

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676137	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2024
NAME OF PROVIDER OR SUPPLIER Legend Oaks Healthcare and Rehabilitation Center -		STREET ADDRESS, CITY, STATE, ZIP CODE 8902 West Rd Houston, TX 77064	

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 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47531</p> <p>Based on observation , interview and record review the facility failed to develop and implement a comprehensive care plan to meet the highest practicable physical, mental, and psychosocial wellbeing for 1 (Resident #1) of 5 residents reviewed for care plans.</p> <p>1. The facility failed to develop and implement a Care Plan for Resident #1's fall out of bed on 12/13/2023 and as a result, Resident #1 suffered a second fall out of bed on 4/1/2024. Resident #1 was hospitalized with a fractured hip from 12/13/2023 to 12/28/2023. Resident #1 was hospitalized from 4/1/2024 to 4/11/2024 due to second fall on 4/1/2024.</p> <p>An IJ was identified on 4/18/2024. The IJ template was provided to the facility on [DATE] at 5:23pm. The immediate jeopardy was determined to have been removed on 4/20/2024 due to the facilities implemented actions that corrected the non-compliance.</p> <p>This failure could place residents at risk for not receiving care required to meet their individualized needs and place them at risk for harm.</p> <p>Findings:</p> <p>Record review of Resident #1's Face Sheet dated 4/18/2024 revealed a [AGE] year old female who was admitted on [DATE] with diagnoses of encounter for closed fracture with routine healing (Hip fracture), Type 2 Diabetes Mellitus (High blood sugar) with Unspecified Complications(Insulin), Unspecified Fall, Subsequent Encounter (Receiving routine care), Muscle Wasting and Atrophy (Weakened Muscles), Unspecified Site, Muscle Weakness, Pain, Unspecified, Encounter for Other Orthopedic Aftercare (Care and treatment with a bone specialist), Acquired Absence of Right Leg Below the Knee (Amputation), Paranoid Personality Disorder (Distrust and suspicion), Vascular Dementia (Brain damage caused by strokes), Unspecified Severity, With Agitation, Schizoaffective Disorder (Mood disorder), Bipolar Type.</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 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record Review of Resident #1's MDS dated [DATE] revealed Resident #1 had a BIMS score of 15 indicating the resident was cognitively intact. Section E revealed, no potential indicators of psychosis (Hallucinations) . Section GG revealed Resident #1 was dependent on toileting hygiene, showering/bathing, and lower body dressing. Section GG also revealed Resident #1 was, Substantial/maximal assistance with roll to the left and right. Section H revealed resident was, always incontinent of urine and bowel. Section I revealed Resident #1 had, Medically Complex Conditions, Hip Fracture, Cerebrovascular Accident (Stroke), and Non-Alzheimer's Dementia (Memory loss).</p> <p>Record Review of Resident #1's Care Plan dated 8/6/2023 read in part . Will safely perform her ADLs through the review date .date initiated 8/6/2023 .Bed Mobility: Requires staff participation to reposition and turn in bed date initiated 8/10/2023. Resident #1 at risk for falls related to right below the knee amputation, incontinence, limited mobility, confusion, late effects of CVA (Stroke) date initiated 8/6/2023 .Revision 12/14/2023 .Will not sustain serious injury through the review date .date initiated 8/6/2023 bed in lowest position .date initiated 8/6/2023.</p> <p>Record Review of Resident #1's orders dated 4/18/2024 revealed there were no orders for fall preventions or interventions for fall prevention</p> <p>Record Review of Resident #1's Change in Condition dated 12/13/2023 at 3:19pm read in part .situation Falls .Back, injuries, complaints abrupt onset of severe pain secondary to fall or injury or pain with new abnormal neurological signs .site .left trochanter hip (Bony prominence) laboratory tests/diagnostic procedures x-ray .Resident #1 states she fell with CNA during bed bath.</p> <p>Record Review of Resident #1's X-Ray dated 12/13/2023 Read in part, Impression .A fracture of the left femur (Hip) neck. The age of the fracture is indeterminate.</p> <p>Record review of Nursing note dated 12/14/2023 9:13am read in part .Resident #1 to be sent out to ER (emergency room) .</p> <p>Record Review of Resident #1's hospital notes dated 2/14/2024 read in part . female with a past medical history of CVA(Cerebrovascular disease) .claims the CNA was with her while cleaning her and she did not have a good grip of the rail before moving and she rolled out of bed and fell impacting her left leg and complained of severe left leg pain 1. Acute left femoral fracture consult orthopedics .Cardiology has cleared the patient for surgery with moderate risk patient is status post segmental resection arthroplasty of left femoral neck Consult social services for possible APS (Adult Protective Services) evaluation since patient claims that the CNA was impatient with her during her bed sponge which was responsible for her fall the patient was oriented to place person and time during history taking.</p> <p>Record Review of Hospital #3 Physical Therapy initial evaluation and discharge read in part .non weight bearing left lower extremity .Hoyer lift to chair .Resident #11 with chronic decreased motor control overall . coordination impaired right and left .BED MOBILITY: Rolling: Total Assistance (<25%), Needs 2.</p> <p>Record Review of hospital discharge summary dated 1/1/2024 revealed in part .Discharge diagnoses: Closed fracture of left hip .Procedure: Left Hip [NAME] Resection (Remove head and neck of thigh bone) CT Pelvis(Cat Scan)s .Impression: Complex left proximal femoral age indeterminate sub capital fracture and acute appearing distal neck fracture(Fractured hip).</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview in 4/18/2024 at 9:08am ADON A said she had worked at the facility for a year and a half. She said she did most of the in-services. She said Resident #1 should have been deemed a 2 person assist after the first fall because it's an intervention. No other interventions were put in place. The staff can access the Kardex (Care Plan for CNA) and it was in their POC (Point of Care) documentation, and they get report, the nurse was supposed to provide the information to them. I'm not sure when it's in the POC if it populates in the Kardex. I believe Resident #1 should be 2 persons assist. She said the Kardex pulls from the Care Plan. The Kardex was the documentation system for the CNAs and the Care plan too. Staff should have known by Kardex and nursing staff how to provide care for the residents. She said the Kardex pulls from the Care Plan. The Kardex was the documentation system for the CNAs and the Care plan too.</p> <p>Interview on 4/19/24 at 10:22am the DON said the interventions from the IDT (Interdisciplinary Team) meeting they had after Resident #1's first fall were not all put into place for the resident and while receiving bed bath resident rolled off the bed a second time. She said Resident #1 was sent to the hospital and once she returned from hospital there were supposed to be interventions for fall mats placed/wider bed/2 person assist with care, education done with CNA and all staff, falling star identifier. She said Resident #1's second fall happened on 4/1/2024 and the resident was gone for a while, there was a delay and so when Resident #1 was readmitted the interventions didn't all get put in place for the resident. The fall mats, the education for the staff, the falling star identifier, the wider bed and the 2 person staff assist with care and updating the care plan were not put in to place. She said they got missed got missed because Resident #1 was delayed returning to the facility after the second fall. She said Resident #1's family had been looking to send her to another facility.</p> <p>Record review of Resident #1's Care plan dated 8/6/2023 revealed no updated interventions in place to prevent falls.</p> <p>Record review of facilities policy titled: Fall Management System, 12/2023 read in part . It is the policy of the facility to provide an environment that remains free of accident hazards as possible. It is also the policy of the facility of the facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs . 6. The residents care plan will be updated.</p> <p>Record review of facilities policy titled, Care Plans-Comprehensive 2001 read in part .An individualized comprehensive care plan that includes measurable objectives and timetables to meet the residents medical, nursing, mental and psychological needs is developed for each resident Incorporate risk factors associated with identified problems .assessments of residents are ongoing and care plans are revised as information about the resident and the residents condition change .the care planning/interdisciplinary team is responsible for the review and updating of care plans .when there has been a significant change in the residents condition .</p> <p>An IJ was identified on 4/18/2024 and the facility administrator was notified at 5:23pm. The IJ template was provided to the facility on [DATE] at 5:23pm.</p> <p>On 4/20/2024 at 2:16pm the following Plan of Removal was accepted.</p> <p>Facility Plan for Compliance</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>ADHOC meeting sign in sheet in book with Medical Director in attendance. Meeting held on 4/18/2024.</p> <p>Executive Director, DON, Clinical Cluster Leader, Clinical Resources in attendance.</p> <p>Incidents by Resident including Resident #1 in IJ Book (Book containing plan of removal for Immediate Jeopardy).</p> <p>Root Cause Analysis for Resident #1 in IJ book.</p> <p>Updated Care Plan for Resident #1 in IJ Book.</p> <p>Interventions in place since arrival : Resident #1 Requires Assistance of 2 staff members to reposition, may use mobility bars to aide in Easy Turning and repositioning, Resident #1 requires assistance of 2 staff members if receiving a bed bath with mobility bars in place, Resident requires assistance of 2 staff by Hoyer lift with transfers, in IJ book.</p> <p>Fall Risk Evaluations in the POR for all residents were completed.</p> <p>Monitoring for Plan of Removal:</p> <p>In an interview on 4/20/2024 at 9:00am DON said all Care Plans were reviewed and updated as necessary for the residents identified in the Fall Risk Assessments. All persons responsible for care plan updates immediately were herself, the ADONs, Social Work and Wound Care.</p> <p>Review of in Service Training for Resident #1 dated 4/18/2024 reflected resident will have a wide bed, fall mats-bilateral, mobility bars, and two staff members for bed baths/ bed mobility.</p> <p>Review of in-service dated 4/18/2024- Topic Falls .Fall Policy .Fall risk assessment .fall risk management/incident report .Care plans updated .falling star (Emblem place by doors of Residents at risk for falls) .document q (Every)shift x72 hours.</p> <p>Record review on 4/20/2024 at 10:00am of Inservice dated 4/18/24- Topic Bed bath hand hygiene . procedure . ensure safety at all times .follow Kardex .bed height .clean up .call light within reach .do not leave resident lying on side of bed.</p> <p>Record review on 4/20/2024 at 10:00am of Inservice dated - 4/18/24-Topic Mobility, Transfers, Safety, Turning/Repositioning .Do not leave resident unattended while performing care.</p> <p>Record review on 4/20/2024 at 10:00am of Inservice dated 4/18/2024- Topic- Kardex- Clinical, POC, Select Resident. Select Kardex.</p> <p>Record review on 4/20/2024 at 10:00am of Inservice dated 4/18/2024- Topic- Bed Mobility-Levels of assist during bed mobility, independent/setup/limited/eaten/total, mobility bars, 1person/2person assist, always refer to Kardex prior to assisting resident.</p> <p>Record review on 4/20/2024 at 10:00am revealed Falls Post Test taken by all Nurses, CNA's and CMA's.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review on 4/20/2024 at 10:00am of Observations of bathing, complete bed baths of Clients by staff in IJ book.</p> <p>Record review on 4/20/2024 at 10:00am of Observations of Turning and Repositioning of a Client by staff are in the IJ book.</p> <p>Record review on 4/20/2024 at 10:00am of Incidents (Thigs happening) by Residents .Date 4/18/2024 . 1/1/2024 to 4/18/2024 in IJ book.</p> <p>Record review on 4/20/2024 at 10:00am of Fall Risk Evaluation of Residents dated 4-19-2024 in IJ book.</p> <p>Record review on 4/20/2024 at 10:00am of Resident #1's of Care Plan updates in IJ book.</p> <p>Record review on 4/20/2024 at 10:00am of POR for F689 in IJ book.</p> <p>Record review on 4/20/2024 at 10:00am of POR for F656 in IJ Book.</p> <p>Record review on 4/20/2024 at 10:00am of Quality Team Tracking form .Date 4/18/2024 in IJ Book.</p> <p>Interview on 4/19/2024 at 1:20pm with LVN S she said she had worked at the facility for four months, she said she had been in-serviced on care plans, fall prevention, bed baths and bed mobility this morning. She said she would not have left a resident on the side of the bed to perform another task when doing a bed bath. She said she would have found whether the resident was a one or two person assist for ADLs on the Care Plan or the Kardex. She said 2 people were required to assist Resident #1 for bed baths and diaper changes. She said incident reports were immediately after patient assessment. She said they accessed the care plan in Point Click Care (PCC). She said she would have checked the care plan prior to providing care to the resident.</p> <p>Interview on 4/19/2024 at 1:24pm with LVN T she said she had worked at the facility since 2/2023, she said she had been in-serviced on care plans last, fall prevention, bed baths and bed mobility this morning. She said she would not have left a resident on the side of the bed to perform another task when doing a bed bath. She said to prevent falls not to leave the resident at the side of the bed. She said she would have found find whether the resident was a one or two person assist for ADLs on the Care Plan or the Kardex. She said 2 people were required to assist Resident #1 for bed baths and diaper changes. She said they accessed the care plan in Point Click Care (PCC). She said she would have checked the care plan prior to performing care on the resident.</p> <p>Interview on 4/19/2024 at 1:48pm pm with CNA F, said she had been in-serviced on care plans, fall prevention, bed baths and bed mobility 4/18/2024. She said she would not have left a resident on the side of the bed to perform another task when doing a bed bath. She said she would have found whether the resident was a one or two person assist for ADLs on the Kardex or the Care Plan. She said 2 people were required to assist Resident #1 for bed baths and diaper changes. She said they accessed the Kardex and Care Plan in Point of Care (POC) documentation system and she had checked every day.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview on 4/19/2024 at 1:52pm pm with CNA G, said she had been in-serviced on care plans, fall prevention, bed baths and bed mobility 4/18/2024. She said she would not have left a resident on the side of the bed to perform another task when doing a bed bath. She said she would find whether the resident was a one or two person assist for ADLs on the Kardex. She said 2 people are required to assist Resident #1 for bed baths and diaper changes. She said they accessed the Kardex in Point of Care (POC) documentation system. She said she had always checked the Kardex prior to performing care of the resident.</p> <p>Interview on 4/19/2024 at 2:51pm the MDS nurse said other than MDS documentation she was in care plans every day due to change of condition, family request, personal request there was always a reason to be in care plans. She said when a resident fell or was a fall risk she did care planning immediately so the team could have reviewed to see all interventions were there, appropriate and effective. She said the people involved in performing assessments and evaluations for residents after they experienced a fall with minor and major injuries were therapy and they came right away. She said in twenty-four hours they discussed as a team and brainstormed interventions for residents when they fell . She said the team included the MDS nurse the DON, ADON, Social Worker, Administrator, Activities Director and Dietary. She said therapy was notified right away after a resident fell . She said staff were notified as care plans were added to the Kardex, through clinical meetings, 24-hour report sheets and the charge nurse. She said all residents with a high fall risk in the facility had been identified and their care plans had been reviewed and revised.</p> <p>Interview on 4/19/2024 at 3:19pm the DON said care plans were ongoing for residents who had change of condition or a fall and ideally, they would have updated a care plan as needed. She said multiple people were responsible for updating the care plan such as the 2 MDS nurses, 2 ADON's herself and the wound care nurse. She said Resident #1's care plan got missed and she took ownership of that. She said there was a process issue and that was why they put the revision in place, she said for Resident #1, they did train as they saw fit but each time she was hospitalized they were told by the hospital she would not return but it was not an excuse. She said after a residents fall with minor or major injuries therapy would be notified the next morning in the morning meeting. She said the care plan would have been updated quickly after a resident fall. She said direct care staff were notified of care plan updates after a resident fall by herself or the ADON's as they went over the change of conditions with the nurses and what they were doing about it. She said all residents at risk for falls and a fall history had been identified utilizing a fall risk assessment tool and their care plans updated. She said staff were supposed to look at care plans or Kardex at least once per shift to see changes. She said the POC was the charting system, the CNAs used, it had boxes and each one had for expample how much food residents ate, mobility, Foley output, etc. She said CNAs were required to document in each box, the Kardex was on the top right corner in POC and the Kardex was essentially the Care plan. She said the information for the Kardex got pulled from the Care Plan to the Kardex. She said CNAs did not document in the Kardex .they documented in the boxes.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview on 4/19/2024 at 3:30pm ADON B said they did care planning as needed on residents with high falls risk. She said when they fell or near fall. She said they did care planning with change of condition, quarterly care plans and she was not sure how Resident #1's care plan got missed. She said when residents fell and received minor or major injuries the persons involved in assessments and evaluations were the interdisciplinary team, therapy, nursing, and the physician. She said care plans were updated right away after residents fall with minor or major injuries. She said direct care staff were notified in morning meeting and 24-hour reports, she said they did assessments on all residents at high risk for falls and talked to staff, she said they had reviewed and revised the care plans. She said they notified staff and management when the care plan was updated, staff checked the care plan with change of condition and usually every shift, she said they found the care plans in point click care.</p> <p>Interview on 4/19/2024 at 3:40pm RN B said she had worked at the facility for four months. She said they did care planning quarterly and with change of conditions. She said the persons involved in performing assessments and evaluations on residents after falls with minor and major injuries were collaborative. She said it would have been the nurse who was there, the supervisor, physical therapy, occupational therapy, and the interdisciplinary team in the morning. She said therapy was in the building so they would be notified of a resident falling as soon as possible. She said care plan would have been revised in twenty-four hours. She said direct care staff should be notified for updates to the plan of care in morning meeting, her and the DON and ADON would notify staff. She said they did an assessment on residents with high fall risk and their care plans had been reviewed and revised. She said nurses should have looked at care plans with change of condition, as needed, if they had not taken care of the resident before and every day.</p> <p>Interview on 4/19/2024 at 3:50pm with CNA H said she had been in-serviced on care plans, fall prevention, bed baths and bed mobility 4/18/2024. She said she would not have left a resident on the side of the bed to perform another task when doing a bed bath. She said she would have found whether the resident was a one or two person assist for ADLs on the POC in the Kardex. She said 2 people were required to assist Resident #1 for bed baths and diaper changes. She said they accessed the Kardex in Point of Care (POC) documentation system. She said she had checked the Kardex every day because anything could have changed. She said she knew when things had changed through the Kardex and nursing staff.</p> <p>Interview on 4/19/2024 at 4:00pm with CNA I said she had worked at the facility for two years and been in-serviced on care plans, fall prevention, bed baths and bed mobility 4/18/2024. She said she would not have left a resident on the side of the bed to perform another task when doing a bed bath. She said she would have found whether the resident was a one or two person assist for ADLs on the POC in the Kardex. She said 2 people were required to assist Resident #1 for bed baths and diaper changes. She said they accessed the Kardex in Point of Care (POC) documentation system. She said she would check the Kardex daily and care plan interventions were in the Kardex, she said she would know the Kardex was revised in meetings on the residents and from management.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview on 4/19/2024 at 4:05pm with CNA J said she had worked at the facility since December 2023. and been in-serviced on care plans, fall prevention, bed baths and bed mobility 4/18/2024. She said she would not leave a resident on the side of the bed to perform another task when doing a bed bath. She said she would find whether the resident was a one or two person assist for ADLs on the POC then click on the resident then click on the Kardex. She said 2 people are required to assist Resident #1 for bed baths and diaper changes. She said they accessed the Kardex in Point of Care (POC) documentation system. She said she would check the Kardex daily at the beginning of every shift and care plan interventions were in the Kardex, she said she would know the Kardex was revised because the nurse would tell her.</p> <p>Interview on 4/19/2024 at 4:34pm with CNA K said she had been in-serviced on care plans, fall prevention, bed baths and bed mobility 4/19/2024. She said she would find whether the resident is a one or two person assist for ADLs in the Kardex. She said 2 people are required to assist Resident #1 for bed baths and diaper changes. She said they accessed the Kardex in Point of Care (POC) documentation system. She said she would check the Kardex daily at the beginning of every shift and care plan interventions were in the Kardex, she said she would know the Kardex was revised because the charge nurse would tell her.</p> <p>Interview on 4/20/2024 at 10:23am with CNA L said she had been in-serviced on care plans, fall prevention, bed baths and bed mobility 4/19/2024. She said she would find whether the resident is a one or two person assist for ADLs in the Kardex. She said 2 people are required to assist Resident #1 for bed baths and diaper changes. She said they accessed the Kardex in Point of Care in right corner. She said to keep the resident from falling she would pull the resident toward her to keep the resident from falling. She said she would check the Kardex daily at the beginning of every shift and care plan interventions were in the Kardex, she said she would know the Kardex was revised because the nurse would tell her.</p> <p>Interview on 4/20/2024 at 10:27am with CNA M said she had been in-serviced on care plans, fall prevention, bed baths and bed mobility 4/20/2024. She said she would find whether the resident is a one or two person assist for ADLs in the Kardex. She said 2 people are required to assist Resident #1 for bed baths and diaper changes. She said they accessed the Kardex in Point of Care. She said she would report a fall to charge nurse immediately. She said she would check the Kardex daily at the beginning of every shift and care plan interventions were in the Kardex, she said she would know the Kardex was revised because the nurse would tell her.</p> <p>Interview on 4/20/2024 at 10:34am with MA#A1 said she had been working at the facility for almost a year. She said she had been in-serviced on care plans, fall prevention, bed baths and bed mobility 4/19/2024. She said she would find whether the resident is a one or two person assist for ADLs in the Kardex. She said 2 people are required to assist Resident #1 for bed baths and diaper changes. She said they accessed the Kardex in Point of Care then go to patient then go to Kardex. She said she would report a fall to charge nurse immediately. She said she would check the Kardex daily at the beginning of every shift and care plan interventions were in the Kardex, she said she would know the Kardex was revised because the staff would tell her or the Kardex.</p> <p>An IJ was identified on 4/18/2024. The IJ template was provided to the facility Administrator on 4/18/2024 at 5:23pm. The Immediate Jeopardy was determined to have been removed on 4/20/2024 due to the facilities implemented actions that corrected the non-compliance.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</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** 47531</p> <p>Based on observation, interview and record review the facility failed to provide supervision to prevent accidents for 1 (Resident #1) of 5 residents reviewed for accidents.</p> <p>The facility did not provide adequate supervision for Resident #1 while giving a bed bath on two separate occasions causing her to fall off the bed resulting in prolonged hospital stays.</p> <p>Resident #1 was hospitalized with a fractured hip from 12/13/2023 to 12/28/2023 after she rolled off the side of the bed during a bed bath.</p> <p>Resident #1 was hospitalized from 4/1/2024 to 4/11/2024 after she rolled off the side of the bed during a bed bath.</p> <p>An IJ was identified on 4/18/2024. The IJ template was provided to the facility on [DATE] at 5:23pm. The immediate jeopardy was determined to have been removed on 4/20/2024 due to the facilities implemented actions that corrected the non-compliance.</p> <p>This failure placed residents at risk for accidents and injury.</p> <p>Findings:</p> <p>Record review of Resident #1's Face Sheet dated 4/18/2024 revealed a [AGE] year old female who was admitted on [DATE] with diagnoses of encounter for closed fracture with routine healing (Hip fracture), Type 2 Diabetes Mellitus (High blood sugar) with Unspecified Complications (Insulin), Unspecified Fall, Subsequent Encounter (Receiving routine care), Muscle Wasting and Atrophy (Weak muscles), Unspecified Site, Muscle Weakness, Pain, Unspecified, Encounter for Other Orthopedic Aftercare (Care and treatment with a bone specialist), Acquired Absence of Right Leg Below the Knee (Amputation), Paranoid Personality Disorder (Distrust and suspicion), Vascular Dementia (Brain damage caused by strokes), Unspecified Severity, With Agitation, Schizoaffective Disorder (Mood disorder), Bipolar Type.</p> <p>Record Review of Resident #1's MDS dated [DATE] revealed Resident #1 had a BIMS score of 15 indicating the resident was cognitively intact. Section E revealed no potential indicators of psychosis (Hallucinationa). Section GG revealed Resident #1 was dependent on toileting hygiene, showering/bathing, and lower body dressing. Section GG also revealed Resident #1 was Substantial/maximal assistance with roll to the left and right. Section H revealed resident was always incontinent of urine and bowel. Section I revealed Resident #1 had Medically Complex Conditions, Hip Fracture, Cerebrovascular Accident (Stroke), and Non-Alzheimer's Dementia (Memory loss).</p> <p>Record Review of Resident #1's Care Plan dated 8/6/2023 read in part .Will safely perform her ADLs through the review date .date initiated 8/6/2023 .Bed Mobility: Requires staff participation to reposition and turn in bed date initiated 8/10/2023. Resident #1 was at risk for falls related to right below the knee amputation, incontinence, limited mobility, confusion, late effects of CVA date initiated 8/6/2023 . Revision 12/14/2023 . Will not sustain serious injury through the review date .date initiated 8/6/2023 bed in lowest position .date initiated 8/6/2023.</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 - Some</p>	<p>Record Review of Resident #1's orders dated 4/18/2024 revealed there were no orders for fall preventions or interventions for fall prevention</p> <p>Record Review of Resident #1's Change in Condition dated 12/13/2023 at 3:19pm read in part .situation Falls .Back, injuries, complaints abrupt onset of severe pain secondary to fall or injury or pain with new abnormal neurological signs .site .left trochanter hip laboratory tests/diagnostic procedures x-ray .Resident #1 states she fell with CNA during bed bath.</p> <p>Record Review of Resident #1's X-Ray dated 12/13/2023 Read in part .Impression .A fracture of the left femur neck. The age of the fractur is indeterminate.</p> <p>Record review of Nursing note dated 12/14/2023 9:13am read in part .Resident #1 to be sent out to ER .</p> <p>Record Review of hospital notes dated 12/14/2023 read in part . female with a past medical history of CVA(Stroke) .claims the CNA was with her while cleaning her and she did not have a good grip of the rail before moving and she rolled out of bed and fell impacting her left leg and complained of severe left leg pain 1. Acute left femoral fracture consult orthopedics .Cardiology has cleared the patient for surgery with moderate risk patient is status post segmental resection arthroplasty of left femoral neck (Hip replacement) Consult social services for possible APS (Adult protective services) evaluation since patient claims that the CNA was impatient with her during her bed sponge which was responsible for her fall the patient was oriented to place person and time during history taking.</p> <p>Record Review of Hospital #3 Physical Therapy initial evaluation and discharge read in part .non weight bearing left lower extremity .Hoyer lift to chair .Resident #11 with chronic decreased motor control overall . coordination impaired right and left .BED MOBILITY: Rolling: Total Assistance (<25%), Needs 2.</p> <p>Record Review of hospital discharge summary dated 1/1/2024 revealed in part . Discharge diagnoses: Closed fracture of left hip .Procedure: Left Hip [NAME] Resection (Removal of head and neck of thigh bone) CT Pelvis (Cat Scan) .Impression: Complex left proximal femoral age indeterminate sub capital fracture and acute appearing distal neck fracture (Broken hip).</p> <p>Record Review of Change of Condition notes dated 4/1/2024 3:30pm read in part . condition change: Falls.</p> <p>Record review of Nursing notes dated 4/1/2024 at 4:11pm read in part . aide in room giving Resident #1 bed bath. Pt leg slide off bed and patient rolled and fell on to the floor. Resident #1 hit left side of head and complaint of pain to her head and ribs did not specify which side .transportation called, and hospital notified.</p> <p>Record review of hospital record H&P dated 4/2/2024 read in part . Chief Complaint: Fall at the nursing home followed by chest pain.</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 - Some</p>	<p>Record Review of hospital record dated 4/3/2024 7:58am read in part . wanted to find another facility for Resident #1. SW left voice message and text messages requesting for return call back 4/11/2024 Resident #1' had confusion and found to have MDR Klebsiella (Bacteria in urine) .Infectious Disease consulted, and Resident #1 has completed course of intravenous Meropenem (Antibiotic) in house . family wanted to transition to a different long term care facility but unable to. Will return to facility.</p> <p>Resident #1 was found to have no substantial injuries on admission to hospital after fall on 4/1/2024, length of hospital stay was due to urinary tract infection and family trying to find another facility for resident to go to once discharged .</p> <p>Observation on 4/17/2024 11:35am Entered Resident #1's room and resident observed sleeping.</p> <p>Interview on 4/17/2024 at 11:35am DON said the Resident #1 fell off the bed while getting a bed bath on 12/13/2024. She said the CNA doing the bed bath was CNA D she said they did in-services on falls, bed baths and did education with CNA D specifically.</p> <p>Interview on 4/17/2024 at 11:51am RN A said she came to the resident's room at the end of her shift and Resident #1 said her leg hurt, she said she asked CNA D hat happened, and she denied she fell . She said another aid told her she fell . She said she fell when she was given a bed bath by CNA D. She said the facility did education on reporting incidents to nurses and falls. She said she did not remember who the other CNA was.</p> <p>Interview on 4/17/2024 at 12:11pm Family Member #2 said Resident #1 had now fallen out of bed the same way twice and was going to transfer her to another facility.</p> <p>Interview on 4/17/2024 at 1:00pm the DON said the first time Resident #1 fell off the bed they ordered an x-ray and once they had the results, they sent her to the hospital. She said CNA D had her turned on her side and with the BKA she fell off the bed. She said the in-service was only with the CNA D. She said the second time Resident #1 fell off the bed it was with CNA C, she was giving her a bed bath and had her on her side. She said while she was bathing Resident #1, CAN C she stepped away to get a fresh basin of water and when she was in the restroom getting the water Resident #1 cried out, she was slipping and fell off the bed. She said CAN C had already started the bed bath. She said they only in-serviced the CNAs individually as they were isolated incidents.</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 - Some</p>	<p>Interview on 4/17/24 at 1:03pm CNA C said she had worked at facility since July 2023, she said she had washed Resident #1's front side and had asked her to roll over on her side. She said she noticed the water was dirty, so she was going to walk in the bathroom and change the water out, she said Resident #1 was holding on the rail with her good hand and she was on her side. She said Resident #1 had said she was slipping when she was changing the water out of the pail and when she came back from the bathroom she was already on the floor. She said Resident #1 did not tell me she was going to fall, or I would not have left her. She said Resident #1 was not feeling good that day and wanted a bed bath instead of a shower. She said afterward the ADON called her in the office and instructed her on the correct procedures in a bed bath and not to leave Resident #1 by herself anymore. She said the ADON made her sign a sheet and in-service sheet. She said as far as a bed bath, they discussed with management they don't give Resident #1 bed baths by themselves anymore. She said Resident #1's bed baths should have been with two people. She said anytime she did anything with her from then on she did it with 2 people. She said management told them to use 2 people now. When asked if she knew if Resident #1 had a history of falls with bed baths, she said yes, she did but she said Resident #1 did not feel good and wanted a bed bath. She said she was going to do a shower and had everything set up for that. She said she had been in-serviced prior to that maybe 2 or 3 months ago. She said everybody was in-service with the first fall but with the second fall she was in-service by herself. She said with the first in-service it was a general how to give a resident a bed bath. She said there was no discussion to make Resident #1 a 2 person assist after the first fall; it was only after the second fall. When asked why it was important to have everybody on the same page, she said it was for safety reasons to prevent the falls from happening. She said if it had been made clear before the bed bath Resident #1 was a 2 person assist, it would have been preventable.</p> <p>Interview on 4/17/24 at 1:03pm CNA C said she had worked at the facility since July 2023, she said she had washed Resident #1's front and asked her to roll over on her side. She said she noticed the water was dirty, so she was going to walk in the bathroom and change the water out. She said Resident #1 was holding on the bed rail with her good hand, she was on her side, and she was saying she was slipping when she was changing the water out. She said when she came back from the bathroom Resident #1 was already on the floor. She said Resident #1 did not tell her she was going to fall, or she would not have left her. She said Resident #1 was not feeling good that day and wanted a bed bath instead of a shower. She said the ADON called her in and told her about the correct procedures in a bed, not to leave her alone anymore and made her sign an in-service sheet. She said as far as a bed bath they discussed with management, and they do not do Resident #1 by themselves anymore, they should be two people. Anytime she does anything with Resident #1 now she does it with 2 people. She said they told us to use 2 people now. When asked if she knew Resident #1 had a history of falls with bed baths, she said yes, she did but she said Resident #1 did not feel good and wanted a bed bath. She said she was going to do a shower and had everything set up for that. She said she had been in-service prior to that maybe 2 or 3 months ago. Everybody was in-service with the first fall. But with the second fall she was in-service by herself. With the first in-service it was a general how to give a resident a bed bath. There was no discussion to make Resident #1 a 2 person assist after the first fall it was only after the second fall. She said it was important for everyone to be on the same page for safety reasons to prevent the falls from happening. She said if had been made clear before the bed bath she was a 2 person assist, it would have been preventable.</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 - Some</p>	<p>Interview on 4/17/2024 at 1:58pm the DON said with the first fall, they did in-services only with CNA D and not the other staff, she said with the second fall she did in-services with [NAME]. She said staff had done their minimum yearly competencies and there was no policy on how frequently they had to do in-services. She said they had the Relias system (Training system) and those were the yearly competencies. She said she thought it had included safety. When asked how often training was given on safety when providing care, she said they had done the monthly infection control. She said Resident #1's bed baths were two persons as of this last fall. She said Resident #1 was not deemed necessary by Physical Therapy after the first fall. She said Physical Therapy did not recommend Resident #1 to be a 2 person assist. She said Resident #1's normal activity level was she rarely ever wanted to come out of her room, she had seen her out of bed less than 10 times, and she was physically able to sit in a chair but did not want to. She said for quite a while she had been sleeping a lot. When asked how soon the care plan should have been updated after Resident #1's second fall, she said the care plan should have been updated timely. She said she did not feel there was a safety issue with Resident #1, and she did not feel there was an established pattern with her falling out of bed on 2 separate occasions. She said to the CNA, Resident #1 was a one person assist at the time. She said she did not think she could have prevented the incident aside for calling for help from someone to refill the basin. She said it was not known Resident #1 would lose strength in her arms.</p> <p>Interview on 4/17/2024 at 2:24pm CNA D said when Resident #1 fell off the bed on 12/13/2023 she was giving her a bed bath. She said she was washing her backside, and, in the process, she rolled off the bed. She said it happened so fast and Resident #1 did not provide a warning. She said Resident #1 had grab bars to support herself and she tried to grab Resident #1 to prevent her from falling but she slipped out of her hands. She said Resident #1 at the time was a one person assist for most activities and she did not know her to be a high fall risk. She said she called for help and referred her to the nurse. She said Resident #1 was yelling in pain. She said the ADON gave her one to one training on bed baths, and it was determined she did so correctly. She said she had not had another training since then. She said there was no Kardex (Care Plan for CNAs that tell them how much assistance a resident needs), nothing hanging on the walls to show care plans for residents with regards to assistance levels. She said she only determined the level of assistance needed when she was performing a task on her own and realized she could not do it safely without help. She said she would then have called for help from time to time. She said they all got verbal training or reporting from nurses which determined the level of care needed for each resident. She said there was nothing on a Kardex or care plan that she could refer to find out how much assistance she needed to care for a resident, she said a nurse would let them know if a resident needed assistance with feeding.</p> <p>Interview on 4/17/2024 at 2:16pm Resident #1 said the first time she fell off the bed she was oily, and the bed was oily. She said she was turned close to the edge of the bed, and she lost her balance and fell out of the bed. She said she could not hold her grip on the bed rails because she was weak. She said she got pushed too close to the edge of the bed, she could not hold her grip and she fell off the bed. She said she did not want the CNAs again. She said she should have had 2 CNAs help her not one. She said when she fell the first time, she broke her hip and they had to repair it at the hospital. She said the second time she fell out of the bed a different CNA was giving her a bed bath. She said the CNA left and went to throw out the bath water and she left her turned on her side. She said she should have never been left on her side like that. She said she could not reposition herself. She said when she fell the second time she landed on her hip. She said she needed a bigger bed mattress as she was too big for the bed and when they turned her, she was at the edge of the bed. She said she had to go to the hospital, but her leg still was not healed from the first fall.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Legend Oaks Healthcare and Rehabilitation Center -		STREET ADDRESS, CITY, STATE, ZIP CODE 8902 West Rd Houston, TX 77064	
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview on 4/17/2024 at 3:00pm CNA E said she had worked at the facility for 3 weeks, she said she had training as a CNA so she would know her responsibility with the resident's bed bath, bathroom, cleaning, wiping changing diapers, transferring to wheelchair and back to bed. She said the facility trained her on what to do and what she can do for the residents. She said when you look at the chart you know how to take care of the people. She said from her training she knew if residents needed one or 2 people assistance. She said she had worked on 300 halls. She said most of the 2-person assistance were located on 200 halls. She said Resident #1 needs 2 people assist. She said the nurse that attends to her asks for assistance. She said Resident #1 needs 2 people to change her and she felt confident in who needed how much care in the building. She said most of the residents she knew by looking, assessing them and could tell how much help they needed.</p> <p>Interview on 4/18/2024 at 8:43am Physical Therapist A said he worked with Resident #1 going on 2 years since April of 2022. He said they did yearly in-services and they in-serviced the staff on transfers and Hoyer lifts. He said he knew Resident #1. He said Resident #1 had a fall and a fracture with the left leg, and they had seen her for therapy before and after that point. He said they worked with her on her mobility status. He said she had always been able to assist with her right arm, she would roll using her right hand up and over and they had to help her so she could hold and stabilize herself. He said he did not know how she fell off the bed the second time and said he knew with therapy she was able to assist with some help to the right. He said he did not know if she was lethargic. He said he did not know Resident #1 fell out of bed twice. He said they were working with her in therapy. He said they were putting with max or total dependent with 1 person. He said she needed verbal cues. He said he would not have left her when getting her bath, he would not have stepped aside, he would have rolled her to her back. He said he would not have left Resident #1 on a sideline position and left unattended. He said they had to be always with Resident #1, do not leave her there. He said given Resident #1's history since her condition has declined to add two people to care and this would be a strong recommendation for bathing. If they had to take their hands off to bathe her, Resident #1 would have been a two person assist and with her history for precautions. He said Resident #1 had become weaker and just from a tolerance position. He said he could bathe Resident #1 but he would be touching her and not stepping away.</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 - Some</p>	<p>Interview in 4/18/2024 at 9:08am ADON A said she had worked at the facility for a year and a half. She said she did most of the in-services. She said she did skills check off with CNA D the first time Resident #1 fell off the bed. She said she did a 2 person assist on transferring in-service with all CNAs. She said the second time Resident #1 fell off the bed she did a one-to-one in-service with CNA C on bed positioning, making sure there was a second person assisting, bed leveled for safety. She said nurses, CNAs, CMAs received skills check off in December 2023 on transfers, and they focused on the first fall, that specific incident and what they needed to do moving forward. This was a general training, and they did resident specific training with CNA D and CNA C. She said they covered every 2 hours turning resident, and they got turning training in the skills check off. She said CAN C's training was to make sure someone was there to assist them with turning. She said after Resident #1 fell a second time she did training with CNA C with Resident #1. She said Resident #1 should have been deemed a 2 person assist after the first fall because it's an intervention. She said no other interventions were put in place. The staff could have accessed the Kardex (Care Plan for CNA and it is in their POC documentation, and they get report, the nurse was supposed to provide the information to them. She said she was not sure if its in the POC it populates in the Kardex. She said she believed Resident #1 should have been 2 persons assist. She said the checkoffs went over bed baths, 2 pers assists, everything, so no need to do individual in-services, staff should have known by Kardex and nursing staff how to provide care for the residents. She said the Kardex pulls from the Care Plan. The Kardex was in the documentation system for the CNAS and the Care plan too.</p> <p>Record review on 4/18/2024 at 9:20am revealed the Care Plan had no updates for Resident #1 for CNA assistance with ADLs, fall mats, low bed, or big bed, prior to arrival at the facility. Resident #1 had no fall mats, low bed, big bed prior to arrival at facility.</p> <p>Interview on 4/18/2024 at 9:40am Resident #1 said before her fall, she usually got help from only one person when being changed or when being given a bath. She said she was getting adjusted to the new larger mattress that they had provided her this morning.</p> <p>Record Review of Resident #2's Face Sheet dated 4/18/2024 revealed an [AGE] year-old female who was admitted on [DATE] with diagnoses of .Hemorrhage due to vascular prosthetic devices (Blood loss due to implant), implants and grafts, subsequent encounter, End stage renal disease (Kidney disease), altered mental status (Change in clarity), Hypertensive urgency (High blood pressure), Muscle wasting and atrophy and muscle weakness(Muscle loss and stiffness).</p> <p>Record review of Resident #2s MDS dated [DATE] revealed Resident #2 had a BIMS Score of 12 indicating the resident was moderately cognitively impaired. Section E revealed Resident #2 had no indicators of psychosis. Section GG revealed resident used a walker for mobility and had partial to moderate assistance with bathing and toileting. Resident was substantial assistance with lower body dressing.</p> <p>Interview on 4/18/2024 at 9:40am Resident #2 said she had been Resident #1's roommate for 2-3 months and she looked out for Resident #1 when she needed help. She said she would help press the call light to make them come faster. She stated before Resident #1's fall (4/1/2024), the resident only received help from one person when being changed. She said she did not know whether it was because they were short-handed and could not get the extra help, but they were typically alone when providing her care. She said she overheard the bed bath happening when Resident #1 fell recently, she heard when Resident #1 yell I'm slipping, I'm slipping and she heard her hit the ground. She said even after that incident, she was still being provided cared by one person for the most part.</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 - Some</p>	<p>4/18/2024 at 9:40am Resident #1 was observed in her room in her bed, left hand contracted, feeding herself with right hand, right below the knee amputation, large bed, Resident #1 able to communicate effectively. Resident #1 said she was adjusting to her new larger bed.</p> <p>4/18/2024 9:57am LVN R showed the Kardex located in the POC documentation system. She said the Kardex did not show if a person was a one person assist or a 2 person assist. She said the CNAs put in the level of assistance after the care was provided to the resident. She said Resident#1 was a two person assist with turning. She said since she first fell the staff have taken extra precautions and were utilizing two persons with changing briefs.</p> <p>Interview on 4/18/2024 at 10:15am the Administrator he said he had placed resident in a larger bed.</p> <p>Interview on 4/18/2024 at 3:00pm the DON said the staff all knew the resident was a two person assist with bathing after the second fall, she said staff were uncomfortable bathing the Resident #1 without 2-person assistance.</p> <p>4/19/2024 9:20am Resident #1 observed in her room in bed eating breakfast, Resident #1 said she got a bed bath last night, Resident #1 noted to have bilateral fall mats in the room which she did not have prior to 4/19/2024. Resident #1 noted to have a star next to her name on the doorpost indicating she was a fall risk which she did not have prior to 4/19/2024 and noted to be clean in appearance. Resident #1 said only one CNAs gave her a bed bath last night. She said there were not 2.</p> <p>Interview on 4/19/24 at 10:22am the DON said the interventions from the IDT meeting they had after Resident #1's first fall were not all put into place for the resident and while receiving a bed bath Resident#1 rolled off the bed a second time. She said Resident #1 was sent to the hospital and once she returned from the hospital there were supposed to be interventions for fall mats placed, wider bed, 2 person assist with care, education done with CNA and all staff, and falling star identifier. She said Resident #1's second fall happened on 4/1/2024 and the resident was gone for a while, there was a delay with returning and when Resident #1 was readmitted the interventions did not get put in place for the resident. She said the fall mats, the education for the staff, the falling star identifier, the wider bed and the 2 person staff assist with care and updating the care plan were not put in to place. She said they got missed because Resident #1 was delayed returning to the facility after the second fall. She said Resident #1's family had been looking to send her to another facility.</p> <p>Record review on 4/19/2024 at 11:25am revealed staff in-service dated 1/2/2024 . bed baths, 2 persons assist, level bed for safety, when in doubt ask for help. Surveyor confirmed with CNA C she was not on the in-service 1/2/2024. In-service dated 12/15/2024 for transfer training, bed mobility, Hoyer training. CNA D's signature not on in-service.</p> <p>Record review on 4/17/2024 at 11:14am of Resident #1's Care plan dated 8/6/2024 revealed no updated interventions in place to prevent falls.</p> <p>Record review of facilities policy titled; Fall Management System read in part . It is the policy of the facility to provide an environment that remains free of accident hazards as possible. It is also the policy of the facility of the facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs.</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 - Some</p>	<p>An IJ was identified on 4/18/2024 and the facility administrator was notified at 5:23pm. The IJ template was provided to the facility on [DATE] at 5:23pm.</p> <p>On 4/20/2024 at 2:16pm the following Plan of Removal was accepted.</p> <p>On 4/20/2024 at 2:16pm the following Plan of Removal was accepted.</p> <p>Facility Plan for Compliance</p> <p>ADHOC meeting sign in sheet in book with Medical Director in attendance. Meeting held on 4/18/2024.</p> <p>Executive Director, DON, Clinical Cluster Leader, Clinical Resources in attendance.</p> <p>Incidents by Resident including Resident #1 in IJ Book (Book containing plan of removal for Immediate Jeopardy).</p> <p>Root Cause Analysis for Resident #1 in IJ book.</p> <p>Updated Care Plan for Resident #1 in IJ Book.</p> <p>Interventions in place since arrival: Resident #1 Requires Assistance of 2 staff members to reposition, may use mobility bars to aide in Easy Turning and repositioning, Resident #1 requires assistance of 2 staff members if receiving a bed bath with mobility bars in place, Resident requires assistance of 2 staff by Hoyer lift with transfers, in IJ book.</p> <p>Fall Risk Evaluations in the POR for all residents were completed.</p> <p>Monitoring for Plan of Removal:</p> <p>In an interview on 4/20/2024 at 9:00am DON said all Care Plans were reviewed and updated as necessary for the residents identified in the Fall Risk Assessments. All persons responsible for care plan updates immediately were herself, the ADONs, Social Work and Wound Care.</p> <p>Record review on 4/20/2024 at 10:00am of in-Service Training for Resident #1 dated 4/18/2024 reflected resident will have a wide bed, fall mats-bilateral, mobility bars, and two staff members for bed baths/ bed mobility.</p> <p>Record review on 4/20/2024 at 10:00am of in-service dated 4/18/2024- Topic Falls . Fall Policy .Fall risk assessment . fall risk management/incident report .Care plans updated .falling star (Emblem placed by doors of Residents at risk for falls) .document q (Every)shift x72 hours.</p> <p>Record review on 4/20/2024 at 10:00am of Inservice dated 4/18/24- Topic Bed bath hand hygiene . procedure . ensure safety at all times .follow Kardex .bed height .clean up .call light within reach .do not leave resident lying on side of bed.</p> <p>Record review on 4/20/2024 at 10:00am of Inservice dated - 4/18/24-Topic Mobility, Transfers, Safety, Turning/Repositioning .Do not leave resident unattended while performing care.</p> <p>(continued on next page)</p>

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