

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/05/2025
NAME OF PROVIDER OR SUPPLIER Mountain View Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 Murchison Rd El Paso, TX 79902	

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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026</p> <p>Based on observation, interview, and record review the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 9 residents (Residents #1) reviewed for neglect.</p> <p>The facility failed to coordinate care and services with the hospice provider to ensure the written plans of care included both the most recent hospice plan of care and a description of the services furnished by the nursing facility to prevent neglect. The Hospice Aide failed to transfer Resident # 1 on 04/23/25 with a Mechanical lift and two-person assistance that resulted in a fall. The resident sustained a 2 cm laceration to the right side of the forehead and a dense fracture of C1 and C2 (a broken bone in the neck, specifically on second vertebra, breaks at its base).</p> <p>An Immediate Jeopardy (IJ) situation was identified on 05/02/25. While the IJ was removed on 05/05/25, the facility remained out of compliance at a scope of isolated with a potential for more than minimal harm, due to the facility need to evaluate the effectiveness of the corrective systems.</p> <p>This failure could place residents at risk for falls, injury, or death.</p> <p>Findings include:</p> <p>Record review of Resident #1's Admission Record, dated 04/29/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which included: cerebral infraction (a condition where blood flow to the brain is interrupted, causing brain cell to die), altered mental status (there's a change in how your brain is working affecting your ability to think, be aware of your surroundings, and react normally), abnormal gait and mobility (issues with how someone walks or moves, often due to underlying medical conditions or injuries), Alzheimer's disease (is a brain disorder that leads to memory loss and other cognitive decline, eventually impacting a person's ability to perform daily tasks), history of falling, anxiety disorder (mental health conditions characterized by excessive and persistent worry and fear, often leading to physical symptoms and difficulties in daily life), atrial fibrillation (an irregular and often rapid heartbeat that occurs when the electrical signals in the heart's upper chambers (atrial) fire out at the same speed).</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Hospital ED notes dated 04/26/25 at 8:20 a.m., for Resident #1 revealed, Chief Complaint: Pt. presents to the ED s/p fall sustained on Wednesday with head strike per EMS. Patient was being showered by hospice nurse when he fell . Patient is bedbound, left-sided hemiparesis (impairment on the left side of the body). Presented from nursing home apparently had fallen out of bed on Wednesday, did not seek any attention till today. Was brought in today complaining of pain. Patient is non-verbal and does not follow commands. Contracture (a permanent tightening of the muscle, tendons, skin, and nearby tissues that cause the joints shorten and become very stiff) to left upper extremity and contractures of both lower extremities. Physical Exam: 2 cm laceration with steri-strips to forehead. Impression and Plan: Neurosurgeon reported he will not operate and wants to keep the patient at the hospital to treat conservatively. Patient in ICU under trauma services. Medical Decision Making: Patient very cachectic (weakness and wasting of the body) and would not withstand any kind of surgical intervention and place in a hard collar for life. Assessment: C2 dens type II fracture displacement nonoperative.</p> <p>Record review of Resident #1's Hospital Discharge Summary dated 04/28/25, revealed admitted [DATE] and discharge date [DATE]. Resident was admitted to the hospital on 04/26/25 at 11:36 a.m. History of Present Illness: [AGE] year-old male that resident at nursing home. On 04/23/25 he sustained a fall while being showered when he fell forward from the shower chair causing a laceration to the right side of his forehead requiring steri- strips. CT cervical spine revealed an acute unstable type II dens fracture of C1 on C2. Discharge Diagnosis 04/28/25: Type II dens fracture of second cervical vertebra, atrial fibrillation, advanced dementia.</p> <p>Record review of Resident #1's History & Physical dated 01/14/25 for Resident #1 revealed, Patient readmitted under hospice care after a massive cerebrovascular accident. Hemiplegia to left side, dementia, comfort care under Hospice, repeated falls. Neurological: Non-ambulatory, terminally demented, unable to follow commands. Unable to stand or walk.</p> <p>Record review of Physician's Progress Noted dated 04/24/25 written by attending physician revealed, resident seen today due to charge nurse reporting a fall. Recent fall from shower chair and sustained a laceration to the right side of forehead requiring steri-strips. Skull x-ray was obtained which was negative for fracture. Continue comfort care and pain management.</p> <p>Record review of Resident #1's Quarterly MDS, dated [DATE], revealed BIMS was not conducted due to Resident #1's inability to answer questions. Short-term and Long-term Memory Problems. Section C1000. Cognitive Skills for Daily Decision Making - Severely Impaired. Section GG - Functional Abilities revealed Resident #1 required substantial/maximal assistance with toileting hygiene, shower/bathing, sit to stand and chair/bed transfer; partial/moderate assistance with upper body dressing and personal hygiene. Wheelchair for mobility. Functional Limitation in Range of Motion - Impairment on one side to upper extremity; incontinent of bowel & bladder. Active diagnoses - Alzheimer's disease, stroke, cerebral infarction, altered mental status, unsteadiness on feet, abnormal gait, and mobility.</p> <p>Record review of Resident #1's Care Plan, dated 03/17/2025, revealed Resident #1 had an ADL self-care performance deficit. Part of the interventions reads in part, Transfer: The resident requires total assistance with transfer. Mechanical lift for all transfers with 2 staff for assistance. Contractures to all extremities. Risk for falls. Mechanical lift for all transfers with 2 staff for assistance. Resident has a terminal prognosis and is receiving hospice services. Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs are met. Hospice staff (nurse, CNA, SW, Chaplin) to assist with resident care.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Nursing Progress Notes dated 04/26/25 at 7:36 a.m., revealed Resident #1 was picked up by transport ambulance and taken to hospital. Family member at bedside.</p> <p>Record review of Nursing Progress Notes dated 04/26/25 at 9:45 p.m., for Resident #1 revealed, placed a telephone call to follow up on resident and was informed by hospital RN, the resident had been admitted for cervical fx and would be discharged back to nursing home pending discharge orders from physician.</p> <p>Record review of Nursing Progress Notes dated 04/28/25 at 9:19 p.m., for Resident #1 revealed, Admission Note: Arrived by EMS via stretcher. Current diagnoses/conditions: Dementia/Alzheimer's, Cervical Fx. Lethargic, unclear speech, sometimes understood, sometimes understands. Wheelchair. No balance issues. Assistance required for the following ADLs: Bed Mobility: 2 persons assist. Transferring: Mechanical lift. Toileting assistance. Briefs/pads one person assist. Hygiene/bathing: one person assist.</p> <p>Record review of Hospice Physician Telephone Order dated 04/28/25 for Resident #1 revealed, admit to Hospice. DX: Cerebral infarction, unspecified.</p> <p>Record review of Bedside Kardex dated 04/28/25 for Resident #1 revealed, Transferring: The resident required total assistance with transfers. Mechanical lift for all transfers with 2 staff for assistance. Mobility: Bed Mobility requires extensive assist x 2 staff to reposition and turn in bed.</p> <p>Review of Witness Statement dated 05/05/25, written by LVN A revealed, he was sitting at the nurses' station working on documentation, when suddenly hospice CNA C, was standing by the entrance to the room, waving and calling him. He went to Resident #1's room and found the resident on the floor. The shower chair was positioned directly in front of the middle to the bed facing the wall and the resident was next to the chair, with his face on the floor. The CNA C said she could not hold him, and he fell. She did not call for assistance. They were not aware that she was at the facility providing care to the resident. She had been instructed prior to the incident to ask for help with all transfers.</p> <p>Review of Hospice Care Services Agreement dated 09/05/2024, revealed Plans of Care means a written care plan established, maintained, reviewed, and modified, as necessary, at regular intervals, by the IDG. The Plan of Care should reflect the participation of the Hospice, Facility, to the extent possible, which includes identification of the Hospice Services, including interventions and identification of the services to be provided by Facility; and coordinating the Plan of Care to meet the needs of the Hospice patient; and the IDG's documentation of Hospice representative's level of understanding, involvement, and agreement with the Plan of Care.</p> <p>During a telephone interview on 04/30/25 at 8:45 a.m., with Resident #1's family member, revealed LVN A had called on 04/23/25 to report that resident had sustained a fall in the shower. The family member reported that two days after the incident, family member had requested to have resident transferred to the hospital to get an MRI, to see what was wrong with him since he was declining and was no longer was eating, and no longer was able to talk because he was just sleeping.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/30/25 at 10:16 a.m., with LVN A, revealed, Hospice CNA C had not asked the facility staff for assistance on 04/23/25 to transfer Resident #1 from the bed to the shower chair to bathe the resident or after the shower was completed. He said CNA C had transferred the resident from the shower chair to the bed without assistance and had not used the Mechanical lift. He said the resident required a two-person assistance and a Mechanical lift for all transfers. He said that the nurses and the CNAs were always available to help the Hospice CNAs with transfers and use of the Mechanical Lifts as needed. He said that on the day of the incident the Hospice CNA C was standing by the entrance to the resident's room and had called him to the room. He said, When I got to the resident's room, CNA C said that she needed assistance because Resident #1 had fallen off the bed when she had turned to get a diaper. Upon entering the resident's room, the resident was lying on the floor on his left side and his face was planted on the floor and blood was coming out of resident's right side of his head. He said he had assisted CNA C to pick up the resident from the floor and put the resident in bed. He said the attending physician was notified and gave an order for an x-ray of the skull. He said the skull x-ray results were negative for fractures.</p> <p>During a telephone interview on 04/30/25 at 11:15 a.m., with RN B Hospice Director of Clinical Services, revealed the Hospice CNAs had been trained to always ask for help if they could not transfer the patient alone. She said that CNA C had reported to them, that LVN A had helped her on 04/23/25 to do a two-person transfer to sit the resident on the shower chair to bathe him without using the Mechanical lift. She said CNA C, did report that once the resident was bathe, she had not asked LVN A again for assistance to put the resident back in bed and had transferred the resident without assistance. CNA C reported that when she had laid down the resident in the bed, she had turned her back to get a diaper and that is when the resident had rolled off from the bed and fell on the floor. CNA C said that she had asked LVN A for assistance to put the resident in bed, after resident had fallen to the floor. CNA C, reported that sometimes she did not use the Mechanical lift and would ask the CNAs for assistance do a two-person transfer to move the resident from the bed to the shower chair to give him a shower. RN B said, Either way Resident #1 required a two-patient transfer. She said CNA C had not explained to them why she had not asked her help to transfer the resident to the bed on that day.</p> <p>During a telephone interview on 04/30/25 at 1:24 p.m., with Nurse Practitioner D, revealed that she was notified on 04/23/25 that Resident #1 had sustained a fall on 04/23/25 and had come to the facility the next day, to assess the resident. She said that she was not aware that the resident had been transferred without a Mechanical Lift and a two-person transfer. She said that she could not recall the resident's diagnosis but did remember that the resident was [AGE] year-old male and was very fragile. She stated that the cervical fractures could have been related to the fall.</p> <p>During an interview on 04/30/25 at 3:12 p.m., with the DON revealed, I believed that we found out on Sunday 04/27/25, from the hospital paperwork that Resident #1 had a cervical fracture. He had a diagnosis of osteoporosis, so his injuries could have resulted from the fall on 04/23/25.</p> <p>During an interview on 04/30/25 at 4:00 p.m., with the Administrator revealed that he did not know that Resident #1 had sustained a cervical fracture until 04/28/25, when they had received the hospital paperwork upon resident's readmission to the nursing facility.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 04/30/25 at 4:25 p.m., with Hospice CNA C revealed, that she had asked LVN A on 04/23/25 to assist her to transfer Resident #1 from the bed to the shower chair without using a Mechanical lift. She said that after the shower was completed LVN A had assisted her to transfer the resident from the shower chair to the bed without using the Mechanical lift. She said, the resident was lying in bed, and I turned to grab a diaper from a drawer that was approximately 6 feet from the bed and that is when resident fell off the bed. She said that she had called LVN A to help her put the resident on the bed. She said that she had reported the accident to the hospice nurse. She said, I didn't mean it, it just happened so fast. She said that she was aware that Resident #1 needed a Mechanical lift and required a two-person transfer. She said, It was my fault for not using the Mechanical lift. On that day, I could not find the sling to use the Mechanical lift. When I informed LVN A that I could not find the sling to use the Mechanical lift, he said that it was okay, and he would help me to transfer Resident #1. Sometimes I do transfer him without assistance because I cannot find anyone to help me with the two-person transfer. She said that she had been re-trained on 04/28/25 by the hospice staff on how to use of the Mechanical lift and with a two-person transfer.</p> <p>Observation on 04/30/25 at 4:50 p.m., revealed Resident #1's bed was approximately 7 feet from the drawer where the disposable briefs were stored. The resident had a high/low bed and floor mat by the side of the bed.</p> <p>During an interview on 04/30/25 at 5:20 p.m., with CNA G revealed, the facility had provided an in-service training on 04/28/25 on how to use the Mechanical lifts with a two-person transfer.</p> <p>During a second telephone interview on 04/30/25 at 5:29 PM, with LVN A revealed that he had only assisted the hospice CNA C, to lift Resident #1 from the floor after he fell , to put him in bed. LVN A denied assisting CNA C to transfer resident on 04/23/25. He said that when he entered the resident's room, to put the resident in bed, he had not seen the Mechanical lift in the room. He said staff had been trained to always use a Mechanical lift with two-person assistance to transfer Resident #1.</p> <p>During an interview on 04/30/25 at 5:30 p.m., with ADON revealed, that she had done an in-service training on 04/29/25 for all facility nursing staff and Hospice staff on the use of a Mechanical lift with a two-person transfer.</p> <p>During an interview on 05/01/25 at 11:24 a.m., with the Administrator revealed the facility did not have a Fall Prevention policy & procedure.</p> <p>During a second telephone interview on 05/01/25 at 12:07 p.m., with RN B Hospice Director of Clinical Services, revealed, that CNA C had reported to hospice staff in the past, that the facility did not always have the Mechanical sling available, so the facility staff would assist her to do a two-person transfer to move Resident #1 from the bed to the shower chair. She said that CNA C, had reported that on the day of the incident on 04/23/25, it was close to lunch time, and no one had come to help her to transfer Resident #1 from the shower chair to the bed, so she had transferred Resident #1 on her own without using the Mechanical lift. CNA C also reported that the bed was on the lowest position when the resident had rolled off the bed. She said that after the incident involving Resident #1, the hospice staff had been retrained including CNA C on the use of the mechanical lift with two-person assistance and had also completed a competence skills checklist on CNA C. She said that the hospice staff did not attend the facility's care plan meetings because they were never invited.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy on Resident Rights dated 11/28/26 revealed, The right to exercise his or her rights as a resident of the Facility and as a citizen or resident of the United States. Patient has a right to a safe, clean, comfortable, and home like environment including but not limited to receiving treatment and supports for daily living safely. The right to reside and receive services in the facility with reasonable accommodations and resident needs and preferences, except. When to do so would endanger the health or safety of the resident or other residents.</p> <p>This was determined to be an Immediate Jeopardy (IJ) on 05/02/2025 at 3:55 p.m. The Administrator was notified. The Administrator was provided with the IJ template on 05/02/2025 at 3:55 p.m.</p> <p>The following Plan of Removal submitted by the facility was accepted on 5/03/2025 at 8:29 p.m.:</p> <p>Interventions:</p> <ul style="list-style-type: none"> -The alleged perpetrator will not be returning to the facility. Completed on 4/23/2025. -Out of cycle QAPI including this plan was presented to the Medical Director by the facility administrator. The medical director did not request changes to the plan. Completed 5/2/2025. -The Nursing staff/ current hospice agencies CNAs were in-serviced by facility DON/ADON and Regional Compliance Nurse on how to find the level of assistance required in the for transfer and mechanical devices required in the kiosk. Completed on 5/2/2025. -Mechanical lifts were tagged with bright colored sign stating, two people required to operate the lift. This was done by the Maintenance Director. This will give a second opportunity for staff to be reminded prior to using the equipment. Completed on 5/1/2025. -Facility Charge Nurses were in-serviced by the facility DON on how to read the facility Kardex. Completed on 5/2/2025. -Current hospice agencies CNAs/facility nursing staff providing services to residents at the facility were in-serviced by the facility DON on how to review the residents Kardex located in the kiosk with the Charge Nurse prior to providing direct care to the residents to ensure that the staff is aware of the number of people required for transfers and use of any mechanical lifts. This will be randomly monitored by DON/ADON/Admin. To prevent the recurrence of falls and injuries. Completed on 5/2/2025. -The facility Social Worker will be sending reminder emails to contracted hospice agencies to attend the required mandatory care plan meetings at the facility as scheduled. To ensure the coordination of services. This will be randomly monitored by Admin/DON/ADON. Completed on 5/2/2025. -100% of residents' records were reviewed to ensure that the information reflected in the Kardex/Care plans for any residents requiring assistance with transfer to include any assistive devices. This was done by DON/ADON and the Regional Compliance Team. This was completed on 5/2/2025. <p>In-services:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Facility staff and current hospice agencies were in-serviced by the DON/ADON and compliance nurse on Abuse and neglect No facility staff member or contract hospice agency staff will be allowed to provide care until receiving the in-service mentioned above. Completed on 5/3/2025.</p> <p>-05/03/25 Subject: Hospice sign-in and Kardex review process; Summary: Hospice CNAs must sign in upon arrival and review the Kardex with the charge nurse to ensure the plan of care and level of assistance are understood before providing care. Education is posted at the nurse's station.</p> <p>-Inservice dated 5/3/2025 revealed, Subject: All hospice staff must report to charge nurse and review Kardex; Summary: All hospice staff must report to the charge nurse upon arrival and review the Kardex before providing care. They must sign off that they have reviewed and understood the Kardex.</p> <p>-Inservice dated 5/3/2025 revealed, Subject: Hospice staff - Abuse, Neglect and Exploitation; Summary: In-service training on identifying and reporting abuse, neglect, and exploitation for hospice staff.</p> <p>-Inservice dated 5/4/2025 revealed, Subject: Abuse, neglect, and exploitation; Summary: Training addressed recognizing signs of abuse, neglect, and exploitation and the importance of timely reporting.</p> <p>Monitoring of the facility's plan of removal included the following:</p> <p>During an interview on 05/04/25 at 11:42 a.m., with CNA H assigned to the second floor revealed, she had been trained on 05/02/25 on how to use the lift with two-person assist. She said, The hospice staff report to the charge nurse who is assigned to the hospice resident, and they will review the hospice binder that is kept at the nurses' station to review the Kardex and the facility's care plan to verify if the resident needs a Mechanical lift with a two-person transfer. The charge nurse will assign a CNA to help the hospice aide with transfers as needed. She said that the charge nurses are also available to assist the CNAs with transfers. She said the Mechanical lifts have a bright orange sign posted on the Mechanical lift to remind staff that all Mechanical lift transfers require a two-person to transfer the resident. The CNAs were also trained to remind the hospice CNAs to sign in at the nurses' station and get report from the charge nurse prior to providing care to the hospice resident. She said that this process was implemented to communicate with the hospice staff on an on-going basis to ensure that hospice residents receive the necessary care and services according to the facility's care plan approaches.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/04/25 at 11:43 a.m., with CNA I assigned to the first floor in hall 500, revealed the facility staff and hospice staff had been trained on 05/02/25, on the new process for the hospice staff to report to the charge nurse to review the Kardex before providing care to the resident to ensure that hospice staff are following the care plan approaches related to the use of mechanical lifts and two-person transfers. She said there is a binder at the nurses' station that contains the Kardex and copy of facility care plan to verify if the resident needs to be transferred with a Mechanical lift and two-person transfer. The charge nurse will assign a CNA to help the hospice aide with transfers as needed. She said that the charge nurses are also available to assist the CNAs with transfers. She said the Mechanical lifts have a bright orange sign posted on the Mechanical lift to remind staff that all Mechanical lift transfers require a two-person to transfer the resident. The CNAs were also trained to remind the hospice CNAs to sign in at the nurses' station and get report from the charge nurse prior to providing care to the hospice resident. She said that this process was implemented to communicate with the hospice staff on an on-going basis to ensure that hospice residents receive the necessary care and services according to the facility's care plan approaches.</p> <p>During a telephone interview on 05/04/25 at 12:56 p.m., with Hospice Liaison J revealed, the facility had provided in-service training on 05/02/25. She said, the whole team assigned to the nursing facility attended the training. We were informed by the nursing facility staff, that without this training the hospice staff would not be able to enter the facility to perform any clinical duties with their contracted residents. The Hospice Liaison was not able to provide any other specifics regarding the training and advised the state surveyor to contact the hospice Director of Clinical Services RN B who could tell her who had attended the training.</p> <p>During a telephone interview on 05/04/25 at 12:58 p.m., with Hospice Care Consultant/Director of Admissions K revealed, hospice staff had attended an in-service training at the nursing facility on proper use of a Mechanical lift. It was explained that when hospice staff arrives to the facility they are to report and be cleared by the charge nurse before any care is provided to the resident and sign the form in acknowledgment that care plans and Kardex have been reviewed. She said that the hospice staff were scheduled to attend and IDT care plan meeting at the nursing [TRUNCATED]</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026</p> <p>Based on observation, interview and record review the facility failed to implement written policies and procedures that prohibit and prevent neglect of residents, and failed to establish policies and procedures to investigate such allegation for 1 of 9 residents (Residents #1) reviewed for neglect.</p> <p>The facility failed to ensure the Administrator followed the facility's abuse/neglect policy, by not completing an investigation and reporting an allegation of neglect involving Resident #1. The Hospice Aide failed to transfer Resident # 1 on 04/23/25 with a Mechanical lift and two-person assistance that resulted in a fall. The resident sustained a 2 cm laceration to the right side of the forehead and a dense fracture of C1 and C2 (a broken bone in the neck, specifically on second vertebra, breaks at its base).</p> <p>These failures could place residents at risk of not being provided services to meet their needs.</p> <p>Findings include:</p> <p>Record review of Resident #1's Admission Record, dated 04/29/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which included: cerebral infraction (a condition where blood flow to the brain is interrupted, causing brain cell to die), altered mental status (there's a change in how your brain is working affecting your ability to think, be aware of your surroundings, and react normally), abnormal gait and mobility (issues with how someone walks or moves, often due to underlying medical conditions or injuries), Alzheimer's disease (is a brain disorder that leads to memory loss and other cognitive decline, eventually impacting a person's ability to perform daily tasks), history of falling, anxiety disorder (mental health conditions characterized by excessive and persistent worry and fear, often leading to physical symptoms and difficulties in daily life), atrial fibrillation (an irregular and often rapid heartbeat that occurs when the electrical signals in the heart's upper chambers (atrial) fire out at the same speed).</p> <p>Review of Hospital ED notes dated 04/26/25 at 8:20 a.m., for Resident #1 revealed, Chief Complaint: Pt. presents to the ED s/p fall sustained on Wednesday with head strike per EMS. Patient was being showered by hospice nurse when he fell . Patient is bedbound, left-sided hemiparesis (impairment on the left side of the body). Presented from nursing home apparently had fallen out of bed on Wednesday, did not seek any attention till today. Was brought in today complaining of pain. Patient is non-verbal and does not follow commands. Contracture (a permanent tightening of the muscle, tendons, skin, and nearby tissues that cause the joints shorten and become very stiff) to left upper extremity and contractures of both lower extremities. Physical Exam: 2 cm laceration with steri-strips to forehead. Impression and Plan: Neurosurgeon reported he will not operate and wants to keep the patient at the hospital to treat conservatively. Patient in ICU under trauma services. Medical Decision Making: Patient very cachectic (weakness and wasting of the body) and would not withstand any kind of surgical intervention and place in a hard collar for life. Assessment: C2 dens type II fracture displacement nonoperative.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's Hospital Discharge Summary dated 04/28/25, revealed admitted [DATE] and discharge date [DATE]. Resident was admitted to the hospital on 04/26/25 at 11:36 a.m. History of Present Illness: [AGE] year-old male that resident at nursing home. On 04/23/25 he sustained a fall while being showered when he fell forward from the shower chair causing a laceration to the right side of his forehead requiring steri- strips. CT cervical spine revealed an acute unstable type II dens fracture of C1 on C2. Discharge Diagnosis 04/28/25: Type II dens fracture of second cervical vertebra, atrial fibrillation, advanced dementia.</p> <p>Record review of Resident #1's History & Physical dated 01/14/25 for Resident #1 revealed, Patient readmitted under hospice care after a massive cerebrovascular accident. Hemiplegia to left side, dementia, comfort care under Hospice, repeated falls. Neurological: Non-ambulatory, terminally demented, unable to follow commands. Unable to stand or walk.</p> <p>Record review of Physician's Progress Noted dated 04/24/25 written by attending physician revealed, resident seen today due to charge nurse reporting a fall. Recent fall from shower chair and sustained a laceration to the right side of forehead requiring steri-strips. Skull x-ray was obtained which was negative for fracture. Continue comfort care and pain management.</p> <p>Record review of Resident #1's Quarterly MDS, dated [DATE], revealed BIMS was not conducted due to Resident #1's inability to answer questions. Short-term and Long-term Memory Problems. Section C1000. Cognitive Skills for Daily Decision Making - Severely Impaired. Section GG - Functional Abilities revealed Resident #1 required substantial/maximal assistance with toileting hygiene, shower/bathing, sit to stand and chair/bed transfer; partial/moderate assistance with upper body dressing and personal hygiene. Wheelchair for mobility. Functional Limitation in Range of Motion - Impairment on one side to upper extremity; incontinent of bowel & bladder. Active diagnoses - Alzheimer's disease, stroke, cerebral infarction, altered mental status, unsteadiness on feet, abnormal gait, and mobility.</p> <p>Record review of Resident #1's Care Plan, dated 03/17/2025, revealed Resident #1 had an ADL self-care performance deficit. Part of the interventions reads in part, Transfer: The resident requires total assistance with transfer. Mechanical lift for all transfers with 2 staff for assistance. Contractures to all extremities. Risk for falls. Mechanical lift for all transfers with 2 staff for assistance. Resident has a terminal prognosis and is receiving hospice services. Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs are met. Hospice staff (nurse, CNA, SW, Chaplin) to assist with resident care.</p> <p>Record review of Hospice Plan of Care Effective 4/02/25 for Resident #1 revealed, Last Updated: 04/01/25. Problem: Patient at risk for experiencing inability to perform care related to cognitive deficits, functional limitations, weakness, debility, deconditioning, altered mental status, environmental/logistical limitations, lack of supervision. Problem: Patient at risk for/experiencing falls with injury related to deconditioning, altered mental status cognitive decline, neurological deficit, altered gait or balance, medication effects/side effects, functional alterations, other. Goal: Patient will have no fall with injury. Interventions: RN and/or SN will assess fall risk on admission, at recertification, change in level or location of care. SN will identify appropriate DME and collaborate with MD to order as indicated and will train/model how to safely use assistive devices during visits. The Hospice Care Plan did not document resident #1 needed a Mechanical lift and two-person assistance with transfers.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Physician's Order dated 02/16/2025 for Resident #1 revealed, Resident a Mechanical Lift with 2-person transfer.</p> <p>Review of Physician Order Summary undated for Resident #1 revealed, Hospice Mechanical Lift for all transfers.</p> <p>Review of Hospice Admission Orders revealed Resident #1 was admitted to Hospice on 01/14/25, and did not document resident needed a Mechanical Lift with two-person assist for transfers.</p> <p>Review of the Nursing Progress Note dated 04/23/25 at 12:28 p.m., written by LVN A revealed, Resident #1 had a fall in his room. Hospice CNA gave a shower to resident, and during the transfer back to bed the resident fell on the floor and hit his head. Fall information: Hit head, bending over. The fall caused a laceration to right side of the head 3 cm with bleeding. Physician and responsible party were notified. Ordered skull x-rays.</p> <p>Review of the facility's Event Report dated 04/23/25 at 11:00 a.m., revealed, Incident Location: Resident #1's Room. Incident Description: Hospice CNA gave a shower to resident, and during transfer back to bed, the CNA could not hold the resident strongly and fell to the floor. Resident has a laceration on right side of the forehead. Immediate Action Taken: Ordered skull x-rays. Pending results. Interventions in place prior to fall: Floor mat, Low bed.</p> <p>Record review of Resident #1's Event Nurses' Note - Fall dated 04/23/25, revealed, Unwitnessed fall in resident's room. Bending over. Laceration to right side of forehead measuring 3 cm. Nursing description of the event: Hospice CNA gave a shower to resident, and during transfer back to bed the resident fell to the floor.</p> <p>Record review of Hospice Note dated 04/23/25 at 1:50 p.m., written by Hospice Case Manager RN F revealed, Received a call from LVN A from nursing facility, patient sustained a fall while getting showered. Resident sustained a laceration on right side of head.</p> <p>Record review of Resident #1's x-ray report dated 04/23/25 revealed, exam of skull. Unremarkable skull series without obvious evidence of fracture.</p> <p>Record review of Nursing Progress Notes dated 04/26/25 at 7:30 a.m., for Resident #1 revealed Head CT scan pending.</p> <p>Record review of Nursing Progress Notes dated 04/26/25 at 7:36 a.m., revealed Resident #1 was picked up by transport ambulance and taken to hospital. Family member at bedside.</p> <p>Record review of Nursing Progress Notes dated 04/26/25 at 9:45 p.m., for Resident #1 revealed, placed a telephone call to follow up on resident and was informed by hospital RN, the resident had been admitted for cervical fx and would be discharged back to nursing home pending discharge orders from physician.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Nursing Progress Notes dated 04/28/25 at 9:19 p.m., for Resident #1 revealed, Admission Note: Arrived by EMS via stretcher. Current diagnoses/conditions: Dementia/Alzheimer's, Cervical Fx. Lethargic, unclear speech, sometimes understood, sometimes understands. Wheelchair. No balance issues. Assistance required for the following ADLs: Bed Mobility: 2 persons assist. Transferring: Mechanical lift. Toileting assistance. Briefs/pads one person assist. Hygiene/bathing: one person assist.</p> <p>Record review of Hospice Physician Telephone Order dated 04/28/25 for Resident #1 revealed, admit to Hospice. DX: Cerebral infarction, unspecified.</p> <p>Record review of Bedside Kardex dated 04/28/25 for Resident #1 revealed, Transferring: The resident required total assistance with transfers. Mechanical lift for all transfers with 2 staff for assistance. Mobility: Bed Mobility requires extensive assist x 2 staff to reposition and turn in bed.</p> <p>Review of Witness Statement dated 05/05/25, written by LVN A revealed, he was sitting at the nurses' station working on documentation, when suddenly hospice CNA C, was standing by the entrance to the room, waving and calling him. He went to Resident #1's room and found the resident on the floor. The shower chair was positioned directly in front of the middle to the bed facing the wall and the resident was next to the chair, with his face on the floor. The CNA C said she could not hold him, and he fell. She did not call for assistance. They were not aware that she was at the facility providing care to the resident. She had been instructed prior to the incident to ask for help with all transfers.</p> <p>Review of Hospice Care Services Agreement dated 09/05/2024, revealed Plans of Care means a written care plan established, maintained, reviewed, and modified, as necessary, at regular intervals, by the IDG. The Plan of Care should reflect the participation of the Hospice, Facility, to the extent possible, which includes identification of the Hospice Services, including interventions and identification of the services to be provided by Facility; and coordinating the Plan of Care to meet the needs of the Hospice patient; and the IDG's documentation of Hospice representative's level of understanding, involvement, and agreement with the Plan of Care.</p> <p>During a telephone interview on 04/30/25 at 8:45 a.m., with Resident #1's family member, revealed LVN A had called on 04/23/25 to report that resident had sustained a fall in the shower. The family member reported that two days after the incident, family member had requested to have resident transferred to the hospital to get an MRI, to see what was wrong with him since he was declining and was no longer was eating, and no longer was able to talk because he was just sleeping.</p> <p>(continued on next page)</p>

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/30/25 at 10:16 a.m., with LVN A, revealed, Hospice CNA C had not asked the facility staff for assistance on 04/23/25 to transfer Resident #1 from the bed to the shower chair to bathe the resident or after the shower was completed. He said CNA C had transferred the resident from the shower chair to the bed without assistance and had not used the Mechanical lift. He said the resident required a two-person assistance and a Mechanical lift for all transfers. He said that the nurses and the CNAs were always available to help the Hospice CNAs with transfers and use of the Mechanical Lifts as needed. He said that on the day of the incident the Hospice CNA C was standing by the entrance to the resident's room and had called him to the room. He said, When I got to the resident's room, CNA C said that she needed assistance because Resident #1 had fallen off the bed when she had turned to get a diaper. Upon entering the resident's room, the resident was lying on the floor on his left side and his face was planted on the floor and blood was coming out of resident's right side of his head. He said he had assisted CNA C to pick up the resident from the floor and put the resident in bed. He said the attending physician was notified and gave an order for an x-ray of the skull. He said the skull x-ray results were negative for fractures.</p> <p>During a telephone interview on 04/30/25 at 11:15 a.m., with RN B Hospice Director of Clinical Services, revealed the Hospice CNAs had been trained to always ask for help if they could not transfer the patient alone. She said that CNA C had reported to them, that LVN A had helped her on 04/23/25 to do a two-person transfer to sit the resident on the shower chair to bathe him without using the Mechanical lift. She said CNA C, did report that once the resident was bathe, she had not asked LVN A again for assistance to put the resident back in bed and had transferred the resident without assistance. CNA C reported that when she had laid down the resident in the bed, she had turned her back to get a diaper and that is when the resident had rolled off from the bed and fell on the floor. CNA C said that she had asked LVN A for assistance to put the resident in bed, after resident had fallen to the floor. CNA C, reported that sometimes she did not use the Mechanical lift and would ask the CNAs for assistance do a two-person transfer to move the resident from the bed to the shower chair to give him a shower. RN B said, Either way Resident #1 required a two-patient transfer. She said CNA C had not explained to them why she had not asked her help to transfer the resident to the bed on that day.</p> <p>During a telephone interview on 04/30/25 at 1:24 p.m., with Nurse Practitioner D, revealed that she was notified on 04/23/25 that Resident #1 had sustained a fall on 04/23/25 and had come to the facility the next day, to assess the resident. She said that she was not aware that the resident had been transferred without a Mechanical Lift and a two-person transfer. She said that she could not recall the resident's diagnosis but did remember that the resident was [AGE] year-old male and was very fragile. She stated that the cervical fractures could have been related to the fall.</p> <p>During an interview on 04/30/25 at 3:12 p.m., with the DON revealed, I believed that we found out on Sunday 04/27/25, from the hospital paperwork that Resident #1 had a cervical fracture. He had a diagnosis of osteoporosis, so his injuries could have resulted from the fall on 04/23/25.</p> <p>During an interview on 04/30/25 at 4:00 p.m., with the Administrator revealed that he did not know that Resident #1 had sustained a cervical fracture until 04/28/25, when they had received the hospital paperwork upon resident's readmission to the nursing facility.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 04/30/25 at 4:25 p.m., with Hospice CNA C revealed, that she had asked LVN A on 04/23/25 to assist her to transfer Resident #1 from the bed to the shower chair without using a Mechanical lift. She said that after the shower was completed LVN A had assisted her to transfer the resident from the shower chair to the bed without using the Mechanical lift. She said, the resident was lying in bed, and I turned to grab a diaper from a drawer that was approximately 6 feet from the bed and that is when resident fell off the bed. She said that she had called LVN A to help her put the resident on the bed. She said that she had reported the accident to the hospice nurse. She said, I didn't mean it, it just happened so fast. She said that she was aware that Resident #1 needed a Mechanical lift and required a two-person transfer. She said, It was my fault for not using the Mechanical lift. On that day, I could not find the sling to use the Mechanical lift. When I informed LVN A that I could not find the sling to use the Mechanical lift, he said that it was okay, and he would help me to transfer Resident #1. Sometimes I do transfer him without assistance because I cannot find anyone to help me with the two-person transfer. She said that she had been re-trained on 04/28/25 by the hospice staff on how to use of the Mechanical lift and with a two-person transfer.</p> <p>During an interview on 05/01/25 at 12:45 p.m., with the Administrator, DON, and ADON revealed, that prior to the incident with Resident #1, the facility and the hospice staff did not share a copy of the care plans to coordinate the care and services provided to the resident. The DON said, the hospice staff would give a verbal report to the facility staff of what care was provided to the resident when they came to see the resident at the facility.</p> <p>During an interview on 05/01/25 at 1:40 p.m., with the DON revealed the hospice providers did not attend the IDT care plan meetings at the facility and did not know if the facility's Social Worker was inviting the hospice providers to attend the IDT care plan meetings, since the Social Worker was responsible for scheduling the IDT care plan meetings.</p> <p>During an interview on 05/01/25 at 1:44 p.m., with the facility's Social Worker V revealed that she was not aware that she needed to invite the hospice providers to the facility's IDT care plan meetings.</p> <p>During an interview on 05/01/25 at 5:05 p.m., with the Administrator revealed, he was not aware that the hospice aide had transferred Resident #1 on 04/23/25 without using a Mechanical lift and a two-person transfer, until the hospice staff came to the facility on [DATE] to apologize for not using the Mechanical lift. He said, I did not know hospice had made a mistake until they came. He said that he knew about the fall but did not start the investigation process to determine what had caused the fall. He said that he did not know who monitored that residents were transferred according to each resident care plan approaches to ensure that residents received the necessary care and services to prevent neglect.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's Policy & Procedure on Abuse/Neglect revised on 09/09/24 revealed, the resident has the right to be free from abuse, neglect, misappropriation of property and exploitation. Residents should not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members and legal guardians, friends, and other individuals. The facility will provide an ensure their promotion and protection of resident rights.</p> <p>Definitions: Neglect: Is the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.</p> <p>Training: The facility will train through orientation and ongoing in-services on issues related to abuse, neglect, prohibition practices regularly. Prevention.: The facility will provide the residents, families, and staff an environment free from abuse and neglect. All reports of abuse or suspicion of abuse/neglect will be investigated as per facility protocol. The facility will be responsible to identify, correct and intervene in situations of possible abuse/neglect. Protection.: The facility will take necessary measures to protect residents and employees from harm during and following an abuse, neglect, exploitation, mistreatment of residents, or misappropriation of a resident's property.</p> <p>Record review of the facility's document titled In-Service Training Attendance Roster, dated 5/03/2025 In-Service Training Topic: Abuse, Neglect, and Exploitation.</p> <p>The state surveyor requested policies and procedures on Administration, and were not provided prior to exit.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026</p> <p>Based on observation, interview and record review the facility failed to have evidence that all alleged violations of abuse, neglect, exploitation, or mistreatment are thoroughly investigated to prevent further potential while the investigation is in progress for 1 of 9 residents (Residents #1) reviewed for neglect.</p> <p>The facility failed to ensure the Administrator followed the facility's abuse/neglect policy, by not completing an investigation and reporting an allegation of neglect involving Resident #1. The Hospice Aide failed to transfer Resident # 1 on 04/23/25 with a Mechanical lift and two-person assistance that resulted in a fall. The resident sustained a 2 cm laceration to the right side of the forehead and a dense fracture of C1 and C2 (a broken bone in the neck, specifically on second vertebra, breaks at its base).</p> <p>These failures could place residents at risk of not being provided services to meet their needs.</p> <p>Findings include:</p> <p>Record review of Resident #1's Admission Record, dated 04/29/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which included: cerebral infraction (a condition where blood flow to the brain is interrupted, causing brain cell to die), altered mental status (there's a change in how your brain is working affecting your ability to think, be aware of your surroundings, and react normally), abnormal gait and mobility (issues with how someone walks or moves, often due to underlying medical conditions or injuries), Alzheimer's disease (is a brain disorder that leads to memory loss and other cognitive decline, eventually impacting a person's ability to perform daily tasks), history of falling, anxiety disorder (mental health conditions characterized by excessive and persistent worry and fear, often leading to physical symptoms and difficulties in daily life), atrial fibrillation (an irregular and often rapid heartbeat that occurs when the electrical signals in the heart's upper chambers (atrial) fire out at the same speed).</p> <p>Review of Hospital ED notes dated 04/26/25 at 8:20 a.m., for Resident #1 revealed, Chief Complaint: Pt. presents to the ED s/p fall sustained on Wednesday with head strike per EMS. Patient was being showered by hospice nurse when he fell . Patient is bedbound, left-sided hemiparesis (impairment on the left side of the body). Presented from nursing home apparently had fallen out of bed on Wednesday, did not seek any attention till today. Was brought in today complaining of pain. Patient is non-verbal and does not follow commands. Contracture (a permanent tightening of the muscle, tendons, skin, and nearby tissues that cause the joints shorten and become very stiff) to left upper extremity and contractures of both lower extremities. Physical Exam: 2 cm laceration with steri-strips to forehead. Impression and Plan: Neurosurgeon reported he will not operate and wants to keep the patient at the hospital to treat conservatively. Patient in ICU under trauma services. Medical Decision Making: Patient very cachectic (weakness and wasting of the body) and would not withstand any kind of surgical intervention and place in a hard collar for life. Assessment: C2 dens type II fracture displacement nonoperative.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's Hospital Discharge Summary dated 04/28/25, revealed admitted [DATE] and discharge date [DATE]. Resident was admitted to the hospital on 04/26/25 at 11:36 a.m. History of Present Illness: [AGE] year-old male that resident at nursing home. On 04/23/25 he sustained a fall while being showered when he fell forward from the shower chair causing a laceration to the right side of his forehead requiring steri- strips. CT cervical spine revealed an acute unstable type II dens fracture of C1 on C2. Discharge Diagnosis 04/28/25: Type II dens fracture of second cervical vertebra, atrial fibrillation, advanced dementia.</p> <p>Record review of Resident #1's History & Physical dated 01/14/25 for Resident #1 revealed, Patient readmitted under hospice care after a massive cerebrovascular accident. Hemiplegia to left side, dementia, comfort care under Hospice, repeated falls. Neurological: Non-ambulatory, terminally demented, unable to follow commands. Unable to stand or walk.</p> <p>Record review of Physician's Progress Noted dated 04/24/25 written by attending physician revealed, resident seen today due to charge nurse reporting a fall. Recent fall from shower chair and sustained a laceration to the right side of forehead requiring steri-strips. Skull x-ray was obtained which was negative for fracture. Continue comfort care and pain management.</p> <p>Record review of Resident #1's Quarterly MDS, dated [DATE], revealed BIMS was not conducted due to Resident #1's inability to answer questions. Short-term and Long-term Memory Problems. Section C1000. Cognitive Skills for Daily Decision Making - Severely Impaired. Section GG - Functional Abilities revealed Resident #1 required substantial/maximal assistance with toileting hygiene, shower/bathing, sit to stand and chair/bed transfer; partial/moderate assistance with upper body dressing and personal hygiene. Wheelchair for mobility. Functional Limitation in Range of Motion - Impairment on one side to upper extremity; incontinent of bowel & bladder. Active diagnoses - Alzheimer's disease, stroke, cerebral infarction, altered mental status, unsteadiness on feet, abnormal gait, and mobility.</p> <p>Record review of Resident #1's Care Plan, dated 03/17/2025, revealed Resident #1 had an ADL self-care performance deficit. Part of the interventions reads in part, Transfer: The resident requires total assistance with transfer. Mechanical lift for all transfers with 2 staff for assistance. Contractures to all extremities. Risk for falls. Mechanical lift for all transfers with 2 staff for assistance. Resident has a terminal prognosis and is receiving hospice services. Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs are met. Hospice staff (nurse, CNA, SW, Chaplin) to assist with resident care.</p> <p>Record review of Hospice Plan of Care Effective 4/02/25 for Resident #1 revealed, Last Updated: 04/01/25. Problem: Patient at risk for experiencing inability to perform care related to cognitive deficits, functional limitations, weakness, debility, deconditioning, altered mental status, environmental/logistical limitations, lack of supervision. Problem: Patient at risk for/experiencing falls with injury related to deconditioning, altered mental status cognitive decline, neurological deficit, altered gait or balance, medication effects/side effects, functional alterations, other. Goal: Patient will have no fall with injury. Interventions: RN and/or SN will assess fall risk on admission, at recertification, change in level or location of care. SN will identify appropriate DME and collaborate with MD to order as indicated and will train/model how to safely use assistive devices during visits. The Hospice Care Plan did not document resident #1 needed a Mechanical lift and two-person assistance with transfers.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Physician's Order dated 02/16/2025 for Resident #1 revealed, Resident a Mechanical Lift with 2-person transfer.</p> <p>Review of Physician Order Summary undated for Resident #1 revealed, Hospice Mechanical Lift for all transfers.</p> <p>Review of Hospice Admission Orders revealed Resident #1 was admitted to Hospice on 01/14/25, and did not document resident needed a Mechanical Lift with two-person assist for transfers.</p> <p>Review of the Nursing Progress Note dated 04/23/25 at 12:28 p.m., written by LVN A revealed, Resident #1 had a fall in his room. Hospice CNA gave a shower to resident, and during the transfer back to bed the resident fell on the floor and hit his head. Fall information: Hit head, bending over. The fall caused a laceration to right side of the head 3 cm with bleeding. Physician and responsible party were notified. Ordered skull x-rays.</p> <p>Review of the facility's Event Report dated 04/23/25 at 11:00 a.m., revealed, Incident Location: Resident #1's Room. Incident Description: Hospice CNA gave a shower to resident, and during transfer back to bed, the CNA could not hold the resident strongly and fell to the floor. Resident has a laceration on right side of the forehead. Immediate Action Taken: Ordered skull x-rays. Pending results. Interventions in place prior to fall: Floor mat, Low bed.</p> <p>Record review of Resident #1's Event Nurses' Note - Fall dated 04/23/25, revealed, Unwitnessed fall in resident's room. Bending over. Laceration to right side of forehead measuring 3 cm. Nursing description of the event: Hospice CNA gave a shower to resident, and during transfer back to bed the resident fell to the floor.</p> <p>Record review of Hospice Note dated 04/23/25 at 1:50 p.m., written by Hospice Case Manager RN F revealed, Received a call from LVN A from nursing facility, patient sustained a fall while getting showered. Resident sustained a laceration on right side of head.</p> <p>Record review of Resident #1's x-ray report dated 04/23/25 revealed, exam of skull. Unremarkable skull series without obvious evidence of fracture.</p> <p>Record review of Nursing Progress Notes dated 04/26/25 at 7:30 a.m., for Resident #1 revealed Head CT scan pending.</p> <p>Record review of Nursing Progress Notes dated 04/26/25 at 7:36 a.m., revealed Resident #1 was picked up by transport ambulance and taken to hospital. Family member at bedside.</p> <p>Record review of Nursing Progress Notes dated 04/26/25 at 9:45 p.m., for Resident #1 revealed, placed a telephone call to follow up on resident and was informed by hospital RN, the resident had been admitted for cervical fx and would be discharged back to nursing home pending discharge orders from physician.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Nursing Progress Notes dated 04/28/25 at 9:19 p.m., for Resident #1 revealed, Admission Note: Arrived by EMS via stretcher. Current diagnoses/conditions: Dementia/Alzheimer's, Cervical Fx. Lethargic, unclear speech, sometimes understood, sometimes understands. Wheelchair. No balance issues. Assistance required for the following ADLs: Bed Mobility: 2 persons assist. Transferring: Mechanical lift. Toileting assistance. Briefs/pads one person assist. Hygiene/bathing: one person assist.</p> <p>Record review of Hospice Physician Telephone Order dated 04/28/25 for Resident #1 revealed, admit to Hospice. DX: Cerebral infarction, unspecified.</p> <p>Record review of Bedside Kardex dated 04/28/25 for Resident #1 revealed, Transferring: The resident required total assistance with transfers. Mechanical lift for all transfers with 2 staff for assistance. Mobility: Bed Mobility requires extensive assist x 2 staff to reposition and turn in bed.</p> <p>Review of Witness Statement dated 05/05/25, written by LVN A revealed, he was sitting at the nurses' station working on documentation, when suddenly hospice CNA C, was standing by the entrance to the room, waving and calling him. He went to Resident #1's room and found the resident on the floor. The shower chair was positioned directly in front of the middle to the bed facing the wall and the resident was next to the chair, with his face on the floor. The CNA C said she could not hold him, and he fell. She did not call for assistance. They were not aware that she was at the facility providing care to the resident. She had been instructed prior to the incident to ask for help with all transfers.</p> <p>Review of Hospice Care Services Agreement dated 09/05/2024, revealed Plans of Care means a written care plan established, maintained, reviewed, and modified, as necessary, at regular intervals, by the IDG. The Plan of Care should reflect the participation of the Hospice, Facility, to the extent possible, which includes identification of the Hospice Services, including interventions and identification of the services to be provided by Facility; and coordinating the Plan of Care to meet the needs of the Hospice patient; and the IDG's documentation of Hospice representative's level of understanding, involvement, and agreement with the Plan of Care.</p> <p>During a telephone interview on 04/30/25 at 8:45 a.m., with Resident #1's family member, revealed LVN A had called on 04/23/25 to report that resident had sustained a fall in the shower. The family member reported that two days after the incident, family member had requested to have resident transferred to the hospital to get an MRI, to see what was wrong with him since he was declining and was no longer was eating, and no longer was able to talk because he was just sleeping.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/30/25 at 10:16 a.m., with LVN A, revealed, Hospice CNA C had not asked the facility staff for assistance on 04/23/25 to transfer Resident #1 from the bed to the shower chair to bathe the resident or after the shower was completed. He said CNA C had transferred the resident from the shower chair to the bed without assistance and had not used the Mechanical lift. He said the resident required a two-person assistance and a Mechanical lift for all transfers. He said that the nurses and the CNAs were always available to help the Hospice CNAs with transfers and use of the Mechanical Lifts as needed. He said that on the day of the incident the Hospice CNA C was standing by the entrance to the resident's room and had called him to the room. He said, When I got to the resident's room, CNA C said that she needed assistance because Resident #1 had fallen off the bed when she had turned to get a diaper. Upon entering the resident's room, the resident was lying on the floor on his left side and his face was planted on the floor and blood was coming out of resident's right side of his head. He said he had assisted CNA C to pick up the resident from the floor and put the resident in bed. He said the attending physician was notified and gave an order for an x-ray of the skull. He said the skull x-ray results were negative for fractures.</p> <p>During a telephone interview on 04/30/25 at 11:15 a.m., with RN B Hospice Director of Clinical Services, revealed the Hospice CNAs had been trained to always ask for help if they could not transfer the patient alone. She said that CNA C had reported to them, that LVN A had helped her on 04/23/25 to do a two-person transfer to sit the resident on the shower chair to bathe him without using the Mechanical lift. She said CNA C, did report that once the resident was bathe, she had not asked LVN A again for assistance to put the resident back in bed and had transferred the resident without assistance. CNA C reported that when she had laid down the resident in the bed, she had turned her back to get a diaper and that is when the resident had rolled off from the bed and fell on the floor. CNA C said that she had asked LVN A for assistance to put the resident in bed, after resident had fallen to the floor. CNA C, reported that sometimes she did not use the Mechanical lift and would ask the CNAs for assistance do a two-person transfer to move the resident from the bed to the shower chair to give him a shower. RN B said, Either way Resident #1 required a two-patient transfer. She said CNA C had not explained to them why she had not asked her help to transfer the resident to the bed on that day.</p> <p>During a telephone interview on 04/30/25 at 1:24 p.m., with Nurse Practitioner D, revealed that she was notified on 04/23/25 that Resident #1 had sustained a fall on 04/23/25 and had come to the facility the next day, to assess the resident. She said that she was not aware that the resident had been transferred without a Mechanical Lift and a two-person transfer. She said that she could not recall the resident's diagnosis but did remember that the resident was [AGE] year-old male and was very fragile. She stated that the cervical fractures could have been related to the fall.</p> <p>During an interview on 04/30/25 at 3:12 p.m., with the DON revealed, I believed that we found out on Sunday 04/27/25, from the hospital paperwork that Resident #1 had a cervical fracture. He had a diagnosis of osteoporosis, so his injuries could have resulted from the fall on 04/23/25.</p> <p>During an interview on 04/30/25 at 4:00 p.m., with the Administrator revealed that he did not know that Resident #1 had sustained a cervical fracture until 04/28/25, when they had received the hospital paperwork upon resident's readmission to the nursing facility.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's Policy & Procedure on Abuse/Neglect revised on 09/09/24 revealed, the resident has the right to be free from abuse, neglect, misappropriation of property and exploitation. Residents should not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members and legal guardians, friends, and other individuals. The facility will provide an ensure their promotion and protection of resident rights.</p> <p>Definitions: Neglect: Is the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.</p> <p>Training: The facility will train through orientation and ongoing in-services on issues related to abuse, neglect, prohibition practices regularly. Prevention.: The facility will provide the residents, families, and staff an environment free from abuse and neglect. All reports of abuse or suspicion of abuse/neglect will be investigated as per facility protocol. The facility will be responsible to identify, correct and intervene in situations of possible abuse/neglect. Protection.: The facility will take necessary measures to protect residents and employees from harm during and following an abuse, neglect, exploitation, mistreatment of residents, or misappropriation of a resident's property.</p> <p>Record review of the facility's document titled In-Service Training Attendance Roster, dated 5/03/2025 In-Service Training Topic: Abuse, Neglect, and Exploitation.</p> <p>The state surveyor requested policies and procedures on Administration, and were not provided prior to exit.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026</p> <p>Based on observation, interview, and record review the facility failed to ensure each resident receives adequate supervision and assistance devices to prevent for 1 of 9 residents (Residents #1) reviewed for accidents.</p> <p>The facility failed to ensure the Hospice Aide failed to transfer Resident # 1 on 04/23/25 with a Mechanical lift and two-person assistance that resulted in a fall. The resident sustained a 2 cm laceration to the right side of the forehead and a dense fracture of C1 and C2 (a broken bone in the neck, specifically on second vertebra, breaks at its base).</p> <p>An Immediate Jeopardy (IJ) situation was identified on 05/02/25. While the IJ was removed on 05/05/25, the facility remained out of compliance at a scope of isolated with a potential for more than minimal harm, due to the facility need to evaluate the effectiveness of the corrective systems.</p> <p>This failure could place residents at risk for falls, injury, or death.</p> <p>Findings include:</p> <p>Record review of Resident #1's Admission Record, dated 04/29/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which included: cerebral infraction (a condition where blood flow to the brain is interrupted, causing brain cell to die), altered mental status (there's a change in how your brain is working affecting your ability to think, be aware of your surroundings, and react normally), abnormal gait and mobility (issues with how someone walks or moves, often due to underlying medical conditions or injuries), Alzheimer's disease (is a brain disorder that leads to memory loss and other cognitive decline, eventually impacting a person's ability to perform daily tasks), history of falling, anxiety disorder (mental health conditions characterized by excessive and persistent worry and fear, often leading to physical symptoms and difficulties in daily life), atrial fibrillation (an irregular and often rapid heartbeat that occurs when the electrical signals in the heart's upper chambers (atrial) fire out at the same speed).</p> <p>Review of Hospital ED notes dated 04/26/25 at 8:20 a.m., for Resident #1 revealed, Chief Complaint: Pt. presents to the ED s/p fall sustained on Wednesday with head strike per EMS. Patient was being showered by hospice nurse when he fell . Patient is bedbound, left-sided hemiparesis (impairment on the left side of the body). Presented from nursing home apparently had fallen out of bed on Wednesday, did not seek any attention till today. Was brought in today complaining of pain. Patient is non-verbal and does not follow commands. Contracture (a permanent tightening of the muscle, tendons, skin, and nearby tissues that cause the joints shorten and become very stiff) to left upper extremity and contractures of both lower extremities. Physical Exam: 2 cm laceration with steri-strips to forehead. Impression and Plan: Neurosurgeon reported he will not operate and wants to keep the patient at the hospital to treat conservatively. Patient in ICU under trauma services. Medical Decision Making: Patient very cachectic (weakness and wasting of the body) and would not withstand any kind of surgical intervention and place in a hard collar for life. Assessment: C2 dens type II fracture displacement nonoperative.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's Hospital Discharge Summary dated 04/28/25, revealed admitted [DATE] and discharge date [DATE]. Resident was admitted to the hospital on 04/26/25 at 11:36 a.m. History of Present Illness: [AGE] year-old male that resident at nursing home. On 04/23/25 he sustained a fall while being showered when he fell forward from the shower chair causing a laceration to the right side of his forehead requiring steri- strips. CT cervical spine revealed an acute unstable type II dens fracture of C1 on C2. Discharge Diagnosis 04/28/25: Type II dens fracture of second cervical vertebra, atrial fibrillation, advanced dementia.</p> <p>Record review of Resident #1's History & Physical dated 01/14/25 for Resident #1 revealed, Patient readmitted under hospice care after a massive cerebrovascular accident. Hemiplegia to left side, dementia, comfort care under Hospice, repeated falls. Neurological: Non-ambulatory, terminally demented, unable to follow commands. Unable to stand or walk.</p> <p>Record review of Physician's Progress Noted dated 04/24/25 written by attending physician revealed, resident seen today due to charge nurse reporting a fall. Recent fall from shower chair and sustained a laceration to the right side of forehead requiring steri-strips. Skull x-ray was obtained which was negative for fracture. Continue comfort care and pain management.</p> <p>Record review of Resident #1's Quarterly MDS, dated [DATE], revealed BIMS was not conducted due to Resident #1's inability to answer questions. Short-term and Long-term Memory Problems. Section C1000. Cognitive Skills for Daily Decision Making - Severely Impaired. Section GG - Functional Abilities revealed Resident #1 required substantial/maximal assistance with toileting hygiene, shower/bathing, sit to stand and chair/bed transfer; partial/moderate assistance with upper body dressing and personal hygiene. Wheelchair for mobility. Functional Limitation in Range of Motion - Impairment on one side to upper extremity; incontinent of bowel & bladder. Active diagnoses - Alzheimer's disease, stroke, cerebral infarction, altered mental status, unsteadiness on feet, abnormal gait, and mobility.</p> <p>Record review of Resident #1's Care Plan, dated 03/17/2025, revealed Resident #1 had an ADL self-care performance deficit. Part of the interventions reads in part, Transfer: The resident requires total assistance with transfer. Mechanical lift for all transfers with 2 staff for assistance. Contractures to all extremities. Risk for falls. Mechanical lift for all transfers with 2 staff for assistance. Resident has a terminal prognosis and is receiving hospice services. Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs are met. Hospice staff (nurse, CNA, SW, Chaplin) to assist with resident care.</p> <p>Record review of Hospice Plan of Care Effective 4/02/25 for Resident #1 revealed, Last Updated: 04/01/25. Problem: Patient at risk for experiencing inability to perform care related to cognitive deficits, functional limitations, weakness, debility, deconditioning, altered mental status, environmental/logistical limitations, lack of supervision. Problem: Patient at risk for/experiencing falls with injury related to deconditioning, altered mental status cognitive decline, neurological deficit, altered gait or balance, medication effects/side effects, functional alterations, other. Goal: Patient will have no fall with injury. Interventions: RN and/or SN will assess fall risk on admission, at recertification, change in level or location of care. SN will identify appropriate DME and collaborate with MD to order as indicated and will train/model how to safely use assistive devices during visits. The Hospice Care Plan did not document resident #1 needed a Mechanical lift and two-person assistance with transfers.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Physician's Order dated 02/16/2025 for Resident #1 revealed, Resident a Mechanical Lift with 2-person transfer.</p> <p>Review of Physician Order Summary undated for Resident #1 revealed, Hospice Mechanical Lift for all transfers.</p> <p>Review of Hospice Admission Orders revealed Resident #1 was admitted to Hospice on 01/14/25, and did not document resident needed a Mechanical Lift with two-person assist for transfers.</p> <p>Review of the Nursing Progress Note dated 04/23/25 at 12:28 p.m., written by LVN A revealed, Resident #1 had a fall in his room. Hospice CNA gave a shower to resident, and during the transfer back to bed the resident fell on the floor and hit his head. Fall information: Hit head, bending over. The fall caused a laceration to right side of the head 3 cm with bleeding. Physician and responsible party were notified. Ordered skull x-rays.</p> <p>Review of the facility's Event Report dated 04/23/25 at 11:00 a.m., revealed, Incident Location: Resident #1's Room. Incident Description: Hospice CNA gave a shower to resident, and during transfer back to bed, the CNA could not hold the resident strongly and fell to the floor. Resident has a laceration on right side of the forehead. Immediate Action Taken: Ordered skull x-rays. Pending results. Interventions in place prior to fall: Floor mat, Low bed.</p> <p>Record review of Resident #1's Event Nurses' Note - Fall dated 04/23/25, revealed, Unwitnessed fall in resident's room. Bending over. Laceration to right side of forehead measuring 3 cm. Nursing description of the event: Hospice CNA gave a shower to resident, and during transfer back to bed the resident fell to the floor.</p> <p>Record review of Hospice Note dated 04/23/25 at 1:50 p.m., written by Hospice Case Manager RN F revealed, Received a call from LVN A from nursing facility, patient sustained a fall while getting showered. Resident sustained a laceration on right side of head.</p> <p>Record review of Resident #1's x-ray report dated 04/23/25 revealed, exam of skull. Unremarkable skull series without obvious evidence of fracture.</p> <p>Record review of Nursing Progress Notes dated 04/26/25 at 7:30 a.m., for Resident #1 revealed Head CT scan pending.</p> <p>Record review of Nursing Progress Notes dated 04/26/25 at 7:36 a.m., revealed Resident #1 was picked up by transport ambulance and taken to hospital. Family member at bedside.</p> <p>Record review of Nursing Progress Notes dated 04/26/25 at 9:45 p.m., for Resident #1 revealed, placed a telephone call to follow up on resident and was informed by hospital RN, the resident had been admitted for cervical fx and would be discharged back to nursing home pending discharge orders from physician.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Nursing Progress Notes dated 04/28/25 at 9:19 p.m., for Resident #1 revealed, Admission Note: Arrived by EMS via stretcher. Current diagnoses/conditions: Dementia/Alzheimer's, Cervical Fx. Lethargic, unclear speech, sometimes understood, sometimes understands. Wheelchair. No balance issues. Assistance required for the following ADLs: Bed Mobility: 2 persons assist. Transferring: Mechanical lift. Toileting assistance. Briefs/pads one person assist. Hygiene/bathing: one person assist.</p> <p>Record review of Hospice Physician Telephone Order dated 04/28/25 for Resident #1 revealed, admit to Hospice. DX: Cerebral infarction, unspecified.</p> <p>Record review of Bedside Kardex dated 04/28/25 for Resident #1 revealed, Transferring: The resident required total assistance with transfers. Mechanical lift for all transfers with 2 staff for assistance. Mobility: Bed Mobility requires extensive assist x 2 staff to reposition and turn in bed.</p> <p>Review of Witness Statement dated 05/05/25, written by LVN A revealed, he was sitting at the nurses' station working on documentation, when suddenly hospice CNA C, was standing by the entrance to the room, waving and calling him. He went to Resident #1's room and found the resident on the floor. The shower chair was positioned directly in front of the middle to the bed facing the wall and the resident was next to the chair, with his face on the floor. The CNA C said she could not hold him, and he fell. She did not call for assistance. They were not aware that she was at the facility providing care to the resident. She had been instructed prior to the incident to ask for help with all transfers.</p> <p>During a telephone interview on 04/30/25 at 8:45 a.m., with Resident #1's family member, revealed LVN A had called on 04/23/25 to report that resident had sustained a fall in the shower. The family member reported that two days after the incident, family member had requested to have resident transferred to the hospital to get an MRI, to see what was wrong with him since he was declining and was no longer was eating, and no longer was able to talk because he was just sleeping.</p> <p>During an interview on 04/30/25 at 10:16 a.m., with LVN A, revealed, Hospice CNA C had not asked the facility staff for assistance on 04/23/25 to transfer Resident #1 from the bed to the shower chair to bathe the resident or after the shower was completed. He said CNA C had transferred the resident from the shower chair to the bed without assistance and had not used the Mechanical lift. He said the resident required a two-person assistance and a Mechanical lift for all transfers. He said that the nurses and the CNAs were always available to help the Hospice CNAs with transfers and use of the Mechanical Lifts as needed. He said that on the day of the incident the Hospice CNA C was standing by the entrance to the resident's room and had called him to the room. He said, When I got to the resident's room, CNA C said that she needed assistance because Resident #1 had fallen off the bed when she had turned to get a diaper. Upon entering the resident's room, the resident was lying on the floor on his left side and his face was planted on the floor and blood was coming out of resident's right side of his head. He said he had assisted CNA C to pick up the resident from the floor and put the resident in bed. He said the attending physician was notified and gave an order for an x-ray of the skull. He said the skull x-ray results were negative for fractures.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 04/30/25 at 11:15 a.m., with RN B Hospice Director of Clinical Services, revealed the Hospice CNAs had been trained to always ask for help if they could not transfer the patient alone. She said that CNA C had reported to them, that LVN A had helped her on 04/23/25 to do a two-person transfer to sit the resident on the shower chair to bathe him without using the Mechanical lift. She said CNA C, did report that once the resident was bathe, she had not asked LVN A again for assistance to put the resident back in bed and had transferred the resident without assistance. CNA C reported that when she had laid down the resident in the bed, she had turned her back to get a diaper and that is when the resident had rolled off from the bed and fell on the floor. CNA C said that she had asked LVN A for assistance to put the resident in bed, after resident had fallen to the floor. CNA C, reported that sometimes she did not use the Mechanical lift and would ask the CNAs for assistance do a two-person transfer to move the resident from the bed to the shower chair to give him a shower. RN B said, Either way Resident #1 required a two-patient transfer. She said CNA C had not explained to them why she had not asked her help to transfer the resident to the bed on that day.</p> <p>During a telephone interview on 04/30/25 at 1:24 p.m., with Nurse Practitioner D, revealed that she was notified on 04/23/25 that Resident #1 had sustained a fall on 04/23/25 and had come to the facility the next day, to assess the resident. She said that she was not aware that the resident had been transferred without a Mechanical Lift and a two-person transfer. She said that she could not recall the resident's diagnosis but did remember that the resident was [AGE] year-old male and was very fragile. She stated that the cervical fractures could have been related to the fall.</p> <p>During an interview on 04/30/25 at 3:12 p.m., with the DON revealed, I believed that we found out on Sunday 04/27/25, from the hospital paperwork that Resident #1 had a cervical fracture. He had a diagnosis of osteoporosis, so his injuries could have resulted from the fall on 04/23/25.</p> <p>During an interview on 04/30/25 at 4:00 p.m., with the Administrator revealed that he did not know that Resident #1 had sustained a cervical fracture until 04/28/25, when they had received the hospital paperwork upon resident's readmission to the nursing facility.</p> <p>During a telephone interview on 04/30/25 at 4:25 p.m., with Hospice CNA C revealed, that she had asked LVN A on 04/23/25 to assist her to transfer Resident #1 from the bed to the shower chair without using a Mechanical lift. She said that after the shower was completed LVN A had assisted her to transfer the resident from the shower chair to the bed without using the Mechanical lift. She said, the resident was lying in bed, and I turned to grab a diaper from a drawer that was approximately 6 feet from the bed and that is when resident fell off the bed. She said that she had called LVN A to help her put the resident on the bed. She said that she had reported the accident to the hospice nurse. She said, I didn't mean it, it just happened so fast. She said that she was aware that Resident #1 needed a Mechanical lift and required a two-person transfer. She said, It was my fault for not using the Mechanical lift. On that day, I could not find the sling to use the Mechanical lift. When I informed LVN A that I could not find the sling to use the Mechanical lift, he said that it was okay, and he would help me to transfer Resident #1. Sometimes I do transfer him without assistance because I cannot find anyone to help me with the two-person transfer. She said that she had been re-trained on 04/28/25 by the hospice staff on how to use of the Mechanical lift and with a two-person transfer.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Observation on 04/30/25 at 4:50 p.m., revealed Resident #1's bed was approximately 7 feet from the drawer where the disposable briefs were stored. The resident had a high/low bed and floor mat by the side of the bed.</p> <p>During an interview on 04/30/25 at 5:20 p.m., with CNA G revealed, the facility had provided an in-service training on 04/28/25 on how to use the Mechanical lifts with a two-person transfer.</p> <p>During a second telephone interview on 04/30/25 at 5:29 PM, with LVN A revealed that he had only assisted the hospice CNA C, to lift Resident #1 from the floor after he fell , to put him in bed. LVN A denied assisting CNA C to transfer resident on 04/23/25. He said that when he entered the resident's room, to put the resident in bed, he had not seen the Mechanical lift in the room. He said staff had been trained to always use a Mechanical lift with two-person assistance to transfer Resident #1.</p> <p>During an interview on 04/30/25 at 5:30 p.m., with ADON revealed, that she had done an in-service training on 04/29/25 for all facility nursing staff and Hospice staff on the use of a Mechanical lift with a two-person transfer.</p> <p>During an interview on 05/01/25 at 11:24 a.m., with the Administrator revealed the facility did not have a Fall Prevention policy & procedure.</p> <p>During a second telephone interview on 05/01/25 at 12:07 p.m., with RN B Hospice Director of Clinical Services, revealed, that CNA C had reported to hospice staff in the past, that the facility did not always have the Mechanical sling available, so the facility staff would assist her to do a two-person transfer to move Resident #1 from the bed to the shower chair. She said that CNA C, had reported that on the day of the incident on 04/23/25, it was close to lunch time, and no one had come to help her to transfer Resident #1 from the shower chair to the bed, so she had transferred Resident #1 on her own without using the Mechanical lift. CNA C also reported that the bed was on the lowest position when the resident had rolled off the bed. She said that after the incident involving Resident #1, the hospice staff had been retrained including CNA C on the use of the mechanical lift with two-person assistance and had also completed a competence skills checklist on CNA C. She said that the hospice staff did not attend the facility's care plan meetings because they were never invited.</p> <p>During an interview on 05/01/25 at 12:18 p.m., with RN F Hospice Case Manager who was assigned to Resident #1 revealed that the Hospice CNAs were expected to follow the Hospice care plans, and that he verified that the care plan was being followed by the Hospice CNAs when he went to see the resident. He said, after the fall, they would be working with the nursing home to compare their care plans to make sure that everyone is on the same page because the hospice and the nursing facility have their own care plans. We keep a copy of the hospice care plan in the hospice binder that is provided to the nursing facility. I was aware that Resident #1 required a two-person transfer because when the resident was admitted to hospice, he was bedbound and automatically that will require a two-person transfer. I did not know that Resident #1 required a lift for transfers, because it was not on the hospice care plan.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/01/25 at 12:45 p.m., with the Administrator, DON, and ADON revealed, that prior to the incident with Resident #1, the facility and the hospice staff did not share a copy of the care plans to coordinate the care and services provided to the resident. The DON said, the hospice staff would give a verbal report to the facility staff of what care was provided to the resident when they came to see the resident at the facility.</p> <p>During an interview on 05/01/25 at 5:05 p.m., with the Administrator revealed, he was not aware that the hospice aide had transferred Resident #1 on 04/23/25 without using a Mechanical lift and a two-person transfer, until the hospice staff came to the facility on [DATE] to apologize for not using the Mechanical lift. He said, I did not know hospice had made a mistake until they came. He said that he knew about the fall but did not start the investigation process to determine what had caused the fall.</p> <p>This was determined to be an Immediate Jeopardy (IJ) on 05/02/2025 at 3:55 p.m. The Administrator was notified. The Administrator was provided with the IJ template on 05/02/2025 at 3:55 p.m.</p> <p>The following Plan of Removal submitted by the facility was accepted on 5/03/2025 at 8:29 p.m.:</p> <p>Interventions:</p> <ul style="list-style-type: none"> -The alleged perpetrator will not be returning to the facility. Completed on 4/23/2025. -Out of cycle QAPI including this plan was presented to the Medical Director by the facility administrator. The medical director did not request changes to the plan. Completed 5/2/2025. -The Nursing staff/ current hospice agencies CNAs were in-serviced by facility DON/ADON and Regional Compliance Nurse on how to find the level of assistance required in the for transfer and mechanical devices required in the kiosk. Completed on 5/2/2025. -Mechanical lifts were tagged with bright colored sign stating, two people required to operate the lift. This was done by the Maintenance Director. This will give a second opportunity for staff to be reminded prior to using the equipment. Completed on 5/1/2025. -Facility Charge Nurses were in-serviced by the facility DON on how to read the facility Kardex. Completed on 5/2/2025. -Current hospice agencies CNAs/facility nursing staff providing services to residents at the facility were in-serviced by the facility DON on how to review the residents Kardex located in the kiosk with the Charge Nurse prior to providing direct care to the residents to ensure that the staff is aware of the number of people required for transfers and use of any mechanical lifts. This will be randomly monitored by DON/ADON/Admin. To prevent the recurrence of falls and injuries. Completed on 5/2/2025. -The facility Social Worker will be sending reminder emails to contracted hospice agencies to attend the required mandatory care plan meetings at the facility as scheduled. To ensure the coordination of services. This will be randomly monitored by Admin/DON/ADON. Completed on 5/2/2025. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-100% of residents' records were reviewed to ensure that the information reflected in the Kardex/Care plans for any residents requiring assistance with transfer to include any assistive devices. This was done by DON/ADON and the Regional Compliance Team. This was completed on 5/2/2025.</p> <p>In-services:</p> <p>-Facility staff and current hospice agencies were in-serviced by the DON/ADON and compliance nurse on Abuse and neglect No facility staff member or contract hospice agency staff will be allowed to provide care until receiving the in-service mentioned above. Completed on 5/3/2025.</p> <p>-05/03/25 Subject: Hospice sign-in and Kardex review process; Summary: Hospice CNAs must sign in upon arrival and review the Kardex with the charge nurse to ensure the plan of care and level of assistance are understood before providing care. Education is posted at the nurse's station.</p> <p>-Inservice dated 5/3/2025 revealed, Subject: All hospice staff must report to charge nurse and review Kardex; Summary: All hospice staff must report to the charge nurse upon arrival and review the Kardex before providing care. They must sign off that they have reviewed and understood the Kardex.</p> <p>-Inservice dated 5/3/2025 revealed, Subject: Hospice staff - Abuse, Neglect and Exploitation; Summary: In-service training on identifying and reporting abuse, neglect, and exploitation for hospice staff.</p> <p>-Inservice dated 5/4/2025 revealed, Subject: Abuse, neglect, and exploitation; Summary: Training addressed recognizing signs of abuse, neglect, and exploitation and the importance of timely reporting.</p> <p>Monitoring of the facility's plan of removal included the following:</p> <p>During an interview on 05/04/25 at 11:42 a.m., with CNA H assigned to the second floor revealed, she had been trained on 05/02/25 on how to use the lift with two-person assist. She said, The hospice staff report to the charge nurse who is assigned to the hospice resident, and they will review the hospice binder that is kept at the nurses' station to review the Kardex and the facility's care plan to verify if the resident needs a Mechanical lift with a two-person transfer. The charge nurse will assign a CNA to help the hospice aide with transfers as needed. She said that the charge nurses are also available to assist the CNAs with transfers. She said the Mechanical lifts have a bright orange sign posted on the Mechanical lift to remind staff that all Mechanical lift transfers require a two-person to transfer the resident. The CNAs were also trained to remind the hospice CNAs to sign in at the nurses' station and get report from the charge nurse prior to providing care to the hospice resident. She said that this process was implemented to communicate with the hospice staff on an on-going basis to ensure that hospice residents receive the necessary care and services according to the facility's care plan approaches.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/04/25 at 11:43 a.m., with CNA I assigned to the first floor in hall 500, revealed the facility staff and hospice staff had been trained on 05/02/25, on the new process for the hospice staff to report to the charge nurse to review the Kardex before providing care to the resident to ensure that hospice staff are following the care plan approaches related to the use of mechanical lifts and two-person transfers. She said there is a binder at the nurses' station that contains the Kardex and copy of facility care plan to verify if the resident needs to be transferred with a Mechanical lift and two-person transfer. The charge nurse will assign a CNA to help the hospice aide with transfers as needed. She said that the charge nurses are also available to assist the CNAs with transfers. She said the Mechanical lifts have a bright orange sign posted on the Mechanical lift to remind staff that all Mechanical lift transfers require a two-person to transfer the resident. The CNAs were also trained to remind the hospice CNAs to sign in at the nurses' station and get report from the charge nurse prior to providing care to the hospice resident. She said that this process was implemented to communicate with the hospice staff on an on-going basis to ensure that hospice residents receive the necessary care and services according to the facility's care plan approaches.</p> <p>During a telephone interview on 05/04/25 at 12:56 p.m., with Hospice Liaison J revealed, the facility had provided in-service training on 05/02/25. She said, the whole team assigned to the nursing facility attended the training. We were informed by the nursing facility staff, that without this training the hospice staff would not be able to enter the facility to perform any clinical duties with their contracted residents. The Hospice Liaison was not able to provide any other specifics regarding the training and advised the state surveyor to contact the hospice Director of Clinical Services RN B who could tell her who had attended the training.</p> <p>During a telephone interview on 05/04/25 at 12:58 p.m., with Hospice Care Consultant/Director of Admissions K revealed, hospice staff had attended an in-service training at the nursing facility on proper use of a Mechanical lift. It was explained that when hospice staff arrives to the facility they are to report and be cleared by the charge nurse before any care is provided to the resident and sign the form in acknowledgment that care plans and Kardex have been reviewed. She said that the hospice staff were scheduled to attend and IDT care plan meeting at the nursing facility to review the care plan approaches and coordinate the care and services provided to the resident.</p> <p>During an interview on 05/04/25 at 1:00 p.m., with family member revealed that she was visiting a resident. She stated that she has never had any issues with the care that is provided to the resident. The family member reported that transfers were always done with two-persons.</p> <p>Observation on 05/04/25 at 1:15 p.m., revealed that the Mechanical lifts were tagged with a bright orange sign that stated, Two-people required to operate the lift.</p> <p>During an interview on 05/04/25 at 1:15 p.m., with the Administrator revealed there was always at least eight CNAs available in the facility to help with transfers as well as the charge nurses and the activities director who is also a CNA.</p> <p>Observation and interview on 05/04/25 at 1:15 PM, revealed CNA M and CNA I were transferring Resident #7 with a Mechanical lift from the bed to the wheelchair. Resident #7 said that the CNAs always completed two-persons when they transferred him with the Mechanical lift. CNAs reported that they had checked the Kardex prior to transfer and had confirmed that Resident #7 required a Mechanical lift with two-persons transfer.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record Review on 05/04/25 at 1:30 p.m., revealed Hospice binders were kept at the nurses' stations on the first and second floor that had the Kardex, copy of facility care plan, Kardex and Sign-In Sheets for hospice staff to acknowledge if the resident required a Mechanical lift and two-person transfer.</p> <p>During an interview on 05/04/25 at 1:55 p.m., with the facility's Social Worker V revealed that she had been in-serviced by the Administrator, DON, and ADON to invite the hospice providers to the IDT care plan meetings.</p> <p>During a telephone interview on 05/04/25 at 3:00 p.m., with RN L Hospice Administrator of Operations revealed that she was present on 05/02/25 to observe the training on how to complete a Mechanical lift transfer with two-persons. The staff were also trained to check in with the charge nurse prior to providing care to the hospice resident to review the Kardex and facility care plan to verify if the resident needed a Mechanical lift transfer with two-persons.</p> <p>Observation and interview on 05/04/25 at 3:35 p.m., revealed CNA H and CNA N were preparing to transfer Resident #9 with a Mechanical lift from the bed to the wheelchair. The CNAs said that they always checked the Kardex prior to transfer to verify if Resident #9 still required a Mechanical lift transfer with two-persons assistance.</p> <p>Observation and interview on 05/04/25 at 3:58 p.m., revealed Hospice CNA P was being assisted by the CNA O to transfer Resident #9, from the wheelchair to the bed using a Mechanical lift. Both CNAs said that checked the Kardex prior to transfer to verify if Resident #9 still required a Mechanical lift transfer with two-persons assistance. The CNA S said they would get the Hospice binder to check the Kardex and facility care plan with the charge nurse and then signed the Kardex Sign-In Sheet to acknowledge if the resident required a Mechanical lift and two-person transfer.</p> <p>During a telephone interview on 05/04/25 at 5:06 p.m., with RN L Hospice Administrator of Operations revealed, in-service training had been provided on 05/02 [TRUNCATED]</p>		

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<p>F 0849</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026</p> <p>Based on observation, interview, and record review the facility failed to ensure coordination of care to ensure hospice services were provided according to the services the LTC facility provided based on resident's care plan for 1 of 9 residents (Residents #1) reviewed for hospice services.</p> <p>The facility failed to coordinate with hospice interdisciplinary team to coordinate care to the resident provided by facility staff and hospice staff for those residents receiving these services. The Hospice Aide failed to transfer Resident # 1 on 04/23/25 with a Mechanical lift and two-person assistance that resulted in a fall. The resident sustained a 2 cm laceration to the right side of the forehead and a dense fracture of C1 and C2 (a broken bone in the neck, specifically on second vertebra, breaks at its base) resulting in placement in the hospital ICU.</p> <p>An Immediate Jeopardy (IJ) situation was identified on 05/02/25. While the IJ was removed on 05/05/25, the facility remained out of compliance at a scope of isolated with a potential for more than minimal harm, due to the facility need to evaluate the effectiveness of the corrective systems.</p> <p>This failure could place residents at risk for falls, injury, or death.</p> <p>Findings include:</p> <p>Record review of Resident #1's Admission Record, dated 04/29/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which included: cerebral infraction (a condition where blood flow to the brain is interrupted, causing brain cell to die), altered mental status (there's a change in how your brain is working affecting your ability to think, be aware of your surroundings, and react normally), abnormal gait and mobility (issues with how someone walks or moves, often due to underlying medical conditions or injuries), Alzheimer's disease (is a brain disorder that leads to memory loss and other cognitive decline, eventually impacting a person's ability to perform daily tasks), history of falling, anxiety disorder (mental health conditions characterized by excessive and persistent worry and fear, often leading to physical symptoms and difficulties in daily life), atrial fibrillation (an irregular and often rapid heartbeat that occurs when the electrical signals in the heart's upper chambers (atrial) fire out at the same speed).</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Hospital ED notes dated 04/26/25 at 8:20 a.m., for Resident #1 revealed, Chief Complaint: Pt. presents to the ED s/p fall sustained on Wednesday with head strike per EMS. Patient was being showered by hospice nurse when he fell . Patient is bedbound, left-sided hemiparesis (impairment on the left side of the body). Presented from nursing home apparently had fallen out of bed on Wednesday, did not seek any attention till today. Was brought in today complaining of pain. Patient is non-verbal and does not follow commands. Contracture (a permanent tightening of the muscle, tendons, skin, and nearby tissues that cause the joints shorten and become very stiff) to left upper extremity and contractures of both lower extremities. Physical Exam: 2 cm laceration with steri-strips to forehead. Impression and Plan: Neurosurgeon reported he will not operate and wants to keep the patient at the hospital to treat conservatively. Patient in ICU under trauma services. Medical Decision Making: Patient very cachectic (weakness and wasting of the body) and would not withstand any kind of surgical intervention and place in a hard collar for life. Assessment: C2 dens type II fracture displacement nonoperative.</p> <p>Record review of Resident #1's Hospital Discharge Summary dated 04/28/25, revealed admitted [DATE] and discharge date [DATE]. Resident was admitted to the hospital on 04/26/25 at 11:36 a.m. History of Present Illness: [AGE] year-old male that resident at nursing home. On 04/23/25 he sustained a fall while being showered when he fell forward from the shower chair causing a laceration to the right side of his forehead requiring steri- strips. CT cervical spine revealed an acute unstable type II dens fracture of C1 on C2. Discharge Diagnosis 04/28/25: Type II dens fracture of second cervical vertebra, atrial fibrillation, advanced dementia.</p> <p>Record review of Resident #1's History & Physical dated 01/14/25 for Resident #1 revealed, Patient readmitted under hospice care after a massive cerebrovascular accident. Hemiplegia to left side, dementia, comfort care under Hospice, repeated falls. Neurological: Non-ambulatory, terminally demented, unable to follow commands. Unable to stand or walk.</p> <p>Record review of Physician's Progress Noted dated 04/24/25 written by attending physician revealed, resident seen today due to charge nurse reporting a fall. Recent fall from shower chair and sustained a laceration to the right side of forehead requiring steri-strips. Skull x-ray was obtained which was negative for fracture. Continue comfort care and pain management.</p> <p>Record review of Resident #1's Quarterly MDS, dated [DATE], revealed BIMS was not conducted due to Resident #1's inability to answer questions. Short-term and Long-term Memory Problems. Section C1000. Cognitive Skills for Daily Decision Making - Severely Impaired. Section GG - Functional Abilities revealed Resident #1 required substantial/maximal assistance with toileting hygiene, shower/bathing, sit to stand and chair/bed transfer; partial/moderate assistance with upper body dressing and personal hygiene. Wheelchair for mobility. Functional Limitation in Range of Motion - Impairment on one side to upper extremity; incontinent of bowel & bladder. Active diagnoses - Alzheimer's disease, stroke, cerebral infarction, altered mental status, unsteadiness on feet, abnormal gait, and mobility.</p> <p>Record review of Resident #1's Care Plan, dated 03/17/2025, revealed Resident #1 had an ADL self-care performance deficit. Part of the interventions reads in part, Transfer: The resident requires total assistance with transfer. Mechanical lift for all transfers with 2 staff for assistance. Contractures to all extremities. Risk for falls. Mechanical lift for all transfers with 2 staff for assistance. Resident has a terminal prognosis and is receiving hospice services. Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs are met. Hospice staff (nurse, CNA, SW, Chaplin) to assist with resident care.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Hospice Plan of Care Effective 4/02/25 for Resident #1 revealed, Last Updated: 04/01/25. Problem: Patient at risk for experiencing inability to perform care related to cognitive deficits, functional limitations, weakness, debility, deconditioning, altered mental status, environmental/logistical limitations, lack of supervision. Problem: Patient at risk for experiencing falls with injury related to deconditioning, altered mental status cognitive decline, neurological deficit, altered gait or balance, medication effects/side effects, functional alterations, other. Goal: Patient will have no fall with injury. Interventions: RN and/or SN will assess fall risk on admission, at recertification, change in level or location of care. SN will identify appropriate DME and collaborate with MD to order as indicated and will train/model how to safely use assistive devices during visits. The Hospice Care Plan did not document resident #1 needed a Mechanical lift and two-person assistance with transfers.</p> <p>Review of Physician's Order dated 02/16/2025 for Resident #1 revealed, Resident a Mechanical Lift with 2-person transfer.</p> <p>Review of Physician Order Summary undated for Resident #1 revealed, Hospice Mechanical Lift for all transfers.</p> <p>Review of Hospice Admission Orders revealed Resident #1 was admitted to Hospice on 01/14/25, and did not document resident needed a Mechanical Lift with two-person assist for transfers.</p> <p>Review of the Nursing Progress Note dated 04/23/25 at 12:28 p.m., written by LVN A revealed, Resident #1 had a fall in his room. Hospice CNA gave a shower to resident, and during the transfer back to bed the resident fell on the floor and hit his head. Fall information: Hit head, bending over. The fall caused a laceration to right side of the head 3 cm with bleeding. Physician and responsible party were notified. Ordered skull x-rays.</p> <p>Review of the facility's Event Report dated 04/23/25 at 11:00 a.m., revealed, Incident Location: Resident #1's Room. Incident Description: Hospice CNA gave a shower to resident, and during transfer back to bed, the CNA could not hold the resident strongly and fell to the floor. Resident has a laceration on right side of the forehead. Immediate Action Taken: Ordered skull x-rays. Pending results. Interventions in place prior to fall: Floor mat, Low bed.</p> <p>Record review of Resident #1's Event Nurses' Note - Fall dated 04/23/25, revealed, Unwitnessed fall in resident's room. Bending over. Laceration to right side of forehead measuring 3 cm. Nursing description of the event: Hospice CNA gave a shower to resident, and during transfer back to bed the resident fell to the floor.</p> <p>Record review of Hospice Note dated 04/23/25 at 1:50 p.m., written by Hospice Case Manager RN F revealed, Received a call from LVN A from nursing facility, patient sustained a fall while getting showered. Resident sustained a laceration on right side of head.</p> <p>Record review of Resident #1's x-ray report dated 04/23/25 revealed, exam of skull. Unremarkable skull series without obvious evidence of fracture.</p> <p>Record review of Nursing Progress Notes dated 04/26/25 at 7:30 a.m., for Resident #1 revealed Head CT scan pending.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Nursing Progress Notes dated 04/26/25 at 7:36 a.m., revealed Resident #1 was picked up by transport ambulance and taken to hospital. Family member at bedside.</p> <p>Record review of Nursing Progress Notes dated 04/26/25 at 9:45 p.m., for Resident #1 revealed, placed a telephone call to follow up on resident and was informed by hospital RN, the resident had been admitted for cervical fx and would be discharged back to nursing home pending discharge orders from physician.</p> <p>Record review of Nursing Progress Notes dated 04/28/25 at 9:19 p.m., for Resident #1 revealed, Admission Note: Arrived by EMS via stretcher. Current diagnoses/conditions: Dementia/Alzheimer's, Cervical Fx. Lethargic, unclear speech, sometimes understood, sometimes understands. Wheelchair. No balance issues. Assistance required for the following ADLs: Bed Mobility: 2 persons assist. Transferring: Mechanical lift. Toileting assistance. Briefs/pads one person assist. Hygiene/bathing: one person assist.</p> <p>Record review of Hospice Physician Telephone Order dated 04/28/25 for Resident #1 revealed, admit to Hospice. DX: Cerebral infarction, unspecified.</p> <p>Review of Witness Statement dated 05/05/25, written by LVN A revealed, he was sitting at the nurses' station working on documentation, when suddenly hospice CNA C, was standing by the entrance to the room, waving and calling him. He went to Resident #1's room and found the resident on the floor. The shower chair was positioned directly in front of the middle to the bed facing the wall and the resident was next to the chair, with his face on the floor. The CNA C said she could not hold him, and he fell. She did not call for assistance. They were not aware that she was at the facility providing care to the resident. She had been instructed prior to the incident to ask for help with all transfers.</p> <p>Review of Hospice Care Services Agreement dated 09/05/2024, revealed Plans of Care means a written care plan established, maintained, reviewed, and modified, as necessary, at regular intervals, by the IDG. The Plan of Care should reflect the participation of the Hospice, Facility, to the extent possible, which includes identification of the Hospice Services, including interventions and identification of the services to be provided by Facility; and coordinating the Plan of Care to meet the needs of the Hospice patient; and the IDG's documentation of Hospice representative's level of understanding, involvement, and agreement with the Plan of Care.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/30/25 at 10:16 a.m., with LVN A, revealed, Hospice CNA C had not asked the facility staff for assistance on 04/23/25 to transfer Resident #1 from the bed to the shower chair to bathe the resident or after the shower was completed. He said CNA C had transferred the resident from the shower chair to the bed without assistance and had not used the Mechanical lift. He said the resident required a two-person assistance and a Mechanical lift for all transfers. He said that the nurses and the CNAs were always available to help the Hospice CNAs with transfers and use of the Mechanical Lifts as needed. He said that on the day of the incident the Hospice CNA C was standing by the entrance to the resident's room and had called him to the room. He said, When I got to the resident's room, CNA C said that she needed assistance because Resident #1 had fallen off the bed when she had turned to get a diaper. Upon entering the resident's room, the resident was lying on the floor on his left side and his face was planted on the floor and blood was coming out of resident's right side of his head. He said he had assisted CNA C to pick up the resident from the floor and put the resident in bed. He said the attending physician was notified and gave an order for an x-ray of the skull. He said the skull x-ray results were negative for fractures.</p> <p>During a telephone interview on 04/30/25 at 11:15 a.m., with RN B Hospice Director of Clinical Services, revealed the Hospice CNAs had been trained to always ask for help if they could not transfer the patient alone. She said that CNA C had reported to them, that LVN A had helped her on 04/23/25 to do a two-person transfer to sit the resident on the shower chair to bathe him without using the Mechanical lift. She said CNA C, did report that once the resident was bathe, she had not asked LVN A again for assistance to put the resident back in bed and had transferred the resident without assistance. CNA C reported that when she had laid down the resident in the bed, she had turned her back to get a diaper and that is when the resident had rolled off from the bed and fell on the floor. CNA C said that she had asked LVN A for assistance to put the resident in bed, after resident had fallen to the floor. CNA C, reported that sometimes she did not use the Mechanical lift and would ask the CNAs for assistance do a two-person transfer to move the resident from the bed to the shower chair to give him a shower. RN B said, Either way Resident #1 required a two-patient transfer. She said CNA C had not explained to them why she had not asked her help to transfer the resident to the bed on that day.</p> <p>During a telephone interview on 04/30/25 at 4:25 p.m., with Hospice CNA C revealed, that she had asked LVN A on 04/23/25 to assist her to transfer Resident #1 from the bed to the shower chair without using a Mechanical lift. She said that after the shower was completed LVN A had assisted her to transfer the resident from the shower chair to the bed without using the Mechanical lift. She said, the resident was lying in bed, and I turned to grab a diaper from a drawer that was approximately 6 feet from the bed and that is when resident fell off the bed. She said that she had called LVN A to help her put the resident on the bed. She said that she had reported the accident to the hospice nurse. She said, I didn't mean it, it just happened so fast. She said that she was aware that Resident #1 needed a Mechanical lift and required a two-person transfer. She said, It was my fault for not using the Mechanical lift. On that day, I could not find the sling to use the Mechanical lift. When I informed LVN A that I could not find the sling to use the Mechanical lift, he said that it was okay, and he would help me to transfer Resident #1. Sometimes I do transfer him without assistance because I cannot find anyone to help me with the two-person transfer. She said that she had been re-trained on 04/28/25 by the hospice staff on how to use of the Mechanical lift and with a two-person transfer.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a second telephone interview on 05/01/25 at 12:07 p.m., with RN B Hospice Director of Clinical Services, revealed, that CNA C had reported to hospice staff in the past, that the facility did not always have the Mechanical sling available, so the facility staff would assist her to do a two-person transfer to move Resident #1 from the bed to the shower chair. She said that CNA C, had reported that on the day of the incident on 04/23/25, it was close to lunch time, and no one had come to help her to transfer Resident #1 from the shower chair to the bed, so she had transferred Resident #1 on her own without using the Mechanical lift. CNA C also reported that the bed was on the lowest position when the resident had rolled off the bed. She said that after the incident involving Resident #1, the hospice staff had been retrained including CNA C on the use of the mechanical lift with two-person assistance and had also completed a competence skills checklist on CNA C. She said that the hospice staff did not attend the facility's care plan meetings because they were never invited.</p> <p>During an interview on 05/01/25 at 12:18 p.m., with RN F Hospice Case Manager who was assigned to Resident #1 revealed that the Hospice CNAs were expected to follow the Hospice care plans, and that he verified that the care plan was being followed by the Hospice CNAs when he went to see the resident. He said, after the fall, they would be working with the nursing home to compare their care plans to make sure that everyone is on the same page because the hospice and the nursing facility have their own care plans. We keep a copy of the hospice care plan in the hospice binder that is provided to the nursing facility. I was aware that Resident #1 required a two-person transfer because when the resident was admitted to hospice, he was bedbound and automatically that will require a two-person transfer. I did not know that Resident #1 required a lift for transfers, because it was not on the hospice care plan.</p> <p>During an interview on 05/01/25 at 12:45 p.m., with the Administrator, DON, and ADON revealed, that prior to the incident with Resident #1, the facility and the hospice staff did not share a copy of the care plans to coordinate the care and services provided to the resident. The DON said, the hospice staff would give a verbal report to the facility staff of what care was provided to the resident when they came to see the resident at the facility.</p> <p>During an interview on 05/01/25 at 1:40 p.m., with the DON revealed the hospice providers did not attend the IDT care plan meetings at the facility and did not know if the facility's Social Worker was inviting the hospice providers to attend the IDT care plan meetings, since the Social Worker was responsible for scheduling the IDT care plan meetings.</p> <p>During an interview on 05/01/25 at 1:44 p.m., with the facility's Social Worker V revealed that she was not aware that she needed to invite the hospice providers to the facility's IDT care plan meetings.</p> <p>During an interview on 05/01/25 at 5:05 p.m., with the Administrator revealed, he was not aware that the hospice aide had transferred Resident #1 on 04/23/25 without using a Hoyer lift, until the hospice staff came to the facility on [DATE] to apologize for not using the Hoyer lift. He said, I did not know hospice had made a mistake until they came. He said that he knew about the fall but did not start the investigation process to determine what had caused the fall.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Mountain View Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 Murchison Rd El Paso, TX 79902	
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<p>F 0849</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the facility's on Hospice Services dated 02/13/2007, revealed, As an end-of-life measure. The resident or responsible family member may choose to use Hospice services within the facility. Procedures: The facility may have a legally binding written agreement with the provision of arranged services with a recognized Hospice provider. Authorized representatives of the nursing facility and Hospice provider must sign the agreement. A copy of the agreement will be maintained by the facility. The identification of the services to be provided. The manner in which the contracted services are coordinated, supervised and evaluated by the hospice and nursing facility. The delineation of the roles of the hospice and the nursing facility in the admission process, recipient and family assessment and the interdisciplinary team case conferences. The hospice facility will be responsible for appropriately training healthcare personnel to care for the resident is outlined in the State Practice Act. The hospice employees will be responsible for complying with the standards of care for environmental, safety, and infection control practices while employed under contract in the nursing facility. The nursing facility and hospice provider must ensure that a coordinated plan of care reflects the participation of hospice, nursing facility, the recipient, and the legal representative to the extent possible.</p> <p>This was determined to be an Immediate Jeopardy (IJ) on 05/02/2025 at 3:55 p.m. The Administrator was notified. The Administrator was provided with the IJ template on 05/02/2025 at 3:55 p.m.</p> <p>The following Plan of Removal submitted by the facility was accepted on 5/03/2025 at 8:29 p.m.:</p> <p>Interventions:</p> <ul style="list-style-type: none"> -The alleged perpetrator will not be returning to the facility. Completed on 4/23/2025. -Out of cycle QAPI including this plan was presented to the Medical Director by the facility administrator. The medical director did not request changes to the plan. Completed 5/2/2025. -The Nursing staff/ current hospice agencies CNAs were in-serviced by facility DON/ADON and Regional Compliance Nurse on how to find the level of assistance required in the for transfer and mechanical devices required in the kiosk. Completed on 5/2/2025. -Mechanical lifts were tagged with bright colored sign stating, two people required to operate the lift. This was done by the Maintenance Director. This will give a second opportunity for staff to be reminded prior to using the equipment. Completed on 5/1/2025. -Facility Charge Nurses were in-serviced by the facility DON on how to read the facility Kardex. Completed on 5/2/2025. -Current hospice agencies CNAs/facility nursing staff providing services to residents at the facility were in-serviced by the facility DON on how to review the residents Kardex located in the kiosk with the Charge Nurse prior to providing direct care to the residents to ensure that the staff is aware of the number of people required for transfers and use of any mechanical lifts. This will be randomly monitored by DON/ADON/Admin. To prevent the recurrence of falls and injuries. Completed on 5/2/2025. <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The facility Social Worker will be sending reminder emails to contracted hospice agencies to attend the required mandatory care plan meetings at the facility as scheduled. To ensure the coordination of services. This will be randomly monitored by Admin/DON/ADON. Completed on 5/2/2025.</p> <p>-100% of residents' records were reviewed to ensure that the information reflected in the Kardex/Care plans for any residents requiring assistance with transfer to include any assistive devices. This was done by DON/ADON and the Regional Compliance Team. This was completed on 5/2/2025.</p> <p>In-services:</p> <p>-Facility staff and current hospice agencies were in-serviced by the DON/ADON and compliance nurse on Abuse and neglect No facility staff member or contract hospice agency staff will be allowed to provide care until receiving the in-service mentioned above. Completed on 5/3/2025.</p> <p>-05/03/25 Subject: Hospice sign-in and Kardex review process; Summary: Hospice CNAs must sign in upon arrival and review the Kardex with the charge nurse to ensure the plan of care and level of assistance are understood before providing care. Education is posted at the nurse's station.</p> <p>-Inservice dated 5/3/2025 revealed, Subject: All hospice staff must report to charge nurse and review Kardex; Summary: All hospice staff must report to the charge nurse upon arrival and review the Kardex before providing care. They must sign off that they have reviewed and understood the Kardex.</p> <p>-Inservice dated 5/3/2025 revealed, Subject: Hospice staff - Abuse, Neglect and Exploitation; Summary: In-service training on identifying and reporting abuse, neglect, and exploitation for hospice staff.</p> <p>-Inservice dated 5/4/2025 revealed, Subject: Abuse, neglect, and exploitation; Summary: Training addressed recognizing signs of abuse, neglect, and exploitation and the importance of timely reporting.</p> <p>Monitoring of the facility's plan of removal included the following:</p> <p>During an interview on 05/04/25 at 11:42 a.m., with CNA H assigned to the second floor revealed, she had been trained on 05/02/25 on how to use the lift with two-person assist. She said, The hospice staff report to the charge nurse who is assigned to the hospice resident, and they will review the hospice binder that is kept at the nurses' station to review the Kardex and the facility's care plan to verify if the resident needs a Mechanical lift with a two-person transfer. The charge nurse will assign a CNA to help the hospice aide with transfers as needed. She said that the charge nurses are also available to assist the CNAs with transfers. She said the Mechanical lifts have a bright orange sign posted on the Mechanical lift to remind staff that all Mechanical lift transfers require a two-person to transfer the resident. The CNAs were also trained to remind the hospice CNAs to sign in at the nurses' station and get report from the charge nurse prior to providing care to the hospice resident. She said that this process was implemented to communicate with the hospice staff on an on-going basis to ensure that hospice residents receive the necessary care and services according to the facility's care plan approaches.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/04/25 at 11:43 a.m., with CNA I assigned to the first floor in hall 500, revealed the facility staff and hospice staff had been trained on 05/02/25, on the new process for the hospice staff to report to the charge nurse to review the Kardex before providing care to the resident to ensure that hospice staff are following the care plan approaches related to the use of mechanical lifts and two-person transfers. She said there is a binder at the nurses' station that contains the Kardex and copy of facility care plan to verify if the resident needs to be transferred with a Mechanical lift and two-person transfer. The charge nurse will assign a CNA to help the hospice aide with transfers as needed. She said that the charge nurses are also available to assist the CNAs with transfers. She said the Mechanical lifts have a bright orange sign posted on the Mechanical lift to remind staff that all Mechanical lift transfers require a two-person to transfer the resident. The CNAs were also trained to remind the hospice CNAs to sign in at the nurses' station and get report from the charge nurse prior to providing care to the hospice resident. She said that this process was implemented to communicate with the hospice staff on an on-going basis to ensure that hospice residents receive the necessary care and services according to the facility's care plan approaches.</p> <p>During a telephone interview on 05/04/25 at 12:56 p.m., with Hospice Liaison J revealed, the facility had provided in-service training on 05/02/25. She said, the whole team assigned to the nursing facility attended the training. We were informed by the nursing facility staff, that without this training the hospice staff would not be able to enter the facility to perform any clinical duties with their contracted residents. The Hospice Liaison was not able to provide any other specifics regarding the training and advised the state surveyor to contact the hospice Director of Clinical Services RN B who could tell her who had attended the training.</p> <p>During a telephone interview on 05/04/25 at 12:58 p.m., with Hospice Care Consultant/Director of Admissions K revealed, hospice staff had attended an in-service training at the nursing facility on proper use of a Mechanical lift. It was explained that when hospice staff arrives to the facility they are to report and be cleared by the charge nurse before any care is provided to the resident and sign the form in acknowledgment that care plans and Kardex have been reviewed. She said that the hospice staff were scheduled to attend and IDT care plan meeting at the nursing facility to review the care plan approaches and coordinate the care and services provided to the resident.</p> <p>During an interview on 05/04/25 at 1:00 p.m., with family member revealed that she was visiting a resident. She stated that she has never had any issues with the care that is provided to the resident. The family member reported that transfers were always done with two-persons.</p> <p>Observation on 05/04/25 at 1:15 p.m., revealed that the Mechanical lifts were tagged with a bright orange sign that stated, Two-people required to operate the lift.</p> <p>During an interview on 05/04/25 at 1:15 p.m., with the Administrator revealed there was always at least eight CNAs available in the facility to help with transfers as well as the charge nurses and the activities director who is also a CNA.</p> <p>Observation and interview on 05/04/25 at 1:15 PM, revealed CNA M and CNA I were transferring Resident #7 with a Mechanical lift from the bed to the wheelchair. Resident #7 said that the CNAs always completed two-persons when they transferred him with the Mechanical lift. CNAs reported that they had checked the Kardex prior to transfer and had confirmed that Resident #7 required a Mechanical lift with two-persons transfer.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record Review on 05/04/25 at 1:30 p.m., revealed Hospice binders were kept at the nurses' stations on the first and second floor that had the Kardex, copy of facility care plan, Kardex and Sign-In Sheets for hospice staff to acknowledge if the resident required a Mechanical lift and two-person transfer.</p> <p>During an interview on 05/04/25 at 1:55 p.m., with the facility's Social Worker V revealed that she had been in-serviced by the Administrator, DON, and ADON to invite the hospice providers to the IDT care plan meetings.</p> <p>During a telephone interview on 05/04/25 at 3:00 p.m., with RN L Hospice Administrator of Operations revealed that she was present on 05/02/25 to observe the training on how to complete a Mechanical lift transfer with two-persons. The staff were also trained to check in with the charge nurse prior to providing care to the hospice resident to review the Kardex and facility care plan to verify if the resident needed a Mechanical lift transfer with two-persons.</p> <p>Observation and interview on 05/04/25 at 3:35 p.m., revealed CNA H and CNA N were preparing to transfer Resident #9 with a Mechanical lift from the bed to the wheelchair. The CNAs said that they always checked the Kardex prior to transfer to verify if Resident #9 still required a Mechanical lift transfer with two-persons assistance.</p> <p>Observation and interview on 05/04/25 at 3:58 p.m., revealed Hospice CNA P was being assisted by the CNA O to transfer Resident #9, from the wheelchair to the bed using a Mechanical lift. Both CNAs said that checked the Kardex prior to transfer to verify if Resident #9 still required a Mechanical lift transfer with two-persons assistance. The CNA S said they would get the Hospice binder to check the Kardex and facility care plan with the charge nurse and then signed the Kardex Sign-In Sheet to acknowledge if the resident required a Mechanical lift and two-person transfer.</p> <p>During a telephone interview on 05/04/25 at 5:06 p.m., with RN L Hospice Administrator of Operations revealed, in-service training had been provided on 05/02/25, to all the hospice staff by the facility's administrative staff on complete a transfer with a Mechanical lift with two-persons assistance. The hospice staff will review the care plan and Kardex that are kept in the hospice binder with the charge nurse prior to providing care to the resident to make sure that the information is the same on the hospice plan o [TRUNCATED]</p>		