STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285282	A. Building B. Wing	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jefferson Community Health & Life Gardenside	2200 North H Street Fairbury, NE 68352

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47312 Licensure Reference Number 175 NAC 12-006.09D7b Based on interview and record review; the facility failed to conduct a thorough investigation to determine the root-cause of falls and failed to develop and implement effective interventions to minimize and/or prevent falls for 3 (Residents 5, 16, and 18) of 3 sampled residents. The facility census was 32. Findings are: Review of the facility Fall Assessment policy, updated 2/2023, revealed the following: -Interventions for residents at risk for falls will be found in the care plan and are specific for that resident. -The Quality Improvement Coordinator will be responsible for trending falls/looking for patterns. This will be done by the following criteria: place of fall, time of fall, day of week of fall, injuries vs. no injuries, medical diagnosis/contributing factors. Review of the facility Fall Committee notes, dated 7/15/24 and 8/19/24, revealed the following: The number of falls in May, June, July (up to 7/15/24 in July notes and all of July in 8/19/24 notes) and those that had occurred in August as of 8/19/24. There was a brief description of how the fall occurred. The notes do not mention a root-cause analysis for each of the falls or the intervention developed and implemented for the falls. Review of the facility QAPI minutes, dated 9/5/24, revealed the following: -PIP (Performance Improvement Project): Falls: Each resident who does have falls is tracked for fall score, safety features in use, etc. (continued on next page)

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

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 11/13/24 at 10:30 AM, Licensed Practical Nurse (LPN)-B revealed after a resident has a fall that the nurse is to fill out a post fall evaluation which would include where it occurred, if anyone was involved, how the resident was found, what contributed to the fall, medical practitioner, and family notification, and if there were any injuries. LPN-B further revealed that the interventions typically put into place are to make sure the bed is in low position, a padded mat is next to the bed, personal items are within reach or an alarm to notify staff if the resident were to attempt to get up. LPN-B further revealed that [gender] will try to come up with a new intervention based on the root cause but usually does not. LPN-B confirmed that the previously listed interventions are not directly related to the root cause of a fall and that an intervention should be put into place that is specific to the cause of the fall. An interview on 11/13/24 at 12:36 PM the Assistant Director of Nursing (ADON) revealed that Performance Improvement Plans (PIP) are audited routinely and changed as needed. The ADON further revealed that there were no audits available that tracked the root-cause of a resident's fall was determined and that a new intervention was developed and implemented for that specific fall the resident had. A. Review of the facility Fall Log 2024 revealed the following entries for Resident 16: -10/19/24 at 6:10 AM was in bed, rolled out of bed onto padded mat, low bed -10/22/24 at 1:40 AM was in bed, found sitting on padded mat beside bed Review of Resident 16's comprehensive care plan (CCP- written instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care), dated 7/14/21 revealed the following: -Problem/Need: Falls: History of falling. Resident 16 is admitted to Gardenside with a history of falling at home due to weakness, and 4 falls while [gender] was in the ALF (Assisted Living Facility) for just over 1 month. Resident 16 is at high risk for falls due to right sided weakness, status post Cardiovascular Accident (CVA-interruption of blood flow to the brain), dementia as [gender] forgets [gender] limitations and has some short-term memory problems, incontinence. -Approach(es): remind to ask staff for assistance with ambulation-keep call light in place at all times; refer to restorative nursing program, no longer walks but does AROM (Active Range of Motion); provide with non-slip shoes/footwear; ensure an environment free of clutter/clear pathways; assess for changes in condition that may warrant increased supervision/assistance and notify the physician as needed; transfers with 1 assist and sit to stand; bed in low position Review of Resident 16's Minimum Data Set (MDS- a comprehensive assessment of each resident's functional capabilities used to develop a resident's plan of care), dated 9/11/24, revealed the following: -admitted : 6/30/21 -Brief Interview for Mental Status (BIMS- a test used to get a quick snapshot of a resident's cognitive function, scored from 0-15, the higher the score, the higher the cognitive function) of 3 which indicate sever cognitive impairment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Transferred from chair/bed-to-chair transfer with maximum assistance and did not walk. -Active Diagnoses: Non-Alzheimer's Dementia and hemiplegia or hemiparesis (loss of muscle function on one side of the body). -No falls since the prior assessment. -Chair alarm used daily. Review of Resident 16's Post Fall Evaluation, dated 10/19/24, revealed the following: -Description of Fall Activity: roll from low bed to mat. -Injury type: No apparent injury -Post Fall Analysis: Environmental Safety Plan Fall Prevent: adequate room lighting, bed in low position, call device within reach, encourage handrail/safety bar use, non-slip footwear, patient specific safety measure, personal items within reach -Interventions in place at time of fall: no qualifying data available. Review of Resident 16's Post Fall Evaluation, dated 10/22/24, revealed the following: -Description of Fall Activity: from hi/low bed -Injury type: No apparent injury -Post Fall Analysis: Environmental Safety Plan Fall Prevent: adequate room lighting, bed in low position, call device within reach, night light -Interventions in place at time of fall: no qualifying data available -Interventions in place to prevent falls: remind to use call light An interview on 11/13/24 at 11:35 AM, the ADON confirmed that a root cause had not been determined when Resident 16 had fallen on 10/19/24 and 10/22/24 and that a new intervention based on the root cause was not developed or implemented to be put on the care plan for either fall. B. Review of the facility Fall Log 2024 revealed the following entries for Resident 18: -5/9/24 at 11:00 PM sitting on floor by bed, -5/18/24 at 6:50 AM top half of left side still on bed, bottom half sitting on floor, -9/9/24 at 1:40 AM was in bed, found sitting on floor back against bed, low bed, padded mat, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-10/16/24 at 11:10 PM was in bed, found sitting on padded mat on floor holding onto body pillow. Review of Resident 18's comprehensive CCP, dated 5/26/22 revealed the following: -Problem/Need: Falls: Resident 18 is no longer able to ambulate and is dependent on 2 staff to use a full body lift for all transfers. [Gender] doesn't attempt to get out of [gender] wheelchair. [Gender] will occasionally roll out of bed, whether it be on purpose trying to get up or just being restless and rolling out of bed on accident is unknown. Bed is in low position with padded mat next to bed for this reason. Current fall risk is 55 which puts [gender] at high risk still. -Approach(es): anticipate and meet needs; be sure call light is within reach and encourage to use it for assistance as needed. Respond promptly to all requests for assistance. Coordinate with appropriate staff to ensure a safe environment with: Floors even and free from spills or clutter. Adequate, glare-free light. Call light. Bed in low position at night. Side rails as ordered. Handrails on walls. Personal items within reach; Use silent wheelchair and floor alarm when in bed, does not use call light to ask for help. Padded gray mat beside bed. Bed in low position when in bed. 5/9/24 was in bed, found sitting on floor, back against bed, stated she didn't fall, just slid out of bed. 5/18/24 attempted to get out of bed on [gender] own. Top half of left side including elbow/arm still on bed. Bottom on floor, sitting on floor mat. Bed in low position. Review of Resident 18's MDS, dated [DATE], revealed the following: -admitted : 5/10/22. -Severely impaired cognitive skills for daily decision making. -Transferred from chair/bed-to-chair transfer with total dependence and did not walk. -Active Diagnoses: Schizophrenia (mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions). -2 or more falls with no injury since the prior assessment. -Chair alarm and floor mat alarm in place daily. Review of Resident 18's nursing narrative note, dated 5/9/24 at 11:35 PM revealed the following: -summoned to room at 11:00 PM, note resident sitting on floor with back against bed. [Gender] stated, I didn't fall, I slid out of bed. Was incontinent of urine at time of fall. Review of Resident 18's Post Fall Evaluation, dated 5/9/24, revealed the following: -Description of Fall Activity: roll from low bed to mat. -Injury type: No apparent injury. -Post Fall Analysis: Environmental Safety Plan Fall Prevent: bed in low position, call device within reach, mobility support items readily available. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Interventions in place at time of fall: no qualifying data available. -Intervention in place to prevent falls: frequent observations. Review of Resident 18's nursing narrative note, dated 5/18/24 at 10:50 AM, revealed the following: -6:50 AM staff call this nurse to room, noted Resident 18 sitting on floor, next to bed, [gender] had attempted to get out of bed. [Gender] top half (left side), elbow/arm remained in bed, while [gender] bottom was sitting on floor, on top of padded fall mat, bed was in low position. Noted to be incontinent of bowel/bladder once in bed. Staff assist with cleaning/peri cares. Review of Resident 18's electronic health record (EHR) revealed no post fall evaluation completed for 5/18/24 fall. Review of Resident 18's nursing narrative note, dated 9/9/24 at 2:34 AM, revealed the following: -At 1:40 AM note that floor alarm is sounding, entered room, and found resident in sitting position, with back against the bed, sitting on floor. Body pillow behind [gender]. Resident incontinent of urine, was changed. Bed remains in low position, mat beside bed. Review of Resident 18's Post Fall Evaluation, dated 09/9/24, revealed the following: -Description of Fall Activity: roll from low bed to mat. -Injury type: No apparent injury. -Post Fall Analysis: Environmental Safety Plan Fall Prevent: adequate room lighting, bed in low position, call device within reach, patient specific safety measures. -Interventions in place at time of fall: frequent observations. -Interventions in place to prevent falls: frequent observations, low bed with mat, mat placed on floor next to bed. Review of Resident 18's nursing narrative note, dated 10/16/24 at 11:43 PM, revealed the following: -Floor alarm sounded at 11:10 P, entered room and resident sitting on floor beside bed holding on to body pillow. Asked resident what [gender] was doing, and [gender] just stated, Shut the light off asked [gender] how [gender] fell out of bed and [gender] stated, I didn't fall. Resident incontinent of bowel at time of fall. Review of Resident 18's Post Fall Evaluation, dated 10/16/24, revealed the following: -Description of Fall Activity: roll from low bed to mat. -Injury type: No apparent injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Post Fall Analysis: Environmental Safety Plan Fall Prevent: bed in low position, call device within reach, encourage handrail/safety bar use, encourage personal mobility support item use, mobility support items readily available. -Interventions in place at time of fall: frequent observations, low bed with mat, mat placed on floor next to bed. -Interventions in place to prevent falls: frequent observations, low bed with mat, mat placed on floor next to bed. An interview on 11/13/24 at 11:35 AM, the ADON confirmed that a root cause had not been determined when Resident 18 had fallen on 5/9/24, 5/18/24,9/9/24 and 10/16/24 and that a new intervention based on the root cause was not developed or implemented to be put on the care plan for any of the falls. 45613 C. Review of the facility provided fall log revealed that Resident 5 had falls on 9/13/24, 9/28/24, 10/4/24, and 10/18/24. Review of Resident 5's Quarterly MDS dated [DATE] revealed an admitted [DATE] to the facility and a BIMS score of 99 which indicated the resident was unable to complete the interview due to cognitive decline and the following: -2 falls without injuries and 1 fall with an injury. -Resident uses a walker and a wheelchair. -Resident needs assistance with ambulation, transfers, and toileting. Review of Resident 5's Significant change MDS dated [DATE] revealed: -A fall without an injury. -Resident uses a walker and a wheelchair. -Resident needs assistance with ambulation, transfers, and toileting. Review of Resident 5's CCP dated 10/23/24 revealed: - Fall focus dated 7/25/24 which stated the resident is at risk for falls due to forgetting to use assistive devices and being unaware of surroundings. Resident is unsteady while walking. - Goal of the resident is to be free of falls (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Approaches included anticipate needs, call light within reach, ensure a safe environment - no clutter, adequate light, call light, bed in low position, personal items within reach, and appropriate footwear. -Falls were listed on 9/13, 9/28, 10/4, 10/18. Post Fall Evaluations for Resident 5 revealed the following: -Fall dated 9/13/24 the resident fell from her recliner chair with no injury. No interventions in place at the time of fall. New interventions in place to prevent falls were adequate lighting, chair alarm and frequent observations. -Fall dated 9/28/24 another resident reported that this resident was seated on seat of walker and reached down for something and fell . Neurological assessment was initiated. Interventions in place at the time of fall were adequate lighting, chair alarm and frequent observations. Environmental Safety Plan fall prevention was adequate lighting, encourage mobility support, and non-slip footwear. -Fall dated 10/4/24 resident fell while walking and hit head. Neurological assessment initiated. Interventions in place at the time of fall were adequate lighting, chair alarm and frequent observations. Environmental safety plan fall prevention was to encourage person mobility support and nonslip footwear. -Fall dated 10/18/24 resident fell from recliner chair in the general TV room. Interventions in place at the time of fall were adequate lighting, chair alarm and frequent observations. Environmental Safety plan of fall prevention was non-slip footwear and keep personal items within reach. Interview on 11/13/24 at 11:14 AM with LPN - A confirmed that if a resident falls and it is unwitnessed they would start neuro checks, then they should put a new intervention into place that is related to the fall and put it on the fall report. Floor staff does not update the careplan but the fall committee does. Interview on 11/13/24 at 11:35 AM with ADON confirmed that the root cause of the falls had not been identified and new interventions had not been updated to the careplan Interview on 11/13/24 at 12:08 PM with ADON confirmed that new interventions after each resident fall are not listed on the careplan and should have been.