STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325120	A. Building B. Wing	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Bayard Medical Center	41 Fort Bayard Road Santa Clara, NM 88026

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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755 Based on record review and interview, the facility failed to develop an effective discharge plan for 1 (R #1) of 3 (R #1, R #2, and R #3) residents reviewed for discharge planning (the process of transitioning a resident from one level of care to the next), when staff failed to: 1) Involve R #1's Insurance Case Manager (ICM) in obtaining services through Mi Via (a self-directed waiver program for individuals with diagnosed intellectual and developmental disabilities), 2) Obtain services through Mi Via for R #1 (that he had prior to admission) and was brought up by family during a meeting on 11/09/23 prior to discharge on 03/28/24. This deficient practice is likely to result in complicated or unsafe transitions from the facility to the residents' post-discharge settings. The findings are: A. Record review of R #1's Admission Record, no date, revealed R #1 was admitted into the facility on [DATE] and discharged to a private residence on 03/28/24. B. Record review of R #1's progress notes revealed: 1. Social Worker's note, dated 11/09/23, revealed an interdisciplinary team (IDT; a group of health care professionals with various areas of expertise who work together toward the goals of the resident) meeting was held with R #1's mother (legal representative) and the Insurance Case Manager regarding R #1's status and discharge needs. The IDT discussed obtaining care through Mi Via for R #1 when his mother brought it up. 2. Nurse's note, dated 03/21/24, revealed an IDT meeting was held with R #1's legal representative and the facility IDT team to discuss R #1 discharge home on 03/28/24. Staff did not document any information about Mi Via. C. Record review of Case Conference Summary (discharge meeting), dated 03/21/24, revealed R #1's Insurance Case Manager did not attend the conference. D. On 06/04/24 at 11:50 am, during an interview with R #1's Insurance Case Manager, he stated the facility did not contact him to attend the meeting prior to R #1's discharge home to ensure Mi Via services were in place and a safe discharge for R #1. (continued on next page)

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

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	E. On 06/11/24 at 3:52 PM during an interview, Unit Manager #1 confirmed the facility held a discharge meeting for R #1 on 03/21/24, and the medical record did not contain any documentation as to why the Insurance Case Manager did not attend. She also confirmed the medical records did not document any notes whether staff contacted the Mi Via program prior to R #1's discharge to ensure services were in place for the resident.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 41755 Based on record review and interview, the facility failed to ensure staff completed a discharge summary that included a recapitulation (a summary describing the resident's course of treatment while residing in the facility) and a reconciliation of all medication at the time of discharge for 3 (R #1, R #2 and R #3) of 3 (R #1, R #2 and R #3) residents sampled for discharge from the facility. This deficient practice could likely lead to the receiving facility, community agency, or family member not knowing what the current care needs and/or current medications are for the resident. The findings are: R#1 A. Record review of R #1's Electronic Medical Record (EMR) revealed: 1. Resident was discharged from the facility on 03/28/24. 2. The Recapitulation of Stay form, effective date 03/28/24, was not completed until 04/02/24 (five days after the resident's discharge) and did not contain R #1's discharge medication list. R #2 B. Record review of R #2's EMR revealed: 1. Resident was discharged from the facility on 02/20/24 with home health services. 2. A discharge medication list was in the EMR, but the record did not contain a recapitulation for of the resident's stay or a discharge summary. R#3 C. Record review of R #3's EMR revealed: 1. Resident was discharged from the facility on 04/24/24 with home health services. 2. The Recapitulation of Stay form, effective date 04/21/24, was not completed until 04/25/24 (one day after the resident's discharge). D. On 06/11/24 at 3:21 PM, during an interview, the DON confirmed staff did not complete R #1's, #2's, and #3's discharge summaries at the time of discharge. The DON stated each resident's discharge had different documents completed, but she expected all discharges to have the same information. The DON also stated staff should complete and sign the resident recapitulation of stay on the same day of the resident's discharge, not later than the discharge date .

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755 Based on record review and interview, the facility failed to provide quality of care for 1 (R #4) of 3 (R #3, R #4, and R #5) residents reviewed for diabetes (chronic condition that happens from persistently high blood sugar levels) when staff did not administer diabetic medications to R #4 upon admission to the facility and did not monitor the resident's blood glucose when exhibiting symptoms of high blood sugar. This deficient practice likely resulted in R #4 being admitted to the hospital for diabetic ketoacidosis (DKA; a serious complication of diabetes that can be life-threatening. Occurs when blood sugar is very high, and ketones [acids your body makes when it's using fat instead of sugar for energy] build up in the body, causing symptoms of increased thirst, frequent urination, weakness and fatigue) and could likely result in other diabetic residents not starting their diabetes medications leading to complications, DKA, and potentially death. The findings are: A. Record review of R #4's admission record, no date, revealed she was admitted to the facility on [DATE] from the local hospital. B. Record review of the R #4's hospital discharge summary, dated 02/29/24, revealed a discharge plan: 1. Continued medications: a. Januvia (oral diabetes medication used to help lower blood sugar), 100 milligrams (mg; strength of medication) by mouth daily. b. Jardiance (oral diabetes medication used to help lower blood sugar and helps protect the kidneys), 10 mg by mouth daily. c. Glipizide (oral diabetes medication that helps control blood sugar levels by helping your pancreas produce insulin), 5 mg by mouth twice daily. d. Insulin glargine/Lantus (long-acting insulin that helps control blood sugar and starts to work several hours after injection and keeps working evenly for 24 hours), 20 units (measurement of insulin medication) subcutaneously (injected under the skin) twice daily. C. Record review of R #4's admission physician's orders (handwritten orders), dated 02/29/24, revealed the following: 1. Jardiance, 10 mg tablet. One tablet by mouth daily for diabetes type 2 (condition resulting from insufficient production of insulin, causing high blood sugar). 2. Other diabetic medications were not ordered. D. Record review of R #4's physician's order (order placed in computer), dated 02/29/24, revealed the following: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. Accu-Check as needed for symptoms high or low, as needed for hyperglycemia (high blood sugar) symptoms or hypoglycemia (low blood sugar) symptoms. 2. Physician did not document orders for Januvia, Glipizide, and Insulin glargine/Lantus. E. Record review of R #4's admission nursing assessment, completed by RN #13 and dated 02/29/24, revealed the resident had blood glucose which measured 241 (If blood sugar over 240 mg/dL, you may be at risk for ketoacidosis (when your body produces high levels of blood acids called ketones) (normal non-fasting blood sugar level is 150 or less) on admission. F. Record review of R #4's progress notes revealed the following: 1. Medical Doctor note, dated 03/01/24, Note type: History and Physical. Diagnosis, Assessment and Plan: Type 2 diabetes mellitus with diabetic neuropathy (type of nerve damage caused by diabetes), unspecified whether long term insulin use. 2. Medical Doctor note, dated 03/03/24, on admission, the patient was continued on her oral diabetes medications (Januvia, glipizide and Jardiance). 3. Therapy note, dated 03/03/24, resident fatigued during task and required max assistance with clothing management and toilet hygiene from two CNAs. Resident verbalized she needed to drink a lot of water but it goes through me. 4. Therapy note, dated 03/04/24, resident struggled to perform stand, pivot, and transfer to commode. Resident verbalized I can't after two steps. Resident made five attempts to perform sit-to-stand from commode to front wheeled walker with failed attempts. Resident was provided time to rest and calm down but got more frustrated with each attempt. Resident began to cry. Certified Occupational Therapy Assistant (COTA) then called CNA for assistance. Resident required a two person assist for transfer to wheelchair from commode. 5. Therapy note, dated 03/05/24, resident fatigued very easily with activity and had noted desaturation (low blood oxygen) during limited ambulation. 6. Therapy note, dated 03/06/24, therapy arrived at resident's room for scheduled physical therapy (PT) visit. Resident reported she just got into bed and was tired. Resident refused to participate with PT today. 7. Therapy note, dated 03/07/24, resident fatigued easily with activity. 8. Nursing note, dated 03/08/24, staff did not administer Jardiance to the resident because it was not available. It will be delivered on 03/09/24. 9. Therapy note, dated 03/09/24, resident tolerated all activities well; however, she fatigued easily. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	10. Therapy note, dated 03/10/24, resident was rescheduled for the occupation therapy (OT) session, because the resident was laying down and refused to get out of bed for scheduled time. The COTA observed R #4 in the dining area for the lunch meal, but the resident already completed her meal. The COTA observed the resident, and the resident did not make an attempt to self-propel (move on own) despite spouse leaving the table. The CNA assisted the resident, and she accepted. The COTA intervened and encouraged the resident to self-propel. R #4 used her right lower extremity (leg) and bilateral upper extremities (arms) to get down Hallway 3. R #4 made it to the double door and required extended amount of time, approximately 20 minutes. The CNA and RN were notified to encourage the resident to self-propel if time permitted. Resident complained of fatigue and requested assistance down Hallway 4 to return to her room. 11. Therapy note, dated 03/11/24, resident complained of fatigue and refused to get out of bed for the rescheduled OT session for lunch meal. Resident stated she ate a large breakfast and did not want to attend lunch meal today. 12. Nursing note, dated 03/12/24, resident refused to get up for lunch and stayed in bed to rest and sleep. 13. Therapy note, dated 03/12/24, resident fatigued easily with activity. R #4 had more difficulty with extending knees and picking up feet during transfers when fatigued. 14. Therapy note, dated 03/12/24 at 3:11 PM, resident lay in bed, sleeping. Therapy asked R #4 how she was doing. The resident responded with resting but did not open her eyes. The resident did not want to participate with PT and requested visit be rescheduled for 03/13/24 after lunch. 15. Therapy note, dated 03/12/24 at 7:26 PM, resident complained of being tired but agreed to working with PT initially. The resident appeared more fatigued over the past week, with limited endurance to activities. The resident did not appear highly motivated to work towards gaining strength, endurance, and improved mobility. Therapy planned to discontinue skilled PT and submit referral for the restorative nursing program (nursing care designed to improve or maintain the functional ability of residents). 16. Nursing note, dated 03/19/24 at 2:40 PM, resident's POA (power of attorney) came and took resident out on pass at approximately 2:20 pm. He stated that he felt comfortable transferring her. At 5:10 PM, the resident returned. The POA stated he did not take her out of the vehicle. He stated he drove her around and let her dogs come to the car. He said he did notice she was weaker. 17. Nursing note, dated 03/20/24, resident refused to get up for supper and stated, I am tired and not hungry. 18. Nursing note, dated 04/02/24, staff did not administer Jardiance to R #4, because it was not available. 19. Nursing note, dated 04/04/24, the resident had complaints of pain and not able to use right hand and fingers. The resident's grip strength was weak in bilateral hands, but it was weaker on right. book, and Therapy evaluation sent. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	20. Nursing note, dated 04/07/24, resident sent out to emergency room due to being unresponsive and with a blood sugar of 529. 21. Nursing note, dated 04/08/24 at 2:00 AM, resident was admitted to hospital for management of DKA. 22. The record did not contain documentation staff reported R #4's thirst, increased urination, or fatigue to the physician or nurse practitioner. G. Record review of R #4's Electronic Medical Record revealed: 1. Staff did not check R #4's blood sugar when she had complaints of thirst, increased urination, fatigue, or when she missed doses of her Jardiance. 2. R #4's lab work, completed on 03/01/24, documented an A1C level of 8.8 percent (%) (an average A1C is below 5.6%). H. Record review of R #4's hospital history and physical, dated 04/08/24, revealed insulin was ordered upon discharge, both Lantus insulin and Accu-checks with sliding scale coverage (blood sugar checks with a scale indicating how much insulin is needed dependent on blood sugar reading). Assessment and Plan: DKA Accu-checks with sliding scale, Lantus, and gentle intravenous (IV) hydration (fluid through the vein). I. On 06/05/24 at 12:42 AM, during an interview with the Assistant Unit Manager, she confirmed staff did not start R #4 on all of her diabetes medications. The Assistant Unit Manager stated there was confusion with the resident's hospital discharge paperwork, and the facility was not sure if R #4 was to be on insulin. The Assistant Unit Manager confirmed no one from the facility contacted the hospital to clarify R #4's diabetes medications. J. On 06/05/24 at 3:22 PM, during an interview with RN #1, she stated she admitted R #4, and the provider directed staff to monitor the resident only if she had symptoms of high or low blood sugar. RN #1 stated there were not any specific symptoms for which staff were to monitor the resident. L. On 06/11/24 at 3:21 PM, during an interview, the DON stated R #4 had an order for Jardiance upon admission to the facility, even though the admitting provider reviewed and signed off on the hospital discharge paperwork. She also stated staff did not report R #4's symptoms of elevated blood sugar to a provider and staff did not check R #4's blood sugar levels and they should have. J. Record review of facility's diabetes policy, Nursing Care of the Older Adult with Diabetes Mellitus, revision date November 2020, revealed: 1. Symptoms associated with diabetes include: a. Hyperglycemia: Uncontrolled diabetes from lack of insulin or inadequate insulin results in hyperglycemia (blood sugar above target levels). Signs and symptoms of hyperglycemia include the following: increased thirst, frequent urination, fatigue. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-The DON or designee re-educated licensed nurses on facility policies regarding admission procedures and diabetic management as well as medication reconciliation guidelines. -Facility has secured additional providers to ensure that a provider is available in-house for all admissions. The provider will complete accurate review and completeness of admission assessments through reconciliation of all related admission documents. -Medical providers have been trained on facility protocols regarding review of all related admission documents prior to or at time of admission. Providers shall document agreement with and/or changes with treatment history. -Medical providers shall communicate with discharging entities to clarify any discrepancies in provided documentation. -Direct care staff will be in-service regarding signs and symptoms of hypoglycemia and hyperglycemia and proper procedure to notify appropriate nursing staff. -Direct care staff will be in-service on documenting all pertinent conversations in the electronic medical record. -Licensed nursing staff will document communication with the provider through SBAR process. Evidence of notification will be included in the electronic health record. Date Facility Asserts Likelihood for Serious Harm No Longer Exists: 6/7/2024

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F 0689 Level of Harm - 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** 47510 Based on observation, interview, and record review, the facility failed to keep residents free from accidents for 1 (R #21) of 3 (R #21, R #22, & R #23) residents reviewed for falls, when staff failed to: 1. Identify the cause of R #21's onset of fatigue and weakness. 2. Evaluate R #21's ability to safely use a wheelchair independently. This deficient practice likely resulted in R #21 falling multiple times and sustaining an intracranial hemorrhage (bleeding in the skull or brain tissue). The findings are: A. Record review of R #21's face sheet revealed she was admitted to the facility on [DATE]. B. Record review of R #21's care plan, dated 12/26/23, revealed the following: 1. R #21 had a functional abilities deficit (decreased capability to engage in one's surroundings and carry out desired physical and mental activities). a. R #21 was independent but may require supervision with ambulation (ability to walk without the need for any assistance). She may require greater assistance at times. b. R #21 may use a wheelchair during times of illness or unsteadiness. The care plan did not state the level of assistance for staff to provide when R #21 used a wheelchair. 2. R #21 was at risk for falls a. Monitor for any acute illness or any other changes, including level of consciousness which could increase resident's risk for falls. b. Note any decline in ADL (activities of daily living; all the basic skills you need in regular daily life, including walking and activities to maintain personal hygiene, such as toileting, dressing, and eating) performance or change in gait (a person's manner of walking), and notify nurse or provider PRN (as needed). c. PT (Physical Therapy; the treatment of disease, injury, or deformity physical methods with methods such as massage, heat treatment, and exercise rather than by drugs or surgery)/OT (Occupational Therapy; help residents relearn their daily living activities, like dressing or eating) evaluate and treat as ordered or PRN (as needed). C. Record review of R #21's Fall risk assessment, dated 03/22/24, revealed R #21 had a high risk for falling. D. Record review of R #21's PT Narrative Note, dated 10/23/23, revealed the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	1. R #21 reported difficulty walking, fatigue, weakness, and dizziness. 2. R #21 requested a wheelchair. 3. PT recommended that R #21 ask for a wheelchair when she needed it (No evaluation for R #21's ability to use the wheelchair was done). 4. PT recommended that the wheelchair not be left in R #21's room. E. Record review of R #21's OT evaluation, dated 06/04/24, revealed the following: 1. R #21 reported symptoms of being lethargic (an unusual decrease in consciousness) and weakness starting in November or December 2023. 2. R #21 started using the unit wheelchair (wheelchair not assigned to any resident but was available to use for any resident on the unit) on 04/20/24. F. Record review of R #21's PT Narrative note, dated 05/21/24, revealed the following: 1. On 05/08/24, PT received a referral from nursing to evaluate R #21 due to unsteadiness in gait which the nurse believed would cause a fall. 2. On 05/14/24, PT met with R #21, and she stated she felt weaker and had been using the unit wheelchair. PT encouraged the resident to get out of bed for activities (No PT assessment or evaluation for R #21's ability to use the wheelchair was completed). 3. On 05/17/24, PT met with R #21 after she fell during a transfer to the wheelchair. a. R #21 reported pain to her right knee when she extended her knee. b. PT submitted a work order to get R #21 a wheelchair (R #21 was using the unit wheelchair) that she was able to self-propel (move herself) using her feet (No PT assessment or evaluation for R #21's ability to use the wheelchair was done). 4. On 05/20/24, R #21 was provided her own wheelchair (No PT assessment or evaluation for R #21's ability to use the wheelchair was done). G. Record review of R #21's nursing progress note, dated 05/17/24, revealed R #21 had an unwitnessed fall when she transferred self from her bed to the wheelchair. R #21 denied pain or injury to her head. H. Record review of R #21's provider note, dated 05/17/24, revealed the provider saw R #21 after her fall that day (05/17/24) and the resident reported pain in her right knee. I. Record review of the Acute Care Plan Fall Risk dated 05/17/24, revealed the following: 1. Problem: Has increase fall risk due to: weakness. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	2. Staff did not document any other causes for R #21 fall or increased fall risk. J. Record review of R #21's nursing progress note revealed the following: 1. 05/18/24, revealed she was very weak and unable to sit straight up in bed. 2. 05/19/24, revealed R #21 reported being weak. Nurse told the resident if she did not get out of bed then she would get pneumonia. K. Record review of R #21's provider progress note, dated 05/20/24 (prior to the fall), revealed the following: 1. R #21 did not have breakfast in the morning and did not get up for lunch since her fall on 05/17/24. 2. R #21 reported she was very fatigued, lethargic, slept a lot, was not hungry, and did not feel good. 3. R #21 reported pain to her left leg and had a bruise on her right tibia (bone in the lower part of the leg). L. Record review of R #21's nursing progress note, dated 05/20/24, revealed the following: 1. Staff found R #21 sitting on the bathroom floor. 2. The resident reported she missed the toilet. 3. Staff transferred R #21 to the wheelchair. 4. The resident's pupils (round opening in the center of the eye) were unequal and unreactive to light. The right pupil was larger than the left (may be a sign of a very serious condition). 5. Staff contacted the provider, and the provider ordered for R #21 to go to the emergency department. M. Record review of R #21's Emergency Department Notes, dated 05/21/24, revealed the following: 1. The resident's right pupil was dilated (larger than usual). 2. The residents right and left pupils were not reactive to light. 3. The resident's visual fields (the portion of space in which objects are visible at the same moment during steady fixation of the gaze in one direction) were not intact. 4. The computed tomography scan (CT; a medical imaging technique used to obtain detailed internal images of the body) of the head and neck showed R #21 had a hematoma (bad bruise), a hemorrhage (an emergency condition in which a ruptured blood vessel causes bleeding inside the brain), and a midline shift in the brain (a shift of brain tissue across the center line of the brain). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325120	A. Building B. Wing	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Bayard Medical Center	41 Fort Bayard Road Santa Clara, NM 88026

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F 0689 Level of Harm - Actual harm Residents Affected - Some	5. R #21 was transferred to another hospital that had a neurosurgeon (a specially trained medical doctor who diagnoses and treats conditions that affect the brain, spinal cord and nerves) on 05/21/24. N. On 06/11/24 at 2:29 PM, during an interview with CNA #21, she stated the following: 1. R #21 currently needed assistance to get out of bed or to transfer out of a wheelchair. 2. R #21 was aware of how to use the call bell to call for assistance. 3. R #21 did not get up without assistance. O. On 06/11/24 at 2:32 PM, during an interview with RN #21, he stated the following: 1. Prior to her falls: a. RN #21 stated R #21 was too weak to go to the main dining room so she ate in the unit dining room (R #21's weakness had been going on for sometime prior to the falls). b. R #21 was independent with all activities. 2. He referred R #21 to therapy on 05/09/24 due to her weakness, unsteady gait, and inability to walk outside the confines of her room. P. On 06/11/24 at 4:57 PM, during an interview with CNA #22, she stated the following: 1. Prior to R #21's falls on 05/17/24 and 05/20/24, R #21 was independent with all ADLs, except she needed some assistance for showers. 2. R #21 would use the wheelchair when she felt dizzy or weak. 3. R #21 would notify staff when she needed assistance. 4. CNA #22 was never told R #21 needed assistance to transfer into or out of the wheelchair. 5. CNA #22 did not notice R #21 was weaker or used the wheelchair prior to R #21's falls on 05/17/24 or 05/20/24. Q. On 06/11/24 at 4:15 PM, during an interview with PT #11 she stated the following: 1. Staff provided R #21 with a unit wheelchair. 2. Staff asked for R #21 to be evaluated for her own wheelchair. PT #11 said she talked to R #21 (but did not assess), and R #21 said she felt weaker than normal. 3. R #21 was given her own wheelchair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	4. PT #11 said she did not assess R #21 for the use of the wheelchair. PT #11 said R #21 had used a wheelchair before in the past, and she knew how to use it. R #21 used the wheelchair for mobility. R #21 transferred on her own without any problems [in the past]. 5. PT #11 confirmed that R #21 fell on [DATE], and the resident used the unit wheelchair at that time. PT #11 said she did not assess the resident to confirm the resident knew how to safely transfer at that time. PT confirmed that she should have assessed R #21 for the use of the wheelchair. 6. PT #11 confirmed that R #21 fell on [DATE], and she used her own wheelchair at that time. 7. PT #11 said staff evaluated R #21 after the second fall, and it was determined R #21 needed the assistance of one person. 8. PT #11 said an assessment was not done to confirm R #21 knew how to safely transfer after the second fall, because she was to be assisted with transfers. 9. PT #11 said she should have done an assessment to make sure R #21 knew how to transfer safely to and from the wheelchair prior to R #21 using the wheelchair. R. On 06/12/24 at 11:32 AM, during an interview with UM #22, the following was revealed: 1. One wheelchair was designated for each unit. 2. There was not a process for a resident to use the wheelchair. Anyone could grab the wheelchair and use it. 3. Staff used the wheelchair if a resident was weak. 4. Staff would notify the nurse that the resident needed a wheelchair, and the nurse would put in a screening for therapy. 5. If the resident needed the wheelchair for a prolonged period of time, the unit wheelchair would remain with the resident until the facility was able to get them their own personal wheelchair (R #21 had the unit wheelchair for a prolonged time). 6. The decision to leave the wheelchair with a resident was determined by nursing and therapy (they made the decision to leave the wheelchair with R#21 for extended period of time without an assessment). 7. UM #22 thought therapy did the evaluation for a resident to have their own personal wheelchair (therapy only met with R #21 and did not evaluate her before putting in work order for her to have her own wheelchair). 8. She was not aware if the unit wheelchair was left with the R #21 unsupervised (R #21 used unit wheelchair during the fall on 05/17/24). 9. A wheelchair should not be left with a resident who was not assessed for their ability to transfer safely. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	10. UM #22 confirmed that on 05/17/24, R #21 fell trying to transfer from her bed to her wheelchair. 11. The fall on 05/17/24 was an unwitnessed fall. 13. The wheelchair was left in R #21's room for her use 14. It was common for a resident to use the unit wheelchair without staff assessing the resident's ability to use the wheelchair and transfer to and from the wheelchair safely. 15. UM #22 confirmed that on 05/20/24, R #21 was given her own wheelchair. 16. PT should have assessed R #21's ability to use and transfer in and out of the wheelchair prior to being given her own wheelchair. 17. R #21 had an unwitnessed fall in the bathroom on 05/20/24 that resulted in R #21 obtaining an intracranial hemorrhage. 18. R #21 returned from the hospital on 06/03/24. S. On 6/12/24 at 12:03 PM, during an interview with the DON, she confirmed the following: 1. The unit wheelchair was to be used if a resident had a change in condition like pain or weakness. 2. If a resident needed the unit wheelchair long term, they should be evaluated by the provider and a referred to PT. 3. Nurses can use their judgement to leave the unit wheelchair with a resident in their room without a therapy evaluation. 49313

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 41755 Based on record review and interview, the facility failed to ensure residents have a written, signed, and dated progress note from the provider (physician or nurse practitioner) at each visit for 3 (R #2, R #4 and R #5) of 3 (R #2, R #4 and R #5) residents reviewed for physician's visits. This deficient practice could likely result in the resident's needs not being met due to facility staff being unaware of resident's status related to lack of written, signed, and dated progress notes at the time of the visit. A. Record review of R #2's progress notes revealed: 1. Nurse Practitioner (NP) note: New patient encounter, effective date 01/26/24. The NP did not sign the note until 01/28/24. B. Record review of R #4's progress notes revealed: 1. Medical Doctor (MD) note: Progress note, effective date 03/03/24. The MD did not sign the note until 03/06/24. C. Record review of R #5's progress notes revealed: 1. Medical Doctor note: Chronic Care Management, effective date 05/31/24. The MD did not sign the note until 06/03/24. D. On 06/11/24 at 4:39 PM, during an interview with the Health Information Manager, she stated the providers see the residents then dictate their notes using software. She stated the notes then go into the provider's computer system and get transferred to the facility's electronic progress notes for the resident (she did not specify how long this process takes). She said the notes don't always have the time of the visit because the provider dictates the notes after they see the residents. The Health Information Manager stated the provider has to log in and sign the note after it populates in the resident's electronic record .