when checking on him/her, reminded him/her to use the call light if he/she needed LPN A. -LPN A checked on the resident throughout the night, when entering the room, he/she would stop yelling. -This occurred multiple times throughout the night. -LPN A would inquire if he/she was in pain or discomfort and he/she would smile and not answer the question. -He/she had documented history of yelling out at night for no reason for doing so when assessed by LPN A. -He/she had dementia and history of exhibiting this type of behavior during late evening and night. -LPN A offered emotional support and encouraged him/her to use his/her call light which was kept within reach. -LPN A also offered drinks and snacks for comfort and was assessed for pain and discomfort every time which he/she did not have when LPN A went into room. Review of written statements by CNA C and CNA D, dated 1/6/24, showed: -Around 8:30 A.M., CNA C heard the resident yelling out, so he/she and CNA D went to see what the resident needed. -They proceeded to get the resident up, when they noticed he/she was not very responsive to questions being asked. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The resident was pale in color and was yelling out in pain when turned from side to side during changing. - They asked the resident several times if he/she was having pain, but the resident could not tell them if he/she was in pain. -The resident was Hoyer lifted into his/her wheelchair and was still moaning. -The resident was asked again about pain with no response. -CNA C went and got the Assistant Director of Nursing (ADON) while CNA D stayed with the resident. -CNA D changed the resident's shirt and that is when the bruising on the resident left upper arm and chest were noticed. -The ADON took over the care of the resident at that time. Review of the resident's Behavior Note, dated 1/6/24 at 7:24 A.M., showed: -Resident screamed for 10 hours of the shift, increased when he/she was put to bed by CNA A. -Resident had no pain or discomfort noted. -LPN A checked on him/her several times throughout the night. -He/she was just sitting in bed with eyes closed screaming and yelling. Review of the resident's Nurse's Note, dated 1/6/24 at 10:14 A.M., showed: -ADON was alerted by CNA C and CNA D the resident was not baseline and had bruising to the left arm that was spreading across his/her chest. -Physician was called and received an order for STAT chest X-ray. -Resident was put on oxygen via nasal cannula for low oxygen level and low blood pressure. -Communicated with Nurse Practitioner (NP) and received an order to send resident to the hospital for evaluation and treatment. -Resident left the facility at 9:58 A.M. via Emergency Medical Services (EMS) in route to the hospital. Review of the resident's Treatment Administration Record (TAR), dated 1/1/24 to 1/31/24, showed: - No pain medications was given to the resident on the night of 1/5/24 or on 1/6/24. Review of the resident's emergency room and Hospital notes, dated 1/6/24, showed: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Resident arrived by EMS on 1/6/24 at 10:45 A.M., from the facility. -The resident's injuries were described as traumatic injuries of unknown source. -He/she was non-ambulatory. -He/she arrived having altered mental status, moaning, writhing and crying out in pain. -He/she had significant bruising to the left upper chest and shoulder and center of his/her chest, and noted to have bruising to right anterior (front) chest which was tender and painful. -He/she had swelling in his/her left knee, left ankle hematoma (a collection of blood outside of the blood vessel), left posterior (back) thigh and had a large right proximal (center) hamstring (a group of three muscles that run along the back of the thigh from hip to below the knee) hematoma 9 centimeter (cm) x 8 cm. -Hemoglobin was 6.0., (normal range is 12 to 16). -Radiology showed no chest fractures. -He/she had multiple comminuted supracondylar fractures (a break to the lower part of this bone) left knee/femur. -The hamstring hematoma was an avulsion injury (bone attached to tendon/ligament gets pulled away from the main part of the bone) which was the source of the blood loss. -He/she required 5 units PRBC (Packed Red Blood Cells) and surgical intervention. Review of the facility investigation, dated 1/6/24, showed: -On 1/6/24 at 10:14 A.M., ADON was alerted by CNA C the resident was exhibiting a deviation from his/her baseline cognitive state. -He/she needed repeated stimuli to awaken, had low blood pressure and oxygen levels. -ADON immediately applied oxygen on the resident. -Further assessment revealed the resident had dark purple bruising on his/her left upper arm extending to his/her left breast area accompanied by trace swelling. -ADON notified the physician and received an order to send the resident to the hospital for evaluation and treatment. -CNA A had attempted to transfer the resident by him/herself and had lowered the resident to the floor on 1/5/24. -LPN A noted no new issues with the resident's knee at 9:30 P.M. on 1/5/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-At 10:15 P.M. on 1/5/24 the resident verbalized pain medication was effective that was given for resident chronic pain in both knees. -Resident was transferred to bed by CNA A at 10:30 P.M. on 1/5/24. CNA A placed his/her arm under the resident's left arm and lifted the resident up. CNA A said that was how he/she transferred the resident 6 to 7 months ago when he/she worked at the facility. He/she said the resident had gained some weight and he/she could not hold the resident up and lowered him/her to the floor. -During the transfer CNA A realized it was not a safe to continue and lowered the resident to the floor. No gait belt, Hoyer, or Sit to Stand was used in the transfer. -CNA A was able to get assistance from CNA B and together they placed their arms under the resident's arms, one on each side and lifted the resident up off the floor and into bed. No gait belt, Hoyer, or Sit to Stand was used to transfer the resident from the floor back to the bed. -Neither of the CNAs informed LPN A about lowering the resident to the floor, because they did not believe it was a fall since he/she was lowered to the floor. -The resident sustained a fracture to his/her left knee from being lowered to the floor by CNA A, as the resident had a contracted left knee and was lowered to the floor with pressure on his/her left knee. -It was ascertained the resident suffered a left knee fracture during the descent to the floor, exerting undue pressure on his/her already contracted left leg, compounded by preexisting comorbidities and the bruising under his/her left arm area was a result from being transferred off the floor into bed by the CNAs. During an interview on 1/23/24 at 2:30 P.M., CNA A said: -He/she had worked at the facility before and had only been back at the facility for three days. -He/she used to transfer the resident by holding onto the resident's arm to help steady the resident. -He/she figured he/she could transfer the resident just like he/she had in the past. -The care plan had not identified any new way to transfer the resident. He/she transferred the resident the same way he/she transferred the resident six to seven months ago when last working with the resident. -Staff are supposed to look at the resident's card-x as well to know how to transfer residents. -The resident had gained some weight and he/she could not hold the resident up, so he/she lowered the resident to the floor. -He/she then left the resident's room to get CNA B to help lift the resident up off the floor and into bed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The resident did not have a Hoyer pad under him/her, so CNA A figured the resident still transferred the same way he/she did six months ago. -He/she did not think it was necessary to notify the nurse of lowering the resident to the floor. -He/she did not think if was a reportable incident since he/she lowered the resident. He/she did not know it was considered fall. Review of a written statement by CNA B, dated 1/6/24, showed: -He/she worked on the 1/5/24 evening shift on the 400 hall. -CNA A asked him/her for help. -He/she went to help CNA A with the resident. -The resident was on the floor next to the bed, feet in front of him/her. -CNA A stated that he/she had alerted LPN A and needed help putting the resident in bed. -He/she assisted CNA A with putting the resident in bed. -He/she used the resident's pants and lifted with one hand in the front and one hand in the back on the right side of the resident. -Once the resident was back in the bed, he/she left the room, because CNA A said he/she was able to finish cares on the resident. During an interview on 1/23/24 at 2:13 P.M., CNA B said: -He/she was working a different hall when CNA A came and asked him/her for help transferring the resident. -He/she went to the resident's room and saw the resident on the floor. -He/she asked CNA A if LPN A said it was okay to get the resident up off the floor. -CNA A said LPN A said it was alright to get the resident up, so they both lifted the resident off the floor by each one taking a side and arm without using a lift or gait belt. -The resident was a Hoyer lift to transfer, but there was no sling under the resident or in the resident's wheelchair to lift the resident up. -CNA A said the Care Plan card-x did not indicate the need for a lift or gait belt. He/she did not look at the care plan themselves. -He/she asked CNA A if she had notified LPN A about lowering the resident to the floor and CNA A said yes, LPN A said it was ok to lift the resident up off the floor. (continued on next page)

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	265727	A. Building B. Wing	02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carmel Hills Wellness & Rehabilitation	810 East Walnut Independence, MO 64050

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of written statement by LPN A, dated 1/6/24, showed: -He/she worked on 1/5/24 from 7:00 P.M. to 7:00 A.M., as the charge nurse for the 300/400 halls. -The resident was at the nurse's station in his/her wheelchair and asked for pain medication for chronic right knee pain. -The resident was transferred to bed by staff. -The resident noted to increase yelling and when asked what the problem was, he/she would not respond, no signs/symptoms of pain or discomfort noted when checking on the resident . -He/she checked on the resident throughout the night, when entering the room the resident would stop yelling. This occurred multiple times during the night. -He/she would ask the resident if he/she was in pain or discomfort, the resident would just smile and not answer any of the questions. -At no time during his/her shift was he/she notified of the resident being lowered to the floor or having a fall. During an interview on 1/24/24 at 8:20 A.M., LPN A said: -He/she had given the resident pain medication for his/her chronic pain before he/she was put to bed. -He/she was not notified by CNA A or CNA B the resident was lowered to the floor, he/she would have expected the staff to notify him/her if that occurred. -To his/her knowledge the resident was put to bed without any problems. -When the resident would yell out, he/she would help the resident and he/she would quit yelling. -He/she checked on the resident for chronic pain several times during the night when he/she was yelling out and it was not normal. -The resident never said he/she was in pain when checking on him/her. -He/she only assessed the resident for pain before the resident was put to bed. -He/she did not turn on the resident's room light when he/she would got to the resident' room, because the resident had a big television that was always on. -He/she did not see any color change in the resident's skin and did not see any signs or symptoms of pain when he/she went into the room. -He/she did not do a skin assessment, because the resident was not due for a skin assessment. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-CNA A was the staff member who checked the resident to see if he/she needed his/her brief changed during the night. -CNA A never said anything about the resident having a change in condition. -The resident's right leg was contracted straight and would not bend and the left leg moved around and was not contracted. -The resident was not able to stand and pivot due to weakness in the left leg. -The resident was a Hoyer lift transfer and it should have been on the care plan card-x. -He/she did not know the resident was lowered to the floor until the administrator called him/her during the investigation. During an interview on 1/30/24 at 2:55 P.M., CNA D said: -CNA C and CNA D were covering the 300 Hall the day shift when he/she heard the resident moaning. -He/she asked the resident if he/she was ready to get up for breakfast. -The resident did not respond, just moaned. -CNA D and CNA C changed the resident's brief and the resident did not say anything about pain or even moan during rolling from side to side. -The resident was pale in color in his/her face and was not at his/her normal baseline. -CNA C went to notify the nurse of the resident's change in condition. -CNA D went to change the resident out of his/her gown and that was when CNA D noticed all the bruising to the resident's left upper arm, left side, and chest. -CNA D asked the resident if the bruising hurt and the resident did not respond. -The resident would yell out when in pain or he/she would tell staff when in pain. -It was not normal behavior for the resident to yell out. -He/she can find how a resident was to transfer on the care plan and card-x for all residents. -Max assist means Hoyer lift with two staff. -Hoyer pad stays with the resident after a transfer. During an interview on 1/30/24 at 3:11 P.M., CNA C said: -The resident was not his/her normal self on the morning of 1/6/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Diabetes Mellitus (a disease in which the body's ability to produce or respond to the insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine). -Major Depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest). -High blood pressure. -Heart failure (the heart does not pump blood as well as it should). Review of the resident's Order Summary Report, MAR & TAR dated 1/1/24, showed: -Resident to receive hemodialysis on Tuesday, Thursday, and Saturday. -Chair time is 11:00 A.M. -Transportation to pick up resident every day shift on Tuesday, Thursday, and Saturday. -PM medications were Baclofen 5 mg tablet for muscle spasms, Carvedilol 25 mg tablet for high blood pressure, Insulin Glargine 10 units for diabetes, Insulin Aspart 8 units for diabetes. Review showed these medications were not given on 1/9/24. -AM medications were Allopurinol 100 mg tablet for end stage renal disease, Aspirin 81 mg for prophylaxis (action taken to prevent disease), Gabapentin 300 mg capsule for pain, Sertraline 25 mg for depression, Carvedilol 25 mg for high blood pressure, and Insulin Aspart 8 units for diabetes. Review showed these medications were not given as on 1/10/24. Review of the resident's Nurse's Note, dated 1/9/24 at 12:20 P.M., showed: -The resident went to dialysis as scheduled. -Call received from dialysis center after he/she arrived and start of dialysis, nurse stated that he/she coded and was sent to the ER. Review of the resident's hospital visit summary dated 1/9/24, showed the resident went to theER on [DATE] at 11:11 A.M. and discharged back to dialysis on 1/9/24 at 12:40 P.M. He/she received IV Normal Saline 500 ml for hypotension or fluid hydration. Review of the resident's Nurse's Note, dated 1/10/24 at 8:30 A.M., showed: -The resident came back to the facility at 8:00 A.M. -He/she was alert, no complaints of pain or discomfort, skin was dry and intact no concerns currently. -NP notified of his/her return to the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/17/24 at 2:15 P.M., the resident said: -He/she went to dialysis via transportation on 1/9/24 chair time 11:00 A.M. -He/she was taken to what he/she thought was the ER and given fluids for dehydration. -He/she then went back to the chair for dialysis. -After dialysis was over, the clinic nurse took the resident to wait for his/her ride back to the facility. -The ride never came, and he tried to call the facility several times with no one answering the phone. -He/she fell a sleep in the hospital lobby and woke up about 3:30 A.M. -He/she decided if he/she wanted to get back to the facility he/she needed to call UBER for a ride. -He/she arrived back to the facility around 8:00 A.M. on 1/10/24. -He/she did not receive his/her evening medications or any supper on 1/9/24. During an interview on 1/16/24 at 4:30 P.M., LPN B said: -He/she received a call from an unknown staff person at dialysis the resident had a rapid response, but was never told when the resident would be returning to the facility. -He/she assumed rapid response meant the resident had coded at dialysis and was sent to the ER. -He/she never called dialysis or the hospital afterward to check on the resident or if the resident was ready to return. -He/she told LPN A the resident had coded and was at the ER. During an interview on 1/24/24 at 8:20 A.M., LPN A said: -The facility takes the resident to dialysis and picks up the resident from dialysis. -If the resident goes to the ER from dialysis, then the ER at the hospital is responsible for the resident's return to the facility. -The facility transportation driver leaves around 3:00 P.M. daily. -An outside transportation company will bring the resident back to the facility or the ambulance might bring a resident back to the facility. -ER nurse is to set up the resident's transportation back to the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/24/24 at 1:14 P.M., Dialysis Social Worker said: -The resident usually arrives at dialysis around 10:30 A.M. for chair time at 11:00 A.M. -He/she was done with dialysis at 2:30 P.M. -Pick up time is 2:45 P.M. to 3:00 P.M. for ride back to the facility. -A dialysis nurse called the facility for the resident to be transported back to the facility, he/she could remember the facility was specifically called when the resident was finished with dialysis. -Facility informed the nurse that UBER Health would be picking up the resident. -The nurse stayed with Resident #3 while waiting for transportation to pick up the resident. -After awhile the nurse called the facility again to see when transportation was going to show up. -Around 2:30 or 3:00 P.M., facility said transportation should be at dialysis anytime to pick up the resident. -The nurse had to go and help other clients and left the resident in the main lobby. -The resident did not feel good at dialysis and a rapid response was called and the resident was given fluids for dehydration. -The resident never coded or went