STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375559	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver County Nursing Home	200 East 8th Street Beaver, OK 73932

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 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** 46702 Based on record review and interview, the facility failed to ensure a resident's physician and family representative was notified of inappropriate behaviors for one (#35) of 16 sampled residents who were reviewed for notifications. The DON identified 35 residents resided in the facility. Findings: Resident #35 was admitted on [DATE] with diagnoses which included legal blindness, adjustment disorder with depression, and anxiety disorder. Resident #35's quarterly assessment, dated 11/04/24, documented the resident's cognition was mildly impaired. A progress note, dated 12/08/24, read in part, Reported by CNA that neighbor was in dining room this morning at breakfast sitting at the table and stood up and pulled [their] pants down and peed on the floor. On 12/10/24 at 10:03 a.m., Resident #35's POA stated they were not notified of the incident on 12/08/24. On 12/12/24 at 11:33 a.m., LPN #2 was asked who and when was someone contacted when a resident had a behavior like pulling pants down in front of others and urinating on the floor. LPN #2 stated they should contact the physician, the family, the DON, and the administrator. They were asked about Resident #35's behaviors. They stated Resident #35 stood up and pulled their pants down and urinated on the floor on 12/08/24 in the dining room. They stated there was no information in the EHR that anyone was contacted regarding the behavior on 12/08/24. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/24 at 11:40 a.m., the DON was asked to discuss the facility's policy for contacting individuals when there was a behavior in front of other residents such as exposing self and urinating in front of others. They stated first discreetly redirect, notify the charge nurse, notify house keeping, write a progress note, notify family, and the provider. The DON was asked who was contacted on 12/08/24 after the incident. They stated the behavior was out of character for Resident #35 and it was not documented in the EHR the family or the physician was notified. They stated they were unaware if there was a policy regarding notifications. On 12/12/24 at 11:48 a.m., the administrator was asked to discuss the facility's policy for contacting individuals when there was a behavior in front of other residents such as exposing self and urinating in front of others. The administrator stated they should contact the family, the PCP, and the psych provider. They were asked who was contacted on 12/08/24 after the incident in the dining room involving Resident #35. The administrator stated there was no documentation in the EHR the family and/or physician, or psych provider was contacted. They stated the facility did not have a policy regarding notifications.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47453 Based on record review and interview, the facility failed to ensure fall interventions were individualized and revised after a fall for residents assessed as a high risk for falls for two (#13 and #15) of two sampled residents reviewed for individualized care plans. The administrator identified 35 residents resided in the facility Findings: An undated facility Accidents policy, read in part, The intent of this policy is to ensure this facility provides an environment that is free from accidents hazards over which the facility has control and provides supervision and assistive devices are provided for each resident to prevent avoidable accidents. This includes: a. Identifying hazards and risk, b. Evaluating and analyzing hazards and risk, c. Implementing interventions to reduce hazard, and d. Monitoring for effectiveness and modifying interventions when necessary. The policy also read, Individualized, person centered interventions will be implemented, including adequate supervision assistive devices, to reduce risk related to hazards in the environment. A Falls and Fall Risk, Managing policy, revised December 2007, read in part the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. A Comprehensive Care Plan, policy, dated 05/01/22 read in part, Each resident will have a person-centered comprehensive care plan developed and implemented to meet [their] preferences and goals and address the resident/s ,medical, physical, mental and psychosocial needs. The policy also read, The comprehensive care plan will be reviewed and revised, based on the changing goals, preferences and needs of the resident and in response to current interventions. 1. Resident #13 had diagnoses which included heart failure, weakness, dizziness, cataract, and anxiety. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #13's Care plan, date initiated 03/02/22 and revised 10/23/24, documented interventions for fall focus, read in part, Fall interventions: purposeful staff rounding, proper seating in chair for W/C, ensure proper foot wear/nonskid socks, exercise program to improve balance, gait, strength, assist, staffing, environment, friendly to reduce clutter, assess medications - side effects and interactions - PCP and pharmacy review, educate resident regarding risk for falls, increased observation, increased activities, restorative care, staff education on falls and interventions, keep items within reach, bed, and low position when occupied with format. Answer, call promptly, re-orientate to call if needed, use of pictures to provide cues and reminders to call for staff assist, evaluate hearing, vision as needed, root cause analysis for falls, assess for illness, open, parentheses delirium, UTI, respiratory, infection, etc in parentheses, educate resident when applying intervention, create something that makes high-risk followers, identifiable, open, parentheses falling, leaf, pictures, etc. In parentheses involve all staff to prevent falls, maintain daily routine, assist W/toileting before and after each meal, at bedtime as needed. Evaluate B/P for hypotension, rooms/bathrooms with adequate light, call light in reach of resident at all times and remind them to call for staff assist, PT evaluation, evaluate height of bed/toilet seat/chairs, etc. Offer nutritional stacks and meals, offer fluids, everyone- two hours during waking hours promote hydration, proper ambulation, assistive devices (walker, cane W/C space ETC.) and educate on proper use of devices. An Un-Witnessed Fall report, dated 08/01/24, read in part, resident observed laying on [their] stomach on the floor with no bottoms on. Urine and BM on the floor by the bathroom. Neighbor unsure of how [they] fell , just that [they] fell . Resident had abrasions noted to both knees and good range of motion. There was no documentation the care plan was updated with new specific interventions after the fall. A Fall Risk Assessment, dated 09/19/24, documented Resident #13 was a high fall risk with a score of 75. A Significant Change assessment, dated 09/23/24, documented Resident #13's cognition was severly impaired. It also documented Resident #13 was independent with walking with a walker and going to the bathroom independently. A Incident note, dated 11/29/24, read in part, resident reported fall in room- unknown how resident fell . Nurse called to dining room by hospice aid. 2 cuts noted near left eye brow, inner nose swollen and bruised, nurse took resident over to ER- resident refused to stay at ER. Nurse did treatment on eye brow with steri strips and family, PCP notified of her refusal of care in ER. There was no documentation the care plan was updated with new specific interventions after the fall. A Incident note, dated 12/10/24 at 10:41 a.m., read in part, Resident noted yelling out from room. [They]were sitting on floor at foot of bed next to side table. Left foot was rotated outward and [they] did not have ROM in this hip without having pain. [They] also had blood noted running down her cheek. Resident stated 'I fell , help me up and leave me alone' Cleaned face up to assess head wound, laceration appears to be superficial. Assisted [them] up into wheelchair without applying weight to left hip. Notified PCP and brought [them] to ER. Also notified DON, ADM, and [family member]. admitted to hospital. There was no documentation the care plan was updated with new specific interventions after the fall. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/12/24 at 11:02 a.m., MDS coordinator #1 was asked the policy for updating and revising interventions on the care plan. They stated they were updated as needed. MDS Coordinator #1 was asked to review Resident #13's care plan for falls and was then asked if fall interventions were updated or revised after the fall on 08/01/24. They stated no new interventions were put into place. They were then asked about the fall on 11/29/24. They were asked if there were fall interventions updated or revised. MDS Coordinator #1 stated, No. MDS Coordinator #1 was then asked if all fall interventions were from a generic list or were they individualized for the specific resident. They stated if staff started a new intervention then they updated or revised the care plan as needed. 46702 2. Resident #15 was admitted on [DATE] with diagnoses which included unspecified dementia without behaviors and anxiety. Resident #15's Care plan, date initiated 12/20/22 and revised on 10/23/24, documented interventions for fall focus, read in part, Fall interventions: purposeful staff rounding, proper seating in chair for W/C, ensure proper foot wear/nonskid socks, exercise program to improve balance, gait, strength, assist, staffing, environment, friendly to reduce clutter, assess medications - side effects and interactions - PCP and pharmacy review, educate resident regarding risk for falls, increased observation, increased activities, restorative care, staff education on falls and interventions, keep items within reach, bed, and low position when occupied with format. Answer, call promptly, re-orientate to call if needed, use of pictures to provide cues and reminders to call for staff assist, evaluate hearing, vision as needed, root cause analysis for falls, assess for illness, open, parentheses delirium, UTI, respiratory, infection, etc in parentheses, educate resident when applying intervention, create something that makes high-risk followers, identifiable, open, parentheses falling, leaf, pictures, etc. In parentheses involve all staff to prevent falls, maintain daily routine, assist with toileting before and after each meal, at bedtime as needed. Evaluate B/P for hypotension, rooms/bathrooms with adequate light, call light in reach of resident at all times and remind them to call for staff assist, PT evaluation, evaluate height of bed/toilet seat/chairs, etc. Offer nutritional stacks and meals, offer fluids, everyone- two hours during waking hours promote hydration, proper ambulation, assistive devices (walker, cane W/C space ETC.) and educate on proper use of devices. Resident #15's Morse Fall Scale assessment, dated 01/11/24, documented Resident #15 was a high risk for falling. The facility's Un-Witnessed Fall report, dated 02/08/24, read in part, Neighbor observed sitting on the floor at the foot of [their] bed. Wheelchair was flipped over as well. Neighbor stated [they] was getting up to go to the bathroom and grabbed at the wheelchair when [they] started to fall and it flipped over. Assessed for injuries, reports not hurt and did not hit [their] head. Has good ROM noted. Assisted to standing position and returned to bed. Resident #15's Morse Fall Scale assessment, dated 04/09/24, documented Resident #15 was a high risk for falling. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Witnessed Fall report, dated 04/27/24, read in part, CNA informed nurse of neighbor laying on her floor. Neighbor observed to be laying on floor on [their] left side with top of head towards the restroom door,eyes facing towards hall.Neighbor bent at waist with feet and legs pointed towards the hall.ROM performed, neighbor c/o pain to BLE and to back rated at an 8. Asked [them] if [they] hit [their] head and suite mate stated that neighbor did hit [their] head.No skin impairments, hematoma, or injury noted to head. Eyes PERRLA.VS:165/93p-76, T-98.2, O2-92%RA, R-20.Neighbor assisted up slowly via x3 staff to sitting position and then slowly up to WC via x3 staff.Quartersized skin tear noted to left elbow.Call light was observed to be in reach but not on. Alarm to bed was noted to have light on but was not sounding. Neighbor began to vomit into emesis bag.Neighbor then taken to [name withheld] ER. Resident Description: When asked what happened neighbor stated that [they] was going to the restroom. When asked how come [they] didn't use the call light [they] stated 'I did. Resident #15's hospital operative report , dated 04/29/24, read in part, L1 vertebral compression fracture. Resident #15's Care Plan fall focus, revised 08/05/24, read in part, [Resident #15] is a (high) risk for falls r/t weakness/gait/balance problems and impaired mobility. The care plan did not document interventions after the falls on 02/08/24 and 04/27/24. Resident #15's quarterly assessment, dated 11/04/24, documented Resident #15's cognition was moderately impaired and they were dependent on staff for ADLs. On 12/11/24 at 11:43 a.m., MDS coordinator #1 was asked what was the facility fall protocol. They stated after a resident was assessed, they completed a report, huddled with staff for documentation for additional ideas and interventions in the care plan. They were asked what interventions were added after the two falls on 2/08/24 and 4/27/24 to prevent future accidents and hazards. MDS Coordinator #1 stated there were no interventions added to the care plan after the two falls. They were asked about the fall interventions initiated on 12/20/22 and revised 10/23/24. They stated they had a list of interventions for falls and added them to all residents who had falls. They stated those interventions were not specific to the resident, but all residents that fall. They stated it was part of their facility fall protocol. On 12/11/24 at 12:30 p.m., the administrator was asked to review the care plan for Resident #15. The administrator stated there were no new interventions added after the falls on 02/08/24 and 04/27/24. They stated the care plan was not individualized and specific to the resident.

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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** 47453 An IJ was identified from 12/11/24 through 12/12/24. The deficient practice remained at isolated level of a potential for harm. On 12/11/24, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to implement fall interventions for a resident with severe cognitive impairment and high fall risk. On 12/10/24, Resident #13 had a fall with injury in their room. Resident #13 fell during an independent transfer and was found by staff on the floor with their left foot rotated outward with no range of motion to left hip. Resident #13 was taken to the ER by staff. This fall resulted in Resident #13 acquiring a closed displaced intertrochanteric fracture of the left femur and laceration of scalp. On 12/11/24 at 3:04 p.m., the Oklahoma State Department of Health was notified and verified the existence of a IJ situation. On 12/11/24 at 3:56 p.m., the administrator and DON were notified of the IJ situation and the IJ template was provided. On 12/12/24 at 12:34 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal documented the total number of residents at risk for the same deficient practice was 35. It documented the actions to remove the immediacy of the alleged deficient practice were the following: a. on 12/11/24, Resident #13's care plan completed via phone with the family and the family agreed to move Resident #13 to the east side of the facility to be more closely monitored due to high fall risk; b. on 12/11/24, Resident #13's care plan was individualized with specific fall interventions; c. on 12/11/24, all staff were educated in person and by phone on the policy put into place, where to find the master list for fall risk, the falling leaf program, location of the fall manual, and where to find care plans for each resident; and d. all residents deemed a high fall risk care plan interventions were updated and falling leaf program updated. It documented action taken to prevent recurrence of the alleged deficient practice were the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. on 12/11/24, the facility fall policy and procedure manual will be located at the nurse's station for all staff to review at any time. The master list of all high fall risk residents will be located in the front of the binder. A falling leaf program policy will be implemented. Note cards will be available at the nursing station for all residents sorted by hall for quick reference of each residents care needs including fall risk category. The fall intervention list from the care plan for each resident will be available in the fall manual; b. a master fall risk list and note cards will be updated weekly by the DON to ensure accuracy; c. the DON or administrator will randomly interview three to five staff members once a week to ensure each one is aware of the new policies and where to find all the fall risk information. Staff will be reeducated as needed; d. new hires will be educated on fall program and policies and procedures upon hire; e. when a fall happens in the facility, the charge nurse will do a huddle with nursing staff immediately to look for interventions, update care plan if needed, and notify the PCP and family; f. as new interventions are put into place a huddle will be completed with all staff on duty for education; g. the IDT team will meet weekly on all falls. The care plan will be updated with new interventions; and h. the QAPI team will meet monthly and review all falls, monitor tracking and trending, and address any concerns noted. The IJ was lifted, effective 12/12/24 at 2:37 p.m., when all components of the plan of removal had been verified as completed. The deficient practice remained isolated with the potential for more than minimal harm. Based on record review, and interview, the facility failed to update and implement individualized fall interventions in the care plan after a fall for residents assessed as a high fall risk for two (#13 and #15) of two sampled residents reviewed for individualized fall interventions. The administrator identified 35 residents were high fall risk. Findings: An undated facility Accidents policy, read in part, The intent of this policy is to ensure this facility provides an environment that is free from accidents hazards over which the facility has control and provides supervision and assistive devices are provided for each resident to prevent avoidable accidents. This includes: a. Identifying hazards and risk, b. Evaluating and analyzing hazards and risk, c. Implementing interventions to reduce hazard, and d. Monitoring for effectiveness and modifying interventions when necessary. The policy also read, Individualized, person centered interventions will be implemented, including adequate supervision assistive devices, to reduce risk related to hazards in the environment. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's Falls and Fall Risk, Managing policy, read in part, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. 1. Resident #13 had diagnoses which included anxiety, depression, cataract, and dizziness. Resident #13's Care plan, date initiated 03/02/22 and revised 10/23/24, documented interventions for fall focus, read in part, Fall interventions: purposeful staff rounding, proper seating in chair for W/C, ensure proper foot wear/nonskid socks, exercise program to improve balance, gait, strength, assist, staffing, environment, friendly to reduce clutter, assess medications - side effects and interactions - PCP and pharmacy review, educate resident regarding risk for falls, increased observation, increased activities, restorative care, staff education on falls and interventions, keep items within reach, bed, and low position when occupied with format. Answer, call promptly, re-orientate to call if needed, use of pictures to provide cues and reminders to call for staff assist, evaluate hearing, vision as needed, root cause analysis for falls, assess for illness, open, parentheses delirium, UTI, respiratory, infection, etc in parentheses, educate resident when applying intervention, create something that makes high-risk followers, identifiable, open, parentheses falling, leaf, pictures, etc. In parentheses involve all staff to prevent falls, maintain daily routine, assist WF/toileting before and after each meal, at bedtime as needed. Evaluate B/P for hypotension, rooms/bathrooms with adequate light, call light in reach of resident at all times and remind them to call for staff assist, PT evaluation, evaluate height of bed/toilet seat/chairs, etc. Offer nutritional stacks and meals, offer fluids, everyone- two hours during waking hours promote hydration, proper ambulation, assistive devices (walker, cane W/C space ETC.) and educate on proper use of devices. A Un-Witnessed Fall report, dated 08/01/24, read in part, resident observed laying on her stomach on the floor with no bottoms on. Urine and BM on the floor by the bathroom. Neighbor unsure of how she fell , just that she fell . Resident had abrasions noted to both knees and good range of motion. There was no documentation the care plan was updated with new specific interventions after the fall. Resident #13's Morse Fall Scale, dated 09/19/24, documented high fall risk with a score of 75. A Significant Change assessment, dated 09/23/24, documented Resident 13's cognition was severly impaired. It also documented Resident #13 was independent with walking with walker and going to bathroom independently. A Incident note, dated 11/29/24, read in part, resident reported fall in room- unknown how resident fell . Nurse called to dining room by hospice aid. 2 cuts noted near left eye brow, inner nose swollen and bruised, nurse took resident over to ER- resident refused to stay at ER. Nurse did treatment on eye brow with steri strips and family, PCP notified of her refusal of care in ER. There was no documentation the care plan was updated with new specific interventions after the fall. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Incident note, dated 12/10/24 at 10:41 a.m., read in part, Resident noted yelling out from room. [They]were sitting on floor at foot of bed next to side table. Left foot was rotated outward and [they] did not have ROM in this hip without having pain. [They] also had blood noted running down [their] cheek. Resident stated 'I fell , help me up and leave me alone' Cleaned face up to assess head wound, laceration appears to be superficial. Assisted [them] up into wheelchair without applying weight to left hip. Notified PCP and brought [them] to ER. Also notified DON, ADM, and [family member]. admitted to hospital. There was no documentation the care plan was updated with new specific interventions after the fall. An initial State Reportable Incident, dated 12/10/24, documented Resident #13 was found sitting on their floor in room. It documented Resident #13's left foot was rotated outward and did not have range of motion in the left hip without having pain. It documented Resident #13 arrived at theER on [DATE] at 11:57 a.m. Resident #13's ER report, dated 12/10/24, documented they were treated and then transferred to another hospital for a closed displaced intertrochanteric fracture of the left femur and laceration of scalp. There was no documentation the care plan was updated with new specific interventions after the fall on 08/01/24- no injury, the fall on 11/29/24- laceration above left eye and inner nose, and the fall on 12/10/24- injury obtained. On 12/10/24 at 2:56 p.m., the DON was asked the reason Resident #13 was transferred to bigger hospital. The DON stated for a fractured left hip. On 12/12/24 at 11:02 a.m., MDS coordinator #1 was asked the policy for updating and revising interventions on the care plan. They stated they were updated as needed. MDS Coordinator #1 was asked to review Resident #13's care plan for falls and was then asked if new fall interventions were added, updated or revised after the fall on 08/01/24. They stated no new interventions were put into place. They were then asked about the fall on 11/29/24. They were asked if there were new fall interventions put into place, updated or revised. MDS Coordinator #1 stated, No. MDS Coordinator #1 was then asked if all fall interventions were from a generic list or were they individualized for the specific resident. They stated if staff started a new intervention then they updated or revised the care plan as needed. 46702 2. Resident #15 was admitted on [DATE] with diagnoses which included unspecified dementia without behaviors and anxiety. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #15's Care plan, date initiated 12/20/22 and revised on 10/23/24, documented interventions for fall focus, read in part, Fall interventions: purposeful staff rounding, proper seating in chair for W/C, ensure proper foot wear/nonskid socks, exercise program to improve balance, gait, strength, assist, staffing, environment, friendly to reduce clutter, assess medications - side effects and interactions - PCP and pharmacy review, educate resident regarding risk for falls, increased observation, increased activities, restorative care, staff education on falls and interventions, keep items within reach, bed, and low position when occupied with format. Answer, call promptly, re-orientate to call if needed, use of pictures to provide cues and reminders to call for staff assist, evaluate hearing, vision as needed, root cause analysis for falls, assess for illness, open, parentheses delirium, UTI, respiratory, infection, etc in parentheses, educate resident when applying intervention, create something that makes high-risk followers, identifiable, open, parentheses falling, leaf, pictures, etc. In parentheses involve all staff to prevent falls, maintain daily routine, assist WF/toileting before and after each meal, at bedtime as needed. Evaluate B/P for hypotension, rooms/bathrooms with adequate light, call light in reach of resident at all times and remind them to call for staff assist, PT evaluation, evaluate height of bed/toilet seat/chairs, etc. Offer nutritional stacks and meals, offer fluids, everyone- two hours during waking hours promote hydration, proper ambulation, assistive devices (walker, cane W/C space ETC.) and educate on proper use of devices. Resident #15's Morse Fall Scale assessment, dated 01/11/24, documented Resident #15 was at high risk for falling. The facility's Un-Witnessed Fall report, dated 02/08/24, read in part, Neighbor observed sitting on the floor at the foot of [their] bed. Wheelchair was flipped over as well. Neighbor stated [they] were getting up to go to the bathroom and grabbed at the wheelchair when [they] started to fall and it flipped over. Assessed for injuries, reports not hurt and did not hit [their] head. Has good ROM noted. Assisted to standing position and returned to bed. Resident #15's Morse Fall Scale assessment, dated 04/09/24, documented Resident #15 was at high risk for falling. The facility's Witnessed Fall report, dated 04/27/24, read in part, CNA informed nurse of neighbor laying on [their] floor. Neighbor observed to be laying on floor on [their] left side with top of head towards the restroom door,eyes facing towards hall.Neighbor bent at waist with feet and legs pointed towards the hall.ROM performed, neighbor c/o pain to BLE and to back rated at an 8. Asked [them] if [they] hit [their] head and suite mate stated that neighbor did hit [their] head.No skin impairments, hematoma, or injury noted to head. Eyes PERRLA.VS:165/93p-76, T-98.2, O2-92%RA, R-20.Neighbor assisted up slowly via x3 staff to sitting position and then slowly up to WC via x3 staff.Quartersized skin tear noted to left elbow.Call light was observed to be in reach but not on. Alarm to bed was noted to have light on but was not sounding. Neighbor began to vomit into emesis bag.Neighbor then taken to [name withheld] ER. Resident Description: When asked what happened neighbor stated that [they] was going to the restroom. When asked how come [they] didn't use the call light [they] stated 'I did. A Incident Report Form dated 04/27/24, read in part, resident observed lying on the bathroom floor by CNA. Resident stated [they] had gotten up to use the bathroom and fell . It also read, Resident was transferred to [name withheld]. (continued on next page)

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	375559	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #15's hospital operative report , dated 04/29/24, read in part, L1 vertebral compression fracture. Resident #15's Care Plan fall focus, revised 08/05/24, read in part, [Resident #15] is a (high) risk for falls r/t weakness/gait/balance problems and impaired mobility. The care plan did not document interventions after the falls on 02/08/24 and 04/27/24. Resident #15's quarterly assessment, dated 11/04/24, documented their cognition was moderately impaired and they were dependent on staff for ADLs. On 12/11/24 at 11:43 a.m., MDS coordinator #1 was asked what was the facility fall protocol. They stated after a resident was assessed, they completed a report, and huddled with staff for documentation for additional ideas and interventions in the care plan. They were asked what interventions were added after the two falls on 02/08/24 and 04/27/24 to prevent future accidents and hazards. MDS Coordinator #1 stated there were no interventions added to the care plan after the two falls. They were asked about the fall interventions initiated on 12/20/22 and revised 10/23/24. They stated they had a list of interventions for falls and added them to all residents who fall. MDS Coordinator #1 stated those interventions were not specific to the resident, but all residents that fall. They stated that was part of their facility fall protocol. On 12/11/24 at 12:30 p.m., the administrator was asked to review the care plan for Resident #15. The administrator stated that there was no new interventions added after the falls on 02/08/24 and 04/27/24 and the care plan was not individualized and specific to the resident.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702 Based on observation, record review, and interview, the facility failed to ensure the facility policy to change O2 tubing was followed for one (#5) of one sampled resident reviewed for O2 tubing. The DON identified 12 residents had physician orders for O2 therapy. Findings: The facility's Departmental (Respiratory Therapy)-Prevention of Infection policy, revised 11/2011, read in part, The purpose of this procedure is to guide prevention of infection associated with respiratory therapy task and equipment, including ventilators, among residents and staff. The policy also read, Change the oxygen cannula and tubing every (7) days, or as needed. Resident #5 was admitted on [DATE] with diagnoses which included Bartter's syndrome, chronic obstructive pulmonary disease, and anxiety disorder. Resident #5's physician orders, dated 06/19/24, documented O2 at 2 liters via nc and as needed for SOB and HS. On 12/09/24 at 1:35 p.m., Resident #5's O2 tubing was observed labeled in pen on white tape and dated 11/01/24. On 12/12/24 at 2:53 p.m., LPN #2 was asked how often O2 tubing was changed per policy. They stated it should be changed once a month and labeled. They were asked to look at resident #5's O2 tubing and what date was on the O2 tubing. They stated it was dated 11/01/24 and it should of been changed the first of December. On 12/12/24 at 2:57 p.m., the DON what asked what was the facility's policy for changing residents O2 tubing. The DON stated O2 tubing should be changed bimonthly on the first and the 15th by the night nurse. The DON stated there was a form to be completed and it was not documented the O2 tubing was changed. On 12/12/24 at 3:15 p.m., the administrator was asked what the policy was for changing O2 tubing. The administrator stated the tubing should be changed the first of every month. The stated O2 tubing dated 11/01/24 does not follow the policy.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 47453 Based on record review and interview, the facility failed to ensure RN coverage for eight consecutive hours, seven days per week. The administrator identified 35 residents resided in the facility. Findings: A PBJ Staffing Report, dated 07/01/24 through 09/30/24, did not document any RN hours for 07/06/24, 07/07/24, 07/12/24, and 07/13/24. A Nurses Schedule, dated July 2024, were reviewed and schedule did not document RN coverage for 07/06/24, 07/07/24, 07/13/24, and 07/14/24. On 12/11/24 at 11:03 a.m., the administrator was asked what the facility policy for staffing an RN eight hours a day seven days a week. They stated the facility should have RN coverage eight hours a day, seven days a week. The administrator was then asked to review the nurses schedule for 07/06/24, 07/07/24, 07/13/24, and 07/14/24, then asked if the facility had RN coverage for those four days. They stated No.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 47453 Based on observation, record review, and interview, the facility failed to ensure a medication rate of less than 5%. A total of 25 opportunities were observed during the medication pass with two errors identified. The total medication error rate was 8% related to two medications held without physician orders for parameters to hold medications for one (#11) of three sampled residents observed during medication pass. The administrator identified 35 residents resided in the facility. Findings: A Adverse Consequences and Medication Errors policy, revised April 2024, read in part, a medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders. Resident #11 had diagnoses which include hypertension, edema, and dementia. A Order Summary, dated 12/10/24, documented an order for quinapril [hypertensive medication] 10mg by mouth daily and Lasix (furosemide) (diuretic medication) 10mg daily for edema. There was no documentation in the order directions for holding either medication if the blood pressure reading was below certain parameters. On 12/10/24 at 8:15 a.m., a medication pass was conducted with CMA #1. The CMA stated that the quinapril 10mg and Lasix were being held due to a blood pressure reading of 96/59 for Resident #11. CMA #1 was asked what the parameters were for holding the Quinapril and Lasix. CMA #1 stated they were holding both medications due to a B/P reading of 96/59. CMA #1 was asked the reason Lasix was being held due to B/P being low. CMA #1 had no response. The quinapril and Lasix medications were not given. On 12/10/24 at 9:24 a.m., the DON was asked what medications should be held if not in parameters. The DON stated blood pressure and insulin medications. The DON was then asked what would a Lasix medication be held for. The DON stated they were not sure about holding a diuretic medication.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 47453 Based on observation, record review, and interview, the facility failed to ensure a diuretic and blood pressure medication were administered per physician's orders for one (#11) of three sampled residents observed during medication pass. The administrator identified 35 residents resided in facility. Findings: A Adverse Consequences and Medication Errors policy, revised April 2014, read in part, a medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications. It also read in part, examples of medications errors include: omission- a drug is ordered but not administered. Resident #11 had diagnoses which included hypertension, edema, and dementia. A Order Summary dated 12/10/24, documented order for quinapril (hypertensive medication)10mg by mouth daily and Lasix (furosemide) (diuretic medication) 10mg daily for edema. There was no documentation in the order directions for holding either medication if the blood pressure reading was below certain parameters. On 12/10/24 at 8:25 a.m., CMA #1 was observed holding Resident #11's Lasix 20mg and quinapril 10mg due to a blood pressure of 96/49. CMA #1 was asked why the Lasix was being held. They stated because the blood pressure was low. CMA #1 was then asked if Lasix normally was held for low blood pressure, CMA #1 had no response. CMA #1 was asked what the parameters were for holding the quinapril. They stated it was on the order to hold it. There were no orders found regarding the parameters to hold Lasix or quinapril if blood pressure was too low or to high. On 12/10/24 at 9:24 a.m., the DON was asked what medications should be held if no parameters given by doctor. The DON stated blood pressure and insulin medications. The DON was then asked the reason a diuretic medication would be held. The DON stated they were not sure. The DON was asked to review the Lasix and quinapril orders for Resident #11. The DON was asked if there was an order to hold Lasix for any reason. The DON stated, No. The DON was then asked if there was a parameter written in the order for quinapril. The DON stated, No. The quinapril and Lasix medications were not given. On 12/10/24 at 11:51 a.m., the DON was asked what the facility policy was for medication errors. The DON stated if found, the CMA was to inform the nurse, the nurse informed the DON, and DON informed the doctor. The DON stated then they write up a medication error.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702 Based on observation, records review, and interview, the facility failed to ensure staff washed their hands between residents while assisting dependent residents with feeding for three (#11, 19, and #35) of three sampled residents observed during dining. The DON identified six residents required assistance during meals. Findings: The facility's Handwashing/Hand Hygiene policy, revised 08/2015, read in part, Use an alcohol-based hand rub containing at least 62% alcohol: or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: The policy also read, Before and after assisting a resident with meals. 1. Resident #11 was admitted on [DATE] with diagnoses which included unspecified dementia and delusional disorder. Resident #11's quarterly assessment, dated 09/30/24, documented the resident's cognition was significantly impaired and required supervision or touching assistance with eating. 2. Resident #19 was admitted on [DATE] with diagnoses which included Alzheimer's disease and metabolic encephalopathy. Resident #19's quarterly assessment, dated 10/21/24, documented the resident's cognition was significantly impaired and they were fully dependent on staff for eating assist. 3. Resident #35 was admitted on [DATE] with diagnoses which included legal blindness, adjustment disorder with depression, and anxiety disorder. Resident #35's quarterly assessment, dated 11/04/24 documented the resident's cognition was mildly impaired and they required partial to moderate assistance with eating. On 12/09/24 at 11:20 a.m., the DON was observed feeding Resident #19 on their right side using their right hand with no glove. The DON then stopped and turned to the resident on their left and picked up Resident #11's eating utensil with their right hand and assisted Resident #11 with feeding. No hand washing or sanitizing between residents was observed between feeding Resident #19 and Resident #11. The DON was then observed getting up from their chair and went to Resident #35. The DON used their right hand and touched Resident #35's plate, patted the resident's shoulder, and sat back down and resumed feeding Resident #19. No hand washing or sanitizing between residents was observed. On 12/09/24 11:25 a.m., the infection preventionist stated they witnessed no hand washing or sanitizing between the residents during dining when the DON was assisting separate residents. They stated they were unsure of the policy and would have to review it. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/09/24 at 12:49 p.m., the DON was asked what the infection control issues were during dining on 12/09/24 at 11:20 a.m. The DON stated they got up to move pie on Resident #35's plate, patted Resident #35 on the shoulder, returned their chair to Resident #19 to give a bite, and turned to the right to feed Resident #11 without sanitizer or hand washing between the residents. The DON stated they should of sanitized between each resident.