

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525397	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Dove Healthcare - Superior		STREET ADDRESS, CITY, STATE, ZIP CODE 1800 New York Ave Superior, WI 54880	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40181</p> <p>Based on observation, interview and record review, the facility failed to ensure residents received care and treatment in accordance with professional standards of practice and the comprehensive person-centered care plan for 1 of 16 residents (R) reviewed for quality of care (R58).</p> <p>R58 had a witnessed fall and was transferred from floor to bed by Certified Nursing Assistant (CNA) before a Registered Nurse assessed the resident for injuries.</p> <p>Findings include:</p> <p>R58 was admitted to the facility on [DATE] with the following diagnoses in part, unspecified dementia with psychotic disturbance, Alzheimer's disease, age-related physical debility, osteoporosis, unspecified visual disturbance, weakness, and abnormalities of gait and mobility.</p> <p>R58 had a fall risk assessment score of 20 on 02/20/25 which indicated R58 was high risk for falls.</p> <p>R58 had two recent falls resulting in a left humerus fracture and and a left femoral neck fracture.</p> <p>On 03/13/25 at 6:41 AM, Surveyor observed the ambulance team arrive on 3rd floor with a stretcher and Nursing Home Administrator (NHA) A directed them to R58's room. Surveyor asked NHA A what happened and NHA A said R58 fell again and hit her head and she was being transferred to the hospital for evaluation</p> <p>On 03/13/25 at 7:52 AM, Surveyor interviewed Licensed Practical Nurse (LPN) K who was working at the time of R58's most recent fall. LPN K stated she was sitting at the nurses' station completing end of shift documentation when she heard a thump and then a female voice swearing down the hall. LPN K entered R58's room and CNA L was just coming to the door of the room and stated R58 fell . LPN K stated R58 was lying in bed and rubbing the back of her head when LPN K entered the room. R58 had the gait belt around her waist and gripper socks on. Surveyor asked LPN K if CNA L put R58 back in bed before a nurse completed an assessment on R58. LPN K stated R58 was lying in bed when LPN K entered the room, so CNA L must have put R58 in bed.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/13/25 at 8:46 AM, Surveyor interviewed DON B about R58's fall earlier that morning and asked if they interviewed CNA L about R58's fall. DON B stated they interviewed CNA L prior to sending her home. Surveyor asked DON B if CNA L transferred R58 back into bed before a Registered Nurse assessed R58 for injuries. DON B stated CNA L did transfer R58 to bed before calling for help. Surveyor asked if that was an acceptable practice, DON B stated no, the nurse should have assessed R58 before moving her. DON B stated they pulled CNA L from the floor and provided immediate education on the fall policy and procedure and the need to have a nurse assess residents before moving them after a fall.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 48793</p> <p>Based on observation, interview and record review, the facility did not ensure the resident's environment remains as free of accident hazards as possible. The facility did not ensure staff followed transfer precautions and supervision when needed to prevent accidents which had the potential to affect 21 out of 62 residents.</p> <p>-Surveyor observed Certified Nurse Assistant (CNA) U bathe R57 in bath house without a call system in place for emergencies during bath/shower cares.</p> <p>-R41 was at risk for falls. Facility did not implement new interventions put into place post falls.</p> <p>-Staff ambulated R41 without gait belt in place during ambulation transfer process.</p> <p>-R58 had a history of frequent falls with major injury and the facility failed to ensure adequate supervision and implementation of interventions to prevent further falls.</p> <p>Findings include:</p> <p>Example 1</p> <p>Facility policy titled, Fall Prevention Program, dated reviewed on [DATE], states in part:</p> <p>.#6. When any resident experiences a fall, the facility will:</p> <ol style="list-style-type: none"> a. Assess the resident. b. Complete a post-fall assessment. c. Complete an incident report. d. Notify the provider and resident representative. e. Review the resident's care plan and update as indicated. f. Document all assessments/observations and actions. g. Obtain witness statements in the case of injury. <p>-Neruo checks will be completed of any unwitnessed fall or witnessed fall where a resident hits their head.</p> <p>-Initially, then EVERY (Q)15minutes x3, then,</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Q4 hours x 2, then,</p> <p>-Q8 hours x 8, staff to alert provider of any abnormal findings from the neuro checks.</p> <p>#7. Review each fall/fall investigation during the next morning meeting/clinical meeting with the Interdisciplinary team (IDT). Actions may include:</p> <ul style="list-style-type: none"> a. Review investigation and determination of potential root cause of fall. b. Review of fall risk care plan and updates. c. Additional revisions to the care plan. d. Education of staff to as any care plan revisions as needed. e. Scheduling care conferences. f. Verification of timely notification of provider and responsible party . <p>Facility policy titled, Safe Resident Handling/Transfers, dated revised on [DATE], states in part,</p> <p>.#5. Handling aides may include gait belts, transfer boards, and other devices .</p> <p>R41 was admitted to the facility on [DATE], readmitted on [DATE], with following diagnoses, in part, Alzheimer's disease, atherosclerotic heart disease, essential primary hypertension, and depression.</p> <p>R41's minimum data set (MDS) assessment, completed on [DATE] confirmed R3 scored ,d+[DATE] during a brief interview for mental status (BIMS), indicating intact cognition. R3 was at risk for falls. R3 requires substantial maximal assistance from staff for toileting, sit to stand, transferring, dressing lower body, and putting on/taking off footwear.</p> <p>R41's Activities of Daily Living (ADL)s care plan states:</p> <ul style="list-style-type: none"> -Transfer: Assist of 1 with gait belt, assure proper footwear is on before standing initiated on [DATE]. <p>R41's fall care plan states:</p> <ul style="list-style-type: none"> *Falls on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. -Resident will be safe and free from falls through the review date, initiated on [DATE]. -Keep room clean and free of clutter, initiated on [DATE]. -Keep call-light within reach, initiated on [DATE]. -Grabber or reacher provided to resident, initiated on [DATE]. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-On [DATE], R41 had an unwitnessed fall, found on floor. Surveyor reviewed R41's EHR and did not find documentation of neuros completed for R41 after [DATE] fall per the facility policy. Surveyor did not find any significant interventions implemented for unwitnessed fall.</p> <p>-On [DATE], R41 had an unwitnessed fall, found on floor.</p> <p>-On [DATE], R41 had witnessed fall by wife. R41 fell out of recliner.</p> <p>On [DATE] 10:14 AM, Surveyor observed R41 sitting against wall in dining room.</p> <p>On [DATE] at 1:33 PM, Surveyor observed Trained Medication Aide (TMA) V and CNA R transfer R41 from dining room chair and ambulate with R41 down hallway to room. Surveyor observed R41 very unsteady on R41's feet and staff highly encouraged R41 to stand straight and take steps forward. Surveyor did not see TMA V and CNA R utilize a gait belt when ambulating R41. Surveyor observed staff holding onto R41's hands, and R41 kept trying to let go of staff's hands while walking down the hallway towards R41's room. Surveyor did not observe a chair at the nurse's station to provide R41 a rest with R41's unsteadiness.</p> <p>On [DATE] at 1:45 PM, Surveyor interviewed TMA V and asked if R41 should have gait belt on when ambulating to room from dining room. TMA V indicated that R41 should have gait belt on because R41 is sometimes unsteady with gait.</p> <p>On [DATE] at 8:33 AM, Surveyor observed CNA U, CNA T, and CNA R enter R41's room. Surveyor observed CNAs provide peri cares and get R41 up for the day. Surveyor observed CNA U and CNA R swing R41's legs over to the edge of bed and sit R41 up. CNA U and CNA R stood R41 up by grabbing hands and under arm pits to a standing position. CNA U and CNA R had R41 take a step forward and tried to get R41 to lift feet to place shoes on. R41 was confused and did not cooperate well. CNA U and CNA R had to sit R41 back down in the bed and then CNA U suggested to CNA R to apply gait belt. CNA R applied gait belt. Upon placing shoes onto R41, CNAs let go of R41 while R41 was leaning in bed, and R41 fell backwards and hit R41's head into the wall. CNAs quickly grabbed under arms and gait belt and lifted R41 forward to sitting position. CNA R rubbed back of R41's head and finished getting R41 up out of bed. CNA R and CNA U ambulated R41 out of room and down the hall. Surveyor did not observe a chair at the nurse's station to provide R41 a rest with R41's unsteadiness.</p> <p>On [DATE] at 9:42 AM, Surveyor interviewed CNA U and asked if R41 is supposed to have gait belt on when ambulating or transferring. CNA U indicated that CNA U should have told CNA R to apply gait belt before CNA U and CNA R stood R41 up the first time.</p> <p>On [DATE] at 1:20 PM, Surveyor interviewed CNA U and asked if CNA U had reported R41's fall and hitting head to appropriate staff on duty. CNA U indicated that CNA U reported the event to MDS Coordinator P who was on floor at the time. CNA U indicated that once MDS Coordinator P reported off the floor to RN Q, then CNA U reported to Registered Nurse (RN) Q that R41 had fallen and hit head on wall.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On [DATE] at 1:31 PM, Surveyor interviewed RN Q what time RN Q came on shift. RN Q indicated that RN Q arrived around 10:00 AM. Surveyor asked RN Q if RN Q was told in report any issues or concerns with R41. RN Q indicated that only issue that was reported was the staff member who had almost passed out. Surveyor asked RN Q if RN Q was aware that R41 fell backwards in bed and hit R41's head on the wall. RN Q indicated that RN Q did not know about the fall and needs to do something immediately. Surveyor asked RN Q what the facility policy is for resident falls. RN Q indicated that staff should report the fall to nursing. Nursing should have assessed R41, completed vitals, neuros, and notified provider right away. RN Q indicated that next steps would be to open a risk management incident and follow facility protocol. Surveyor asked RN Q if the proper measures have been completed for R41. RN Q indicated no none of this has been done as this is the first time RN Q was notified of the event. RN Q asked Surveyor to follow Surveyor upstairs to MDS Coordinator P's office on 3rd floor to ask MDS Coordinator P about the incident.</p> <p>On [DATE] at 1:45 PM, Surveyor interviewed MDS Coordinator P and asked if MDS Coordinator P was told in report any issues or concerns with R41. Surveyor asked MDS Coordinator P if MDS Coordinator P was aware that R41 fell backwards in bed and hit R41's head on the wall. MDS Coordinator P indicated that MDS Coordinator P did not know about the fall. Surveyor asked MDS Coordinator P what the facility policy is for resident falls. MDS Coordinator P indicated that staff should report the fall to nursing. MDS Coordinator P indicated staff should have assessed R41, completed vitals, neuros, and notified provider right away per the facility falls policy.</p> <p>On [DATE] at 2:33 PM, Surveyor interviewed Director of Nursing (DON) B and asked if DON B was notified of R41 falling this morning. DON B indicated that MDS Coordinator just left DON B's office and made DON B aware of the issue. DON B indicated the correct process that staff should have completed for R41 this morning would be immediately start a risk management incident and complete the work up that includes assessment of R41, vitals, neuros, contact provider and POA, and continue to follow up with frequent assessments through the day. Surveyor indicated to DON B that Surveyor could not find that any of the actions for R41 falling were completed. DON B indicated that staff would get on top of the incident right away and that it was not completed for R41. Surveyor indicated to DON B that Surveyor observed TMA V and CNA R transfer R41 from dining room to bedroom without gait belt. Surveyor observed CNA U and CNA R transfer R41 from bed to standing position and R41 took a step forward and was wobbling in place. Surveyor indicated to DON B that R41 was unsteady on R41's feet and CNA U asked R41 to lift each foot to place shoes on but R41 could not without swaying backwards and to the side. CNA U and CNA R then sat R41 down on the bed and applied gait belt. DON B indicated that staff should always use gait belt with R41 when R41 is standing and ambulating.</p> <p>On [DATE] at 9:23 AM, Surveyor observed CNA U and CNA R set R41 in R41's recliner. Surveyor did not observe R41 to have a Dycem pad in R41's recliner. Surveyor interviewed CNA U and CNA R and asked if R41 has a dycem pad in R41's recliner. CNA U and CNA R indicated there is no Dycem pad in R41's recliner and never has been. Surveyor had CNA U and CNA R check R41's closet. CNA U indicated there is no Dycem pad in R41's closet and has never seen one. Surveyor observed no grip strips in front of recliner in R41's room.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On [DATE] at 7:28 AM, CNA U asked Surveyor if Surveyor could wait in bath house while CNA U goes to get a brief CNA U forgot for R57 in R57's room. Surveyor indicated to CNA U that Surveyor cannot be left alone to supervise R57. Surveyor asked CNA U if this happens often where CNA U will leave R57 in bath house in bath chair. CNA U stated, Not usually, just thought since another person was here, I could grab it since i forgot it. Surveyor asked CNA U what CNA U would normally do. CNA U indicated that CNA U would normally call for assistance. Surveyor looked around for call light and could not find one. Surveyor asked CNA U where the call light was in the bath house. CNA U pointed to the wall near shower and stated, We use to have one in here, but maintenance took it out and placed this panel over the hole. Surveyor asked CNA U what if there is an emergency or like the situation that just occurred when CNA U needed assistance because R57 was falling forward out of the bath chair. CNA U stated, I would peek my head out the door or scream really loud for help. Surveyor asked CNA U if CNA U has any walkie talkies to ask for assistance. CNA U indicated that CNA U does not have walkies. Surveyor then observed CNA U pop head back out from the bath house and ask for assistance. Lack of a call light in the bath house has the potential to affect 21 residents on the second floor.</p> <p>On [DATE] at 7:35 AM, Surveyor observed CNA T enter bath house to assist CNA U with transfer of R57. CNA U and CNA T began pushing stand lift to R57 and instructed R57 to help stand. CNA U and CNA T grabbed underneath R57's arm pits and began lifting. Surveyor did not observe CNAs utilize a gait belt when lifting R57 from bath chair. Surveyor observed CNA U take a dry towel and wipe R57's groin and buttock area without wearing gloves. CNA U then dropped the dry towel as R57 was dropping to sit down. Surveyor observed CNA U don gloves and CNA U and CNA T began standing R57 again. CNA U then used dry towel again to dry off groin area and buttock area. Surveyor observed R57 drop again to sitting on bath chair. CNA U then instructed R57 to stand again while CNA U pulled brief and pants up for R57 with soiled gloves. Surveyor observed R57 was weak and difficult to stand. Surveyor observed R57 kept dropping down to sit instead of standing. CNA U and CNA T had to re-lift R57 under R57's arm pits 5 times before CNA U could pull R57's brief and pants up.</p> <p>On [DATE] at 7:51 AM, Surveyor interviewed CNA U and CNA T. Surveyor asked if CNA U and CNA T should use a gait belt with transfers from bath chair to stand lift as R57 kept dropping to sit down due to weakness. CNA U indicated that usually R57 is easy to stand but today R57 must be feeling weak. CNA U indicated to Surveyor that CNA U probably should have used gait belt instead of lifting under R57's arm pits.</p> <p>On [DATE] at 10:01 AM, Surveyor interviewed Maintenance Director W and asked if Maintenance Director W knew there was no call light in the bath house on second floor. Maintenance Director W indicated that Maintenance Director W was not aware and unsure time frame that the call light became inactive. Surveyor asked Maintenance Director W to visualize no call light in the bath house on second floor. Surveyor and Maintenance Director W entered bath house on second floor. Maintenance Director W observed no call light near the shower where all call lights are supposed to be located. Maintenance Director W observed further in the back of bath house where the bathtub was, and Maintenance Director W indicated there was no call light for that either. Maintenance Director W indicated it is necessary to have a call light in the bath house. Maintenance Director W indicated there must have been a work slip put in a while back and something went wrong that one of the Maintenance Technicians must have taken light out, capped the hole to prevent water from getting in there and then never came back to re-install a call light in bath house. Surveyor asked Maintenance Director W if Maintenance Director W could find when the work slip was placed and how long the call light system has been inoperable.</p> <p>(continued on next page)</p>		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On [DATE] at 10:59 AM, Surveyor interviewed DON B and asked DON B if DON B had knowledge there was not a call light in the bath house on second floor down North wing. DON B indicated that DON B was unaware of a call light issue in the bath house on second floor, which could affect 21 residents on that floor. DON B indicated that all CNAs have walkie talkies that staff utilize if they do need assistance. Surveyor indicated to DON B that Surveyor interviewed CNAs, and CNAs noted they do not have walkie talkies on them. Surveyor asked DON B what DON B would consider to be appropriate for using to call for assistance when CNAs don't have the walkie talkie on them. DON B stated, I guess the CNAs will need to yell out for help.</p> <p>On [DATE] at 8:45 AM, Maintenance Director W approached Surveyor and indicated that Maintenance Director W could not find the work slip that bath house on 2nd floor call light had issues and wasn't working. Maintenance Director W indicated to Surveyor that sometimes staff let maintenance crew know verbally about issues and Maintenance Director W knows that call light has been in failure for at least the last month.</p> <p>40181</p> <p>Example 3</p> <p>R58 was admitted to the facility on [DATE] with the following diagnoses in part, unspecified dementia with psychotic disturbance, Alzheimer's disease, age-related physical debility, osteoporosis, unspecified visual disturbance, weakness, and abnormalities of gait and mobility.</p> <p>R58's Minimum Data Set (MDS) assessment, dated [DATE], identified R58 had a Brief Interview for Mental Status score of 03 out of 15, which indicated R58 had severe cognitive impairment. The MDS identified R58 had disorganized thinking behaviors that fluctuated and varied in severity. R58 also had hallucinations and delusions present during the MDS assessment period.</p> <p>R58 had a fall risk assessment score of 20 on [DATE] which indicated R58 was high risk for falls.</p> <p>R58 had two recent falls resulting in a left humerus fracture and a left femoral neck fracture.</p> <p>R58 had the following care plan focus in place:</p> <p>At risk for falls r/t [related to] history of repeated falls r/t Confusion, Deconditioning, Gait/balance problems, Unaware of safety needs. She is non compliant with wearing her knee brace and her sling. Has order brace and for knee brace and arm sling. She does not use assistive device as recommended for ambulation. She lowers herself to her knees to go in her drawers or look for something and gets herself up and also to clean up spills or just wipe up on the floor. She attempts to rearrange furniture.</p> <p>[DATE]- Fall</p> <p>[DATE]- Fall</p> <p>[DATE]- [R58] was witness to lose her balance and regain her balance when she stumbled. She did not fall but she did report this as a fall.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Remind, Educate, assist [R58] to wear her knee brace and sling as ordered. Date Initiated: [DATE] Revision on: [DATE]</p> <p>S/P Fall [DATE] Intervention Toilet [R58] every ,d+[DATE] hours and as needed. Date Initiated: [DATE] Revision on: [DATE]</p> <p>R58's Activities of Daily Living self-care performance deficit care plan had the following intervention in place, . TRANSFER: Stand pivot transfer with assist of 1, using gait belt. Date initiated: [DATE] Revision on: [DATE] .</p> <p>R58 had the following treatment orders in place, dated [DATE], Direct 1:1 supervision-Staff to stay with her at all times. Stay at arm's length of her. Assigned 1:1 staff member needs to Arrange for 1:1 replacement to be with [R58] at all times before leaving her.</p> <p>On [DATE] at 6:41 AM, Surveyor observed the ambulance team arrive on 3rd floor with a stretcher and Nursing Home Administrator (NHA) A directed them to R58's room. Surveyor asked NHA A what happened and NHA A said R58 fell again and hit her head and she was being transferred to the hospital for evaluation.</p> <p>On [DATE] at 7:52 AM, Surveyor interviewed Licensed Practical Nurse (LPN) K, who was working at the time of R58's most recent fall. LPN K stated she was sitting at the nurses' station completing end of shift documentation when she heard a thump and then a female voice swearing down the hall. LPN K had just sent the Certified Nursing Assistant (CNA) downstairs to take out trash, so she was the only one on the floor other than the 1:1 CNA in R58's room. LPN K got up and checked all the rooms on the hall where the sound came from, but didn't go into R58's room first because CNA L was in that room providing 1:1 care. When LPN K did not find any problems in the other rooms, she entered R58's room and CNA L was just coming to the door of the room and stated R58 fell . LPN K stated R58 was lying in bed and rubbing the back of her head when LPN K entered the room. R58 had the gait belt around her waist and gripper socks on. LPN K immediately assessed and felt a lump at the back of R58's head, but no bleeding or break in skin observed. LPN K did neuro checks and vital signs and assessed for any other injuries, but did not find any other injuries. They applied an ice pack to the back of R58's head, called Director of Nursing (DON) B, notified the provider and got orders to transport R58 to the hospital for evaluation. LPN K asked CNA L what happened and CNA L stated she was assisting R58 with a transfer while holding the wheelchair and instructing R58 to turn and sit in the chair. R58 turned and sat on the very edge of the bed instead and slid off and landed on the floor, hitting her head on the side rail. Surveyor asked if CNA L was holding the gait belt to assist with the transfer. LPN K was not sure, but said it sounded like CNA L was not holding the gait belt, but behind the wheelchair. Surveyor asked if R58 was safe to transfer with just one staff person. LPN K stated R58 was assessed as a one-person transfer with a gait belt. Surveyor asked what that meant. LPN K stated staff should hold onto the gait belt during the transfer. Surveyor asked if CNA L put R58 back in bed before a nurse completed an assessment on R58. LPN K stated R58 was lying in bed when LPN K entered the room, so CNA L must have put R58 in bed.</p> <p>On [DATE] at 8:32 AM, Surveyor interviewed Physical Therapy Assistant (PTA) M who stated she worked with R58 and was familiar with R58's safety issues and therapy-approved transfer status. PTA M stated R58 was safe with a one-person transfer using a gait belt. Surveyor asked what that meant. PTA M stated staff should have the gait belt securely around the resident's torso and should be holding the gait belt and supporting and guiding the resident to pivot when doing a transfer.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On [DATE] at 8:46 AM, Surveyor interviewed DON B about R58's fall earlier that morning and asked if they interviewed CNA L about R58's fall. DON B stated they interviewed CNA L prior to sending her home. CNA L reported R58 was seated in the wheelchair folding laundry while CNA L carried bags of soiled laundry and trash to the doorway of the room for end of shift. CNA L turned and observed R58 stand from the wheelchair and before CNA L could get to R58, R58 turned and sat at the very edge of the bed. R58 then slid off to the floor and hit her head on the bed. CNA L got LPN K who assessed R58. Surveyor asked DON B if CNA L followed the care plan to stay within arms length of R58. DON B stated CNA L stated she had carried bags to the door when R58 stood and fell. Surveyor asked if CNA L transferred R58 back into bed before a Registered Nurse assessed R58 for injuries. DON B stated CNA L did transfer R58 to bed before calling for help. Surveyor asked if that was an acceptable practice, DON B stated no, the nurse should have assessed R58 before moving her. DON B stated they pulled CNA L from the floor and provided immediate education on the fall policy and procedure and the need to have nurse assess residents before moving them after a fall.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40181</p> <p>Based on observation, interview and record review, the facility did not ensure that sufficient nursing staff was provided for the third floor to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident (R). This has the potential to affect all 14 residents residing on the third floor.</p> <p>Residents on the third floor have had multiple falls with injuries.</p> <p>A resident (R19) had an unwitnessed fall and no staff responded to calls for help until Surveyor intervened.</p> <p>R9 who is frequently incontinent of urine did not receive assistance with repositioning or toileting for 4 1/2 hours.</p> <p>Findings include:</p> <p>Facility Assessment, dated 02/03/25, stated in part: .Information About Our Staffing Patterns section stated Average Nurse Aide/Resident Ratio (Direct Care Staff) Average about 1 Nurse Aide to 10 Residents .</p> <p>Surveyor reviewed the daily staffing postings and nursing schedules for the past month. The schedule showed one nurse and one Certified Nursing Assistant (CNA) scheduled for 3rd floor, with one additional CNA who was scheduled for 1:1 care of one resident. That CNA was not available to answer call lights and provide direct care to any other residents on the unit.</p> <p>The daily census on third floor during the survey was 14 residents. During the day and evening shifts on 03/10/25, and on the morning of 03/11/25, Surveyor observed one nurse and one CNA providing direct care on the third floor for 14 residents.</p> <p>On the morning of 03/11/25, Surveyor observed one Licensed Practical Nurse (LPN) and one CNA working on the third floor. At 9:44 AM, Surveyor heard a loud noise from one of the rooms toward the end of the hall farthest from the nursing station. A couple of minutes later, Surveyor heard a resident calling for help from room [ROOM NUMBER]. CNA D was in another resident room and did not hear or respond to the call for help. LPN C was passing medications to a resident on a different hall and did not hear or respond to the call for help. After two minutes, Surveyor walked down to room [ROOM NUMBER] and observed R19 lying on the floor by the bathroom. Surveyor alerted LPN C that R19 had fallen and was calling for help. LPN C finished giving medications to a resident and then went to the room and found R19 on the floor by the bathroom. LPN C yelled for help from the doorway, but CNA D did not hear or respond to the call for help. After a few minutes, Surveyor observed Registered Nurse (RN) X walking down a different hall and headed for the elevator. Surveyor informed RN X a resident had fallen and LPN C needed assistance. RN X responded to the room to assist.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 03/11/25 at 10:22 AM, Surveyor interviewed LPN C who stated R19 was supposed to be up with assistance, but R19 frequently forgot to call for help. LPN C stated with just one CNA and one nurse working on the unit, it was hard to hear R19 when she got up independently. LPN C stated R19 did get a small skin tear on one arm from the fall this AM. Surveyor interviewed LPN C about staffing patterns on the third floor. LPN C stated when she works the third floor they consistently have one nurse and one CNA working on the unit for both day and PM shifts. LPN C stated there are typically about 14 to 15 residents on the unit. LPN C stated they have a staff person scheduled to provide 1:1 care for R58, but that person cannot leave R58's room to help answer call lights or help with cares for residents. LPN C stated they just called in another CNA to help assist with resident cares on the floor after R19 fell , but it probably only happened because the Surveyors were in the building. LPN C stated in her experience they never call extra help up to the third floor. LPN C stated there have been a lot of resident falls on the third floor and they need two CNAs on the unit all the time to try to prevent the falls.</p> <p>On 03/11/25 at 10:53 AM, Surveyor interviewed CNA D who stated they usually worked on the third floor. CNA D stated they usually scheduled just one nurse and one CNA working on the unit for about 15 residents. CNA D stated they had a really busy morning, and it was good that they called in extra help. CNA D stated they try to call in help extra help sometimes, but it was rare that someone agreed to come in. CNA D said it would be better for the residents if they had two CNAs scheduled for the third floor.</p> <p>On 03/11/25 at 10:56 AM, R3 requested to speak to Surveyor in her room. R3 stated she was the resident council president and she had brought up staffing concerns at their meetings in the past, but nothing was ever done about it. They usually have one nurse and one CNA working on the floor for 14-15 residents. R3 stated she is fairly independent, and does not need a lot of physical assistance from the staff, but R3 believes the residents who are more dependent don't get the care they deserve because there is not enough help. R3 stated she had observed multiple residents, who are dependent and can't speak for themselves, left in their chairs at the dining room for many hours, sometimes from before breakfast until after lunch. R3 stated that many of the falls that have occurred are due to not enough staff to assist the residents to the bathroom or with transfers.</p> <p>On 03/12/25 at 8:21 AM, Surveyor observed R19, who had fallen the day before, get up and begin walking with a 4-wheeled walker toward the bathroom. R19 did not press the call light or call for help. R19 appeared unsteady on her feet and there was no staff around to observe or assist R19. Surveyor alerted CNA E who at the other end of the hall providing 1:1 care for R58. CNA E was able to locate CNA D, who came down the hall to assist R19 to the bathroom.</p> <p>On 03/12/25 from 7:06 AM to 11:35, AM, Surveyor had a continuous observation of R9 seated in one position without being assisted to go to the bathroom, or checked for incontinence.</p> <p>Record review identified R9 had severe cognitive impairment, required substantial or maximal assistance for all mobility and toileting, and was frequently incontinent of urine and always incontinent of bowel. R9 was also assessed at risk for development of pressure injuries. R9 had care plan interventions instructing staff to assist with toileting every 2-3 hours and as needed.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 03/12/25 at 7:14 AM, Surveyor interviewed LPN G who was an agency staff member working at the facility since November. LPN G stated she frequently worked on the third floor. LPN G said there is usually one CNA and one nurse scheduled for the third floor when LPN G worked on there. LPN G stated there were usually around 15 residents on the unit and a lot of them have a history of frequent falls. LPN G stated they could use more help on the third floor to try to prevent some of the falls.</p> <p>On 03/12/25 at 7:29 AM, Surveyor interviewed CNA E who was working on the third floor. CNA E stated she usually works on first floor, but was called in extra today and asked to float to the 3rd floor. CNA E she had been assigned to work on the third floor for the first time on 02/14/25 when R58 had a fall. CNA E stated she was the only CNA working the floor and there was another CNA doing 1:1 care with R58. CNA E stated when the other CNA left the unit for a break, the nurse told CNA E to cover the 1:1 care for R58. CNA E was not told she could not leave the room when doing 1:1 care for R58 and the nurse was not answering lights and covering the floor while CNA E was in R58's room. CNA E left to answer call lights on the unit and that is when R58 fell . CNA E stated one nurse and one CNA scheduled for third floor was not enough to safely meet the residents' needs and that is why there were so many falls on that unit.</p> <p>On 03/12/25 at 12:12 PM, Surveyor interviewed Director of Nursing (DON) B about R19's fall on 03/11/25 and explained continuous observation of R9 not repositioned or assisted to the bathroom for 4 1/2 hours. Surveyor also informed DON B of interviews from staff and residents reporting inadequate staffing on the third floor resulting in delayed cares and falls. Surveyor asked DON B if they had considered if some of the resident falls were related to inadequate staffing levels on the third floor. DON B stated they would review staffing levels.</p>		