

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675446	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/27/2024
NAME OF PROVIDER OR SUPPLIER Prairie Meadows Rehabilitation and Healthcare Cent		STREET ADDRESS, CITY, STATE, ZIP CODE 1615 Eleventh St Floresville, TX 78114	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46447</p> <p>Based on interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation was made for 1 (Resident #1) of 6 residents reviewed for reporting of alleged violations, in that:</p> <p>The facility failed to report to the state agency, an incident of neglect regarding Resident #1, after he had an unwitnessed fall in his room with a possible injury to his hip that occurred on 11/01/2024. The unwitnessed fall later revealed through CT scan (a scan to create cross sectional images of organs, bones, and other tissues), Resident #1 had a left femoral hip fracture, and it was not reported to the state as of 11/06/2024.</p> <p>This failure could place facility residents at risk of harm due to delays in reporting allegations of injury of unknown origin, abuse, and neglect.</p> <p>Findings included:</p> <p>Record review of Resident #1's Admission Record, dated 11/07/2024, indicated Resident #1 was initially admitted on [DATE] and readmitted on [DATE]. He was a [AGE] year-old male. He was noted to have discharged on [DATE] to an acute care hospital, Hospital A. His diagnoses included: altered mental status, delirium (a change in mental abilities that results in confused thinking and a lack of awareness of someone's surroundings) due to known physiological condition, unspecified lack of coordination, age-related osteoporosis (brittle and fragile bones), and spina bifida (a birth defect that occurs when the spine and spinal cord do not form properly).</p> <p>Record review of Resident #1's Quarterly MDS assessment, dated 10/07/2024, indicated Resident #1 had a BIMS score of 04, indicating he was severely cognitively impaired. Resident #1 required substantial/maximal assistance with rolling left or right from lying on his back in bed and was dependent on staff assistance for chair/bed-to-chair transfers. He used a wheelchair; however, his ability to use was not attempted due to his medical condition or safety concerns.</p> <p>Record review of Resident #1's Care Plan, accessed 11/07/2024, indicated the following focuses:</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - The resident has had an actual fall with no injury r/t Poor Balance, Unsteady gait, initiated on 05/24/2023 and revised on 09/18/2023. Interventions/Tasks for the focus included: - 1:1 inservice [sic] with cna [sic] and nurse on fall mat for resident, initiated and created 11/02/2024, and - fall mat, initiated and created on 09/18/2023. - The resident is at risk for falls r/t Deconditioning, Gait/balance problems, Incontinence, Psychoactive drug use, initiated on 10/27/2023 and revised on 10/27/2023. Interventions/Tasks for the focus included: - Follow facility fall protocol., initiated and created 10/27/2023, and - The resident needs a safe environment with: (even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; personal items within reach), initiated, created, and revised 10/27/2023. <p>Record review of Resident #1 Progress Note, dated 11/01/2024 at 10:39 p.m. by LPN B, revealed Note Text: went into room to check on resident. resident lying on floor on left side with legs crossed no internal or external rotation of lower extremities no active bleeding asked resident what happened resident stated I was trying to get in the car and fell to floor .sending to ER due to resident complaint of left side hurting . [sic].</p> <p>Record review of Resident #1 Progress Note, dated 11/02/2024 at 04:49 a.m. by LPN B, revealed [hospital A] called [hospital A staff member name] stated impacted left femoral neck hip fracture [a fracture due to high-impact force in the neck of the left femur] notified DON and administrator of call from hospital called [facility's contracted physician group] talked with [name of nurse working with facility's contracted physician group] of new diagnosis impacted left femoral hip fracture and [hospital A] is moving resident to another hospital for ortho [orthopedics; branch of medicine concerned with the correction of injuries of the skeleton and associated structures].</p> <p>Record review of Resident #1 hospital documentation from Hospital A, dated 11/04/2024 revealed a diagnostic report on a CT scan of Resident #1's left hip without contrast. The report, dated 11/02/2024, revealed FINDINGS: Impacted left femoral neck fracture .IMPRESSION: 1. Impacted left femoral neck fracture.</p> <p>Record Review of TULIP (an online platform for long term care licensing and credentialing) on 11/06/2024 for the facility did not indicate a self-report was submitted to report the serious bodily injury of Resident #1.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with CNA C on 11/07/2024 at 05:47 a.m., CNA C stated Resident #1's fall occurred close to 10:00 p.m. She stated that on the night of Resident #1's fall (11/01/2024), it was the first time she had seen Resident #1 that confused. She stated, every time I passed [his room], he was talking to someone that he said was sitting in the chair [chair in his room]. CNA C stated staff repeatedly tried to redirect Resident #1 and explain that he was the only person in his room. She reported that she was the third staff member to respond after Resident #1 had fallen, and when staff asked him why he had gotten out of bed, he would reply that he was getting in his car to leave. CNA C stated that when EMS [Emergency Services personnel] had arrived, Resident #1 was asked where he was, and he replied that he was on the third floor of [local hospital].</p> <p>During an interview with LPN B on 11/07/2024 at 02:38 p.m., LPN B stated she reported Resident #1's fall to the DON, the administrator, and a physician for [facility's contracted physician group]. LPN B stated Resident #1 was his own resident representative, but she also notified the next contact on his face sheet of his transfer to the hospital.</p> <p>During an interview with the DON on 11/07/2024 at 04:52 p.m., the DON stated LPN B called and let her know Resident #1 had fallen around 09:48 p.m. on 11/01/2024. She then stated that LPN B left her a voice message at around 04:00 a.m. about Resident #1's diagnosed fracture. The DON stated at around 08:00 a. m. on 11/02/2024 she notified the Reg Admin that Resident #1 had a fracture. The DON revealed she was not aware if Resident #1's injury had been reported to the state and does not know why it was not reported. The DON stated the Reg Admin would have been responsible for reporting the incident. She stated that the facility administrator was typically responsible for reporting incidents to the state, but because the administrator was out on leave, she was letting the regional team know of any incidents.</p> <p>During an interview with Resident #1's family member on 11/07/2024 at 06:22 p.m., the family member revealed Resident #1 was currently intubated at a local hospital following a partial hip replacement that occurred on the morning of 11/07/2024. The family member indicated Resident #1 was not available for interview or visitation at that time.</p> <p>During an interview with the DON on 11/08/2024 at 11:00 a.m., the DON stated she did not do a self-report to HHSC (Health and Human Services Commission) because she did not know how. She stated she sent the report to her Reg Admin, who is covering for the current administrator.</p> <p>The facility administrator was on leave and unavailable for interview.</p> <p>During an interview with the Reg Admin on 11/08/2024 at 02:55 p.m., the Reg Admin stated she did not do a self-report because we knew what happened to the resident. He was able to tell us what happened and did not change his story. She further revealed that she had read the guidelines for falls and accidents and determined Resident #1's fall on 11/01/2024 was not a reportable incident.</p> <p>Record review of facility policy Policy for Resident Incident and Visitor Accident Report, dated as last revised 07/23/2018 and last reviewed 06 2024, revealed Incidents/Accidents of Unknown Origin will be reported in accordance with state and federal regulations.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of facility policy Abuse Prohibition Policy, dated as last reviewed 01/01/2024, revealed POLICY: . 2. The facility will conduct an investigation of alleged or suspected abuse, neglect, or misappropriation of property, and will provide notification of information to the proper authorities according to state and federal regulations. and under Reporting/Response: . 2.The Abuse Coordinator will report all allegations of abuse, neglect with serious bodily injury, mistreatment with serious bodily injury, exploitation with serious bodily injury, and injuries of unknown source with serious bodily injury immediately or within two hours of the allegation. The Abuse Coordinator will report all other allegations of neglect, mistreatment, exploitation, injuries of unknown source and misappropriation within 24 hours of the allegation.</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>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** 46447</p> <p>Based on observation, interview, and record review the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents for 1 (Resident #1) of 6 residents reviewed for accidents and supervision, in that:</p> <p>The facility failed to provide adequate supervision and assistive devices to prevent accidents when Resident #1 was confused and required assistance to ambulate. A fall mat was not in place and the bed was not in a low position, and Resident #1 fell out of bed and sustained a left femoral neck hip fracture.</p> <p>An IJ was identified on 11/26/2024. The IJ template was provided to the facility on [DATE] at 4:50 PM. While the IJ was removed on 11/27/2024, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm because the facility needed to monitor the implementation of the plan of removal.</p> <p>These failures placed the resident at risk for accidents and serious injuries.</p> <p>Findings included:</p> <p>Record review of Resident #1's Admission Record, dated 11/07/2024, indicated Resident #1 was initially admitted on [DATE] and readmitted on [DATE]. He was a [AGE] year-old male. He was noted to have discharged on [DATE] to an acute care hospital, Hospital A. His diagnoses included: altered mental status, delirium (a change in mental abilities that results in confused thinking and a lack of awareness of someone's surroundings) due to known physiological condition, unspecified lack of coordination, age-related osteoporosis (brittle and fragile bones), and spina bifida (a birth defect that occurs when the spine and spinal cord do not form properly).</p> <p>Record review of Resident #1's Quarterly MDS assessment, dated 10/07/2024, indicated Resident #1 had a BIMS score of 04 indicating he was severely cognitively impaired. Resident #1 required substantial/maximal assistance with rolling left or right from lying on his back in bed and was dependent on staff assistance for chair/bed-to-chair transfers. He used a wheelchair; however, his ability to use was not attempted due to his medical condition or safety concerns.</p> <p>Record review of Resident #1's Care Plan, accessed 11/07/2024, indicated the following focuses:</p> <ul style="list-style-type: none"> - The resident has had an actual fall with no injury r/t Poor Balance, Unsteady gait, initiated on 05/24/2023 and revised on 09/18/2023. Interventions/Tasks for the focus included: - 1:1 inservice [sic] with cna [sic] and nurse on fall mat for resident, initiated and created 11/02/2024, and - fall mat, initiated and created on 09/18/2023. <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 with LPN B on 11/07/2024 at 02:38 p.m., LPN B stated she initially found Resident #1 on 11/01/2024 after his fall. LPN B stated Resident #1 said he was trying to get into the car and lost his footing. LPN B stated when she went into Resident #1's room after his fall, she observed that Resident #1 had moved his bedside table away from his bed. LPN B stated she didn't know if there was a fall mat in Resident #1's room but had observed that Resident #1 had not fallen onto a fall mat. LPN B stated she was unable to say if the fall mat had also been moved by Resident #1 because she was focused on providing care for Resident #1. LPN B stated staff would put Resident #1's bed in the low position; however, he would use his own bed controls and raise the bed back up. LPN B stated Resident #1 had been provided education about his safety, but he preferred to exercise his right to control his bed height.</p> <p>During an interview with the DON on 11/07/2024 at 04:52 p.m., the DON stated LPN B called and let her know Resident #1 had fallen around 09:48 p.m. on 11/01/2024. The DON stated staff did not report that they saw a fall mat in Resident #1's room, but staff had reported that Resident #1 had pushed items away from his bed prior to falling. The DON stated she was not notified that Resident #1 had fallen on a fall mat, but he was expected to have a fall mat in his room.</p> <p>During an interview with Resident #1's family member on 11/07/2024 at 06:22 p.m., the family member revealed Resident #1 was currently intubated at a local hospital following a partial hip replacement that occurred on the morning of 11/07/2024. The family member indicated Resident #1 was not available for interview or visitation at that time.</p> <p>During an interview with the DON on 11/08/2024 at 10:38 a.m., the DON stated she did a re-enactment yesterday, 11/07/2024 with LPN B and CNA C on Resident #1's fall. The DON stated CNA C told her that she had completed rounds with Resident #1 about 15 minutes prior to his fall (on 11/01/2024). The DON stated CNA C recalled that Resident #1 had his fall mat in place with his bed side table over him, as he preferred. The DON stated CNA C reported Resident #1's bed was in a lower position, but Resident #1 moved it back in a higher position himself after care was provided. The DON revealed LPN B recalled going into Resident #1's room to provide a medication and remembered almost tripping over Resident #1's fall mat. LPN B had believed that the fall mat must have moved when Resident #1 had pushed his bedside table away from his bed. LPN B revealed that this occurred at the same time as her finding Resident #1 on the floor and had immediately started providing emergency care.</p> <p>During an interview with CNA C on 11/08/2024 at 01:54 p.m., CNA C revealed she provided Resident #1 care prior to his fall on 11/01/2024. She stated she provided care, lowered his bed, and placed the bedside table and fall mat in place. CNA C revealed that as she was leaving Resident #1's room, he was raising his bed back up. CNA C stated she turned to him and reminded him of safety, to lower it, but said that he replied, I know but I want it up. CNA C stated Resident #1's bedside table and fall mat were in place when she left his room, but fifteen (15) minutes later the nurse found him on the floor and at that time, the bedside table and mat had been moved.</p> <p>Record review of facility policy Fall Prevention Program, dated as last reviewed 06/10/2024, revealed Policy: . specific interventions will be implemented to minimize falls, avoid repeat falls and minimize falls resulting in significant injury.</p> <p>Definition:</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>A fall can be defined as: when a resident is found on the floor; a resident slides to the floor unassisted; a resident rolls off the bed/chair onto the floor, including bedside mat; and a resident falls off any apparatus/equipment used for transfers.</p> <p>A. Procedure</p> <p>.2. Residents identified as being at risk will have interventions identified in their plan of care to minimize falls.</p> <p>3. The following is a list of commonly used interventions that may be considered to minimize falls and injury.</p> <p>.c. Bed maintained in low position with bedside mat</p> <p>.f. Resident teaching regarding safety</p> <p>.4. The resident's plan of care will be updated to reflect risk for falls, and appropriate interventions .</p> <p>An Immediate Jeopardy was identified on 11/26/2024. The Facility Corporate RN and DON were notified of the Immediate Jeopardy on 11/26/2024 at 4:45 PM and were given a copy of the IJ template and a Plan of Removal (POR) was requested.</p> <p>The facility's Plan of Removal for the Immediate Jeopardy was accepted on 11/27/2024 at 12:04 PM and reflected the following:</p> <p>{Facility}</p> <p>Immediate Jeopardy Plan of Removal 11/26/2024</p> <p>Quality of Care- F689</p> <p>DON, in-serviced all nursing and CNA staff on fall prevention protocols, including the proper use and placement of fall mats, maintaining beds in low positions, where and how to check off in POC task that fall interventions were in place, and what to do if residents start having behaviors such as removing fall mats, increased agitation etc. on 11/26/2024 and completed on 11/27/2024.</p> <p>Competency was tested on Fall prevention protocols via quizzes conducted on 11/26/2024 and completed on 11/27/2024.</p> <p>DON/designee will ensure staff will not be able to work the floor until education is provided and competency tested . Staff will not be able to clock in until training is completed.</p> <p>Once resident is identified by staff of exhibiting behaviors, staff will ensure that resident is safe while immediately notifying DON/Designee to ensure fall prevention measures are updated/changed as needed. Concerns brought forward will be addressed immediately. This is included in education completed on 11/27/2024.</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>All training material will be incorporated into new hire orientation by DON on 11/26/2024.</p> <p>Medical Director was notified by DON, 11/26/2024 regarding the Immediate Jeopardy involving Free of Accidents, Hazards, and Supervision.</p> <p>An audit of point of care tasks and care plans was completed by RN, Corporate Clinical Specialist, and DON on 11/26/2024, to ensure fall mitigation techniques were in place.</p> <p>The Director of Nursing/ Designee will perform random observations of fall risk residents 3 times weekly for 90 days and weekly thereafter to ensure proper interventions in place. DON/designee will monitor completion of POC task list 3 times a week for 90 days and weekly thereafter to ensure documentation is compliant.</p> <p>The facility QA Committee will meet weekly for the next 12 weeks to review compliance. If no further concerns are noted, will continue to monitor as per routine facility QA Committee. The facility administrator will be responsible for ensuring that meetings occur weekly.</p> <p>The facility's POR Verification began on 11/27/2024 and was as follows:</p> <p>Interview on 11/27/2024 at 12:10 pm, facility DON stated she notified the facility Medical Director of the IJ on 11/27/2024.</p> <p>Interview on 11/27/2024 at 12:11 pm, facility DON stated she had in-serviced the ADONs and RN, Corporate Clinical Specialist, who assisted with in service training of all the facility nursing staff on fall prevention protocols, including the proper use and placement of fall mats, maintaining beds in low positions, where and how to check off in POC task that fall interventions were in place, and what to do if residents start having behaviors such as removing fall mats, increased agitation etc. on 11/26/2024 and completed on 11/27/2024.</p> <p>During an observation on 11/27/2024 at 9:20 am revealed 17/17 residents i(including Resident #1)(including Resident #1 identified as fall risk, in facility, with fall mats in place.</p> <p>Record review on 11/27/2024 of 17/17 residents (including Resident #1)EMRreflected care plan, POC and TAR have documentation of falls and fall interventions to include fall mats. TAR has nurse sign off to be done on 6a-6p shift and 6p-6a shift each day to indicate fall mat in place.</p> <p>1. During an interview on 11/27/2024 at 11:23 am RN A stated she works 6a-6p shift and had received in service training on fall prevention protocols, including the proper use and placement of fall mats, maintaining beds in low positions, where and how to check off in POC task that fall interventions were in place, and what to do if residents start having behaviors such as removing fall mats, increased agitation etc. on 11/26/2024.</p> <p>2. During an interview on 11/27/2024 at 11:24 am LVN CC stated she works 6a-6pm and received in service training on fall prevention protocols, including the proper use and placement of fall mats, maintaining beds in low positions, where and how to check off in POC task that fall interventions were in place, and what to do if residents start having behaviors such as removing fall mats, increased agitation etc. on 11/26/2024.</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>3. During an interview on 11/27/2024 at 11:25 am CNA DD stated she works 6a-6p and received in service training on fall prevention protocols, including the proper use and placement of fall mats, maintaining beds in low positions, where and how to check off in POC task that fall interventions were in place, and what to do if residents start having behaviors such as removing fall mats, increased agitation etc. on 11/26/2024.</p> <p>4. During an interview on 11/27/2024 at 11:26 am CNA D stated she works 6a-6p and received in service training on fall prevention protocols, including the proper use and placement of fall mats, maintaining beds in low positions, where and how to check off in POC task that fall interventions were in place, and what to do if residents start having behaviors such as removing fall mats, increased agitation etc. on 11/26/2024.</p> <p>5. During an interview on 11/27/2024 at 11:27 am CNA E stated she works 6a-6p and received in service training on fall prevention protocols, including the proper use and placement of fall mats, maintaining beds in low positions, where and how to check off in POC task that fall interventions were in place, and what to do if residents start having behaviors such as removing fall mats, increased agitation etc. on 11/26/2024.</p> <p>6. During an interview on 11/27/2024 at 11:28 am CNA F stated she works 6a-6p and received in service training on fall prevention protocols, including the proper use and placement of fall mats, maintaining beds in low positions, where and how to check off in POC task that fall interventions were in place, and what to do if residents start having behaviors such as removing fall mats, increased agitation etc. on 11/26/2024.</p> <p>7. During an interview on 11/27/2024 at 11:42 am Medication aide G stated she works 6a-6p and received in service training on fall prevention protocols, including the proper use and placement of fall mats, maintaining beds in low positions, where and how to check off in POC task that fall interventions were in place, and what to do if residents start having behaviors such as removing fall mats, increased agitation etc. on 11/26/2024.</p> <p>8. During a telephone interview on 11/27/2024 at 12:54 pm LVN H stated she works 6a-6pm and received in service training on fall prevention protocols, including the proper use and placement of fall mats, maintaining beds in low positions, where and how to check off in POC task that fall interventions were in place, and what to do if residents start having behaviors such as removing fall mats, increased agitation etc. on 11/26/2024.</p> <p>9. During a telephone interview on 11/27/2024 at 11:54 am LVN B stated she works 6pm-6am and received in service training on fall prevention protocols, including the proper use and placement of fall mats, maintaining beds in low positions, where and how to check off in POC task that fall interventions were in place, and what to do if residents start having behaviors such as removing fall mats, increased agitation etc. on 11/26/2024.</p> <p>10. During a telephone interview on 11/27/2024 at 12:32 pm CNA I stated she works 6a-6p and received in service training on fall prevention protocols, including the proper use and placement of fall mats, maintaining beds in low positions, where and how to check off in POC task that fall interventions were in place, and what to do if residents start having behaviors such as removing fall mats, increased agitation etc. on 11/26/2024.</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>11. During an interview on 11/27/2024 at 1:52 pm CNA J stated she works 6a-6p and received in service training on fall prevention protocols, including the proper use and placement of fall mats, maintaining beds in low positions, where and how to check off in POC task that fall interventions were in place, and what to do if residents start having behaviors such as removing fall mats, increased agitation etc. on 11/26/2024.</p> <p>12. During a telephone interview on 11/27/2024 at 1:00 pm MA K stated she works 6a-6pm and received in service training on fall prevention protocols, including the proper use and placement of fall mats, maintaining beds in low positions, where and how to check off in POC task that fall interventions were in place, and what to do if residents start having behaviors such as removing fall mats, increased agitation etc. on 11/26/2024.</p> <p>13. During a telephone interview on 11/27/2024 at 12:45 pm LVN L stated she works 6a-6p and received in service training on fall prevention protocols, including the proper use and placement of fall mats, maintaining beds in low positions, where and how to check off in POC task that fall interventions were in place, and what to do if residents start having behaviors such as removing fall mats, increased agitation etc. on 11/26/2024.</p> <p>14. During a telephone interview on 11/27/2024 at 2:00 pm CNA M stated she works 6a-6pm and received in service training on fall prevention protocols, including the proper use and placement of fall mats, maintaining beds in low positions, where and how to check off in POC task that fall interventions were in place, and what to do if residents start having behaviors such as removing fall mats, increased agitation etc. on 11/26/2024.</p> <p>15. During a telephone interview on 11/27/2024 at 12:54pm CNA N stated he works 6p-6am and received in service training on fall prevention protocols, including the proper use and placement of fall mats, maintaining beds in low positions, where and how to check off in POC task that fall interventions were in place, and what to do if residents start having behaviors such as removing fall mats, increased agitation etc. on 11/26/2024.</p> <p>16. During a telephone interview on 11/27/2024 at 12:29 pm CNA O stated she works 6p-6am and received in service training on fall prevention protocols, including the proper use and placement of fall mats, maintaining beds in low positions, where and how to check off in POC task that fall interventions were in place, and what to do if residents start having behaviors such as removing fall mats, increased agitation etc. on 11/26/2024.</p> <p>17. During a telephone interview on 11/27/2024 at 12:31 pm CNA P stated she works 6p-6am and received in service training on fall prevention protocols, including the proper use and placement of fall mats, maintaining beds in low positions, where and how to check off in POC task that fall interventions were in place, and what to do if residents start having behaviors such as removing fall mats, increased agitation etc. on 11/26/2024.</p> <p>18. During a telephone interview on 11/27/2024 at 12:46 pm RN Q stated she works 6a-6pm and received in service training on fall prevention protocols, including the proper use and placement of fall mats, maintaining beds in low positions, where and how to check off in POC task that fall interventions were in place, and what to do if residents start having behaviors such as removing fall mats, increased agitation etc. on 11/26/2024.</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>19. During a telephone interview on 11/27/2024 at 12:17 pm CNA R stated she works 6p-6am and received in service training on fall prevention protocols, including the proper use and placement of fall mats, maintaining beds in low positions, where and how to check off in POC task that fall interventions were in place, and what to do if residents start having behaviors such as removing fall mats, increased agitation etc. on 11/26/2024.</p> <p>20. During a telephone interview on 11/27/2024 at 12:50 pm CNA S stated she works 6p-6am received in service training on fall prevention protocols, including the proper use and placement of fall mats, maintaining beds in low positions, where and how to check off in POC task that fall interventions were in place, and what to do if residents start having behaviors such as removing fall mats, increased agitation etc. on 11/26/2024.</p> <p>21. During a telephone interview on 11/27/2024 at 1:00 pm CNA T stated he works 6p-6am and received in service training on fall prevention protocols, including the proper use and placement of fall mats, maintaining beds in low positions, where and how to check off in POC task that fall interventions were in place, and what to do if residents start having behaviors such as removing fall mats, increased agitation etc. on 11/26/2024.</p> <p>22. During a telephone interview on 11/27/2024 at 1:02 pm CNA U stated she works 6am-6pm and received in service training on fall prevention protocols, including the proper use and placement of fall mats, maintaining beds in low positions, where and how to check off in POC task that fall interventions were in place, and what to do if residents start having behaviors such as removing fall mats, increased agitation etc. on 11/26/2024.</p> <p>23. During a telephone interview on 11/27/2024 at 2:30 pm LVN V stated she works 6am-6pm and received in service training on fall prevention protocols, including the proper use and placement of fall mats, maintaining beds in low positions, where and how to check off in POC task that fall interventions were in place, and what to do if residents start having behaviors such as removing fall mats, increased agitation etc. on 11/26/2024.</p> <p>24. During a telephone interview on 11/27/2024 at 2:35 pm LVN W stated she works 6am-6pm and received in service training on fall prevention protocols, including the proper use and placement of fall mats, maintaining beds in low positions, where and how to check off in POC task that fall interventions were in place, and what to do if residents start having behaviors such as removing fall mats, increased agitation etc. on 11/26/2024.</p> <p>25. During a telephone interview on 11/27/2024 at 3:00 pm LVN X stated she works 6am-6pm and received in service training on fall prevention protocols, including the proper use and placement of fall mats, maintaining beds in low positions, where and how to check off in POC task that fall interventions were in place, and what to do if residents start having behaviors such as removing fall mats, increased agitation etc. on 11/26/2024.</p> <p>26. During a telephone interview on 11/27/2024 at 2:55 pm LVN Y stated she works 6am-6pm and received in service training on fall prevention protocols, including the proper use and placement of fall mats, maintaining beds in low positions, where and how to check off in POC task that fall interventions were in place, and what to do if residents start having behaviors such as removing fall mats, increased agitation etc. on 11/26/2024.</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>27. During a telephone interview on 11/27/2024 at 3:36pm LVN Z stated she works 6pm-6am and received in service training on fall prevention protocols, including the proper use and placement of fall mats, maintaining beds in low positions, where and how to check off in POC task that fall interventions were in place, and what to do if residents start having behaviors such as removing fall mats, increased agitation etc. on 11/26/2024.</p> <p>28. During a telephone interview on 11/27/2024 at 3:40pm LVN AA stated she works 6pm-6am and received in service training on fall prevention protocols, including the proper use and placement of fall mats, maintaining beds in low positions, where and how to check off in POC task that fall interventions were in place, and what to do if residents start having behaviors such as removing fall mats, increased agitation etc. on 11/26/2024.</p> <p>29. During a telephone interview on 11/27/2024 at 3:44pm CNA BB stated she works 6am-6pm and received in service training on fall prevention protocols, including the proper use and placement of fall mats, maintaining beds in low positions, where and how to check off in POC task that fall interventions were in place, and what to do if residents start having behaviors such as removing fall mats, increased agitation etc. on 11/26/2024.</p> <p>Record review on 11/27/2024 of Inservice conducted on 11/26/2024 by DON; 51of 51 in-serviced all nursing and CNA staff on fall prevention protocols, including the proper use and placement of fall mats, maintaining beds in low positions, where and how to check off in POC task that fall interventions were in place, and what to do if residents start having behaviors such as removing fall mats, increased agitation etc. on 11/26/2024 and completed on 11/27/2024.</p> <p>o Competency was tested on Fall prevention protocols via quizzes conducted on 11/26/2024 and completed on 11/27/2024 .</p> <p>Record review on 11/27/2024 of 51 of 51 nursing employees signed testing.all nursing and CNA staff on fall prevention protocols, including the proper use and placement of fall mats, maintaining beds in low positions, where and how to check off in POC task that fall interventions were in place, and what to do if residents start having behaviors such as removing fall mats, increased agitation etc. on 11/26/2024 and completed on 11/27/2024.</p> <p>o DON/designee will ensure staff will not be able to work the floor until education is provided and competency tested . Staff will not be able to clock in until training is completed.</p> <p>Interview on 11/27/2024 at 12:55 pm DON stated the DON/designee will ensure staff will not be able to work the floor until education is provided and competency tested . Staff will not be able to clock in until training is completed.</p> <p>o Once resident is identified by staff of exhibiting behaviors, staff will ensure that resident is safe while immediately notifying DON/Designee to ensure fall prevention measures are updated/changed as needed. Concerns brought forward will be addressed immediately. This is included in education completed on 11/27/2024.</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>Interview on 11/27/2024 at 12:55 pm DON stated once resident is identified by staff of exhibiting behaviors, staff will ensure that resident is safe while immediately notifying DON/Designee to ensure fall prevention measures are updated/changed as needed. Concerns brought forward will be addressed immediately. This is included in education completed on 11/27/2024.</p> <p>o All training material will be incorporated into new hire orientation by DON on 11/26/2024.</p> <p>Interview on 11/27/2024 at 12:55 pm DON stated All training material will be incorporated into new hire orientation by herself DON on 11/26/2024.</p> <p>o Medical Director was notified by, DON, 11/26/2024 regarding the Immediate Jeopardy involving Free of Accidents, Hazards, and Supervision.</p> <p>Record review of statement by DON that Medical Director was notified on 11/26/2024 regarding the Immediate Jeopardy involving Free of Accidents, Hazards, and Supervision.</p> <p>During an interview on 11/27/2024 at 2:45 pm Medical Director voiced that he had been briefed on the IJ and that he would be participating in QAPI as planned.</p> <p>o An audit of point of care tasks and care plans was completed by RN Corporate Clinical Specialist, and DON on 11/26/2024, to ensure fall mitigation techniques were in place.</p> <p>Record review done on 11/27/2024 by investigator of audit of point of care tasks and care plans which was completed by RN, Corporate Clinical Specialist, and DON on 11/26/2024, to ensure fall mitigation techniques were in place. Record review of audit. 100% complete.</p> <p>Interview on 11/27/2024 at 12:55 pm with DON and RN, Corporate Clinical Specialist, of audit of point of care tasks and care plans which was completed by Corporate Clinical Specialist, and DON on 11/26/2024, to ensure fall mitigation techniques were in place. They both voiced the audit was 100% accurate with point of care tasks and care plans updated for residents with fall interventions such as fall mats.</p> <p>o The Director of Nursing/ Designee will perform random observations of fall risk residents 3 times weekly for 90 days and weekly thereafter to ensure proper interventions in place. DON/designee will monitor completion of POC task list 3 times a week for 90 days and weekly thereafter to ensure documentation is compliant.</p> <p>Interview on 11/27/2024 at 12:55 pm DON stated she -the Director of Nursing/ Designee will perform random observations of fall risk residents 3 times weekly for 90 days and weekly thereafter to ensure proper interventions in place. DON/designee will monitor completion of POC task list 3 times a week for 90 days and weekly thereafter to ensure documentation is compliant.</p> <p>o The facility QA Committee will meet weekly for the next 12 weeks to review compliance. If no further concerns are noted, will continue to monitor as per routine facility QA Committee. The facility administrator will be responsible for ensuring that meetings occur weekly.</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>Interview on 11/27/2024 at 12:55 pm DON stated the facility QA Committee will meet weekly for the next 12 weeks to review compliance. If no further concerns are noted, will continue to monitor as per routine facility QA Committee. The facility administrator will be responsible for ensuring that meetings occur weekly.</p> <p>On 11/27/2024 at 4:42 PM the DON and RN Corporate Clinical Specialist were notified the IJ was removed. While the IJ was removed on 11/27/2024 at 4:42 PM, the facility remained out of compliance at a scope of isolated and a severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy because of the facility's need to monitor the implementation of the plan of removal.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>46447</p> <p>Post nurse staffing information every day.</p> <p>Based on observation, interview, and record review, the facility failed to post daily information that included the facility name, current date, total number and actual hours worked by registered nurses, licensed practical or licensed vocational nurses, certified nurse aides directly responsible for resident care per shift and the resident census for 2 days (11/05/2024 and 11/06/2024) of 3 days reviewed.</p> <p>The facility did not post the required current nurse staffing information for 11/05/2024 and 11/06/2024.</p> <p>This failure could place all residents, their families, and facility visitors at risk of not having access to information regarding staffing data and the facility census.</p> <p>Findings included:</p> <p>During an observation on 11/06/2024 at 04:25 p.m., a document labeled Daily Nurse Staffing Report dated 11/04/2024, was posted in a plastic sheet protector and taped next to the nurses' station and at the entry to the resident 200-hall.</p> <p>During an observation and interview on 11/06/2024 at 04:40 p.m., the DON stated the night nursing shift was typically responsible for posting the daily census and nurse staffing document. The DON was observed removing the document dated 11/04/2024 and stated, let me see if I can find it [referring to the current, 11/06/2024 posting]. The DON was observed searching through two binders and stated she did not find the current document and that she was going to ask the ADON. The DON confirmed the posted document was dated 11/04/2024 and revealed she did not know why the posting for 11/05/2024 or the current day's posting was posted. The DON revealed she did not see any harm for the posting not being updated because the facility reviewed staffing regularly and the resident families were familiar with the facility staffing schedule.</p> <p>During an observation and interview with the ADON on 11/07/2024 at 09:02 a.m., the ADON was observed to bring in the Daily Nurse Staffing Reports dated 11/05/2024 and 11/06/2024. The ADON stated the documents were in her schedule book because she was putting in the scheduled hours. The ADON stated the Daily Nurse Staffing Report was not posted on 11/06/2024 because it was in her schedule book. The ADON did not state why the Daily Nurse Staffing Reports were not posted for 11/05/2024 or 11/06/2024.</p> <p>Record review of facility policy, Posting Direct Care Daily Staffing Numbers, dated reviewed 3-2023, revealed Our facility will post on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. Policy Interpretation and Implementation 1. Within two (2) hours of the beginning of each shift, the number of licensed nurses (RNs, LPNs, LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format .7. The previous shift's forms shall be maintained with the current shift form for a total of 24 hours of staffing information in a single location. Once a form is removed, it shall be forwarded to the director of nursing services' office and filed as a permanent record.</p>		