

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/23/2024
NAME OF PROVIDER OR SUPPLIER  Mememorial City Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1341 Blalock Houston, TX 77055	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37059</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents had a safe, clean, comfortable, and homelike environment for 1 of 10 resident (Resident #2) reviewed for homelike environment.</p> <p>The facility failed to ensure Resident #2's toilet base was free from stains and dirt and toilet was in good repair.</p> <p>These failures could place residents at risk of a diminished quality of life due to exposure to an environment that is unpleasant, unsanitary, uncomfortable, and unsafe.</p> <p>The findings included:</p> <p>Record review of Resident #2's face sheet revealed a [AGE] year-old male admitted on [DATE] with the following diagnoses: Hypertension (high blood pressure), dementia (memory loss), fracture of femur, muscle weakness, unsteadiness of feet and difficulty of walking.</p> <p>Record review of Resident #2's care plan dated 9/19/2024 revealed the following in part:</p> <p>Problem</p> <p>Falls [Resident #] is a risk for fall related to gait/balance problems, hypotension (high blood pressure) (Revision on 5/22/2023).</p> <p>Goal</p> <p>[Resident #1] will not sustain serious injury through the review date. (Revision on 10/13/2023).</p> <p>Interventions</p> <p>.The resident needs a safe environment with, even floors free from spills and/or clutter .</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview on 9/17/2024 at 11:02 a.m. revealed Resident #2's bathroom floor had a liquid substance coming from the base of the toilet. There was approximately a 1-inch black ring around the base of the toilet. The bathroom smelled of urine. Resident #2 said his bathroom was full of water and smelled like urine. He said he told a staff that he could not remember, about fixing his toilet, but it had not been fixed. He said the toilet was leaking and the black ring had been there for months.</p> <p>Interview on 9/17/2024 at 11:46 a.m., with the Activity Dir. said she saw Resident #2's bathroom on 9/16/2024. She said she saw how dirty the toilet was. She said she did not see the water on the floor. She said she put in an order for maintenance. She said the stain around the bottom of the toilet appeared it had accumulated over time and had not just happened. She said she had been Resident #2's ambassador for 1 day and had not seen his room before. She said she completed ambassador rounds, which is where she checks in with residents and made sure there are not problems with their rooms or concerns that a resident would have. She said a resident dignity and rights were at risk.</p> <p>Interview on 9/17/2024 at 12:25 p.m. with the DON said Resident #2's bathroom toilet was missing a ring around the bottom to prevent water from leaking. She said she told the ADMIN to start with 5 or so bathroom at a time and repair them because the building is so old. She said the leaking toilet could be a hazard to Resident #2 because he sometimes stands up when in the bathroom from his wheelchair. She said she saw the toilet had leaked and there was black dirty ring around the bottom.</p> <p>Interview on 9/17/2024 at 12:32 p.m. the Maintenance Dir. said he had not seen Resident #2's room prior to today. He said he checked rooms daily but randomly selected them. He said the bathroom had bad caulking and something was wrong with the wax ring. He said the wax ring was designed to stop sour gas and leaks from under the toilet. He said the bathroom had a had strong odor and it was hard to tell if it was water or urine. He said the black ring around the bottom of the toilet was old caulking that was dirty from dust and dirt that had collected. He said the toilet has deteriorated over time.</p> <p>Record review of facility policy Resident Rights (dated November 2021) revealed the following in part:</p> <p>Dignity and Respect</p> <p>You have the right to:</p> <p>Live in safe, decent and clean conditions .</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>Note: The nursing home is disputing this citation.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37059</p> <p>Based on observations, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident medical, nursing, mental, and psychosocial needs for 1 (Resident #1) of 3 residents reviewed for care plans in that:</p> <p>The facility failed to ensure Resident #1 bed was in the lowest position per care plan while he was in the bed.</p> <p>The facility failed to update falls and interventions for Resident #1's care plan after his last 3 falls.</p> <p>This failure placed facility residents who were fall risk at risk of serious harm and injury.</p> <p>An Immediate Jeopardy (IJ) was identified on 9/18/2024. The IJ template was provided to the Administrator In-Training and DON on 9/18/2024 at 12:46 p.m. While the IJ was removed on 9/20/2024 at 12:30 p.m., the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not an immediate jeopardy and a scope of pattern, due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>These failures could place residents at an increased risk of decline, and diminished quality of life.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet dated 9/17/2024 revealed a [AGE] year-old male who admitted to the facility originally on 2/9/2021 and readmitted on [DATE] with the following diagnoses: Fragile X syndrome (genetic disorder and one of the most common causes of inherited intellectual disability), muscle weakness, unspecified falls, lack of coordination and cognitive communication deficit.</p> <p>Record review of Resident #1's Annual MDS dated [DATE] revealed he had a BIMS score of 0 which indicated severe cognitive impairment. He used a wheelchair for mobility. Resident #1 requires total assistance (helper does all the support) for sit to stand and bed transfers. Section J1900 - Number of Falls since admission/entry or reentry or prior assessment was left blank.</p> <p>Record review of Resident #1's care plan revised 4/18/2024 revealed the following care areas:</p> <p>Problem: [Resident #1] receives anticoagulant/antiplatelet (medications that help reduce blood clotting) therapy (Plavix medication) Date initiated: 2/2021. Revision: 4/18/2024</p> <p>Goal: [Resident #1] will be free from discomfort or adverse reactions related to anticoagulant use through the review date. Date initiated: 2/10/2021. Revision on: 6/20/2024. Target date 11/3/2024.</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>Note: The nursing home is disputing this citation.</p>	<p>Interventions: Administer anticoagulant medications as ordered by physician .Daily skin inspection. Document any abnormalities .Observe/document/report PRN adverse reactions of anticoagulant therapy: . bruising. Revision on 8/6/2023, Resident/family /caregiver teaching to include the following: . avoid activities that could result in injury, take precautions to avoid falls .</p> <p>Problem: [Resident #1] is high risk for falls r/t impaired mobility. Date initiated 2/11/2021. Revision on: 4/18/2024.</p> <p>Goal: [Resident #1] risks and injury potential will be minimized through the next review date. Date initiated: 2/11/2021. Revision on: 6/20/2021. Target date: 11/3/2024.</p> <p>Interventions: Anticipate and meet the resident's needs. Dated initiated: 2/11/2021. Follow facility fall protocol. Date initiated 2/19/2021. PT evaluate and treat as ordered or PRN. 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; side rails as ordered, handrails on walls, person items within reach. Date initiated 2/19/2021. Revision on 8/7/2023.</p> <p>Problem: [Resident #1] has had an actual fall with (Specify: no injury, On 12/28/2022) Poor Balance, Unsteady gait [the way a person walks]. 7/12/2023: actual fall, no injury. Date initiated: 1/9/2023. Revision on: 7/12/2023.</p> <p>Interventions: Continue interventions on the at-risk plan. Date initiated: 1/9/2023. PT consult for strength and mobility. Date initiated: 1/9/2023 .Staff will round frequently and try to anticipate his needs. Date initiated: 7/21/2024. Staff will start offering [Resident #1] to stand and relieve pressure throughout the day. Date initiated 4/1/2024.</p> <p>Record review of facility Incidents by Resident fall report dated 9/17/2024 revealed the following in part:</p> <ul style="list-style-type: none"> <li>o [Resident #1] - Fall on 7/21/2024 at 9:40 p.m.</li> <li>o [Resident #1] - Fall on 9/14/2024 at 7:34 p.m.</li> <li>o [Resident #1] - Fall on 9/15/2024 at 12:15 p.m.</li> </ul> <p>Record review of Resident #1's Fall Risk Evaluations dated 7/21/2024 - 9/14/2024 revealed the following:</p> <p>*Effective Date: 7/21/2024 - Score 13. Category High Risk. Scoring: If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. A prevention protocol should be initiated immediately and documented on the care plan.</p> <p>*Effective Date: 9/14/2024 - Score 15. Category High Risk. Scoring: If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. A prevention protocol should be initiated immediately and documented on the care plan.</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>Note: The nursing home is disputing this citation.</p>	<p>*Effective Date: 9/15/2024 - Score 16. Category High Risk. Scoring: If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. A prevention protocol should be initiated immediately and documented on the care plan.</p> <p>Record review of Resident #1's Order Summary Report dated 9/17/2024 revealed the following in part: orders:</p> <p>*May transfer to [Hospital] and clinical ER for CT of head r/t witness fall with head injury (order date 9/15/2024).</p> <p>*Transfer to .ER for CT of head and X-ray of L [left] shoulder r/t fall (order date 7/22/2024).</p> <p>*Clopidogrel Bisulfate oral tablet 75 mg - Give 1 tablet by mouth one time a day for blood thinner (order date 2/10/2021).</p> <p>Record review of facility nursing notes dated 9/14/2024 at 10:06 p.m. written by LVN B revealed Change of Condition: Signs/Symptoms Details: witnessed fal [sic], started 09/14/2024 .</p> <p>Record review of Resident #1's hospital discharge summary dated 9/14/2024 revealed Visit Summary - discharge diagnoses: tear of skin - primary, closed injury of head - primary, contusion (bruise) of right elbow - primary .</p> <p>Record review of facility nursing notes dated 9/15/2024 at 2:00 a.m. written by LVN B indicated Res arrived back to facility via . Ambulance transport. x2 assist by city ambulance personnel to transfer res from stretcher to bed via slide method. Res arrived back to facility a&amp;o x1 with 0 s/s of distress or discomfort. CT scan of head negative of any new/acute findings. No new orders received with res discharge paperwork from hospital. [name of on call service] on call contact and notified of situation and res return to facility; spoke with NP. NP ordered to hold Plavix [keeps blood from coagulating (clotting)] until Monday; order implemented. POC conts [sic] as ordered. Res in bed with bed in lowest position, call light in place and all safety measures in place at this time.</p> <p>Interview on 9/19/2024 at 7:30 p.m. LVN B, said CNA C notified her Resident #1 was in his room, fell forward out of his wheelchair, fell on the floor and hit his head (on 9/14/2024). LVN B said she went to the Resident #1's room and he had a tear on his right elbow, skin tear to his fifth digit, an abrasion to his right thigh and top of his head. LVN B said the DON told her to fill out the incident report, fall assessment and treat his injuries. LVN B said she was not instructed to update Resident #1's care plan. LVN B said the DON instructed her to complete additional rounding (q 4 hours) and add a fall mat. She said she did not update Resident #1's interventions. LVN B said care management (MDS nurses) was responsible for updating the care plans.</p> <p>Interview on 9/19/2024 at 7:52 p.m. CNA C said he took Resident #1 to his room. CNA C said he turned to adjust the bed and Resident #1 fell out of his wheelchair onto the floor on 9/14/2024. CNA C said Resident #1 fell face first and did not make a sound. CNA C said Resident #1 was sent the hospital. CNA C said when the resident returned, he was told to sit with the resident while he laid in bed. He said he was not aware of new interventions for Resident #1.</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>Note: The nursing home is disputing this citation.</p>	<p>Record review of facility nursing note dated 9/15/2024 12:15 p.m. written by LVN A indicated Res in Bistro area in WC eating lunch and witnessed falling on floor r/t leaning forward in WC after numerous attempts of assistance from staff to reposition him in WC so that res can sit back comfortably. Upon assessment SN (LVN A) noted bleeding and swelling from previous head injury to res forehead. res states it hurts but unable to give pain scale rating .</p> <p>Record review of Resident #1's hospital discharge summary dated 9/15/2024 revealed</p> <p>Visit Summary - discharge diagnoses: Scalp injury, Fall. CT head without contrast. Findings: Right frontal scalp swelling is demonstrated.</p> <p>Interview on 9/18/2024 at 2:40 p.m. LVN A said she worked with Resident #1 while he ate lunch on 9/15/2024. She said Resident #1 leaned forward and pushed back from the table, which was his normal behaviors. She said Resident #1 pushed back from the table, while in the wheelchair, leaned forward, fell to the floor and hit his head. She said Resident #1 yelled out his head hurts. She said she was not told to update Resident #1's care plan. She said she was told by the DON keep a closer eye on him, which meant to keep him in our eyesight. She said Resident #1's leaning was not new, but it was more exaggerated. She said she was aware Resident #1 had a fall the day prior but was not told about new or updated interventions in his care plan. She said his normal interventions were to anticipate his needs and follow the fall protocol. She said the ADON said we needed to update his care plan because this behavior was not new, but it was more frequent. LVN A said the DON and ADON was responsible for updating the care plans.</p> <p>Interview on 9/18/2024 at 3:12 p.m. Resident #1's PCP said she was notified Resident #1 had a fall on 9/14 and he was in his wheelchair, had a hematoma to his head and the nurse [LVN B] said the hematoma was expanding. The PCP said she was at the facility when Resident #1 had the second fall on 9/15/2024 around lunch time. She said he had a raised bump on his head. She said he had tears rolled down his face. She said she observed him today (9/18/2024) in his wheelchair trying to get up using the hand railing. She said she was not sure who updated the care plans but said it was important to include behaviors that caused a risk to the resident's safety and to implement interventions to help to prevent injuries.</p> <p>An attempted Interview and observation on 9/17/2024 at 9:12 a.m. Resident #1 did not respond to questions asked. Resident #1 was lying in bed on a pressure reducing air mattress. Resident #1 had on a brief, no shirt and no pants, glasses and a baseball style cap. The floor on both sides of Resident #1's bed did not have a mat . The Residents bed was in a low position.</p> <p>Interview on 9/17/2024 at 11:46 a.m. the Activity Dir. said, Resident #1 liked to be placed against the wall next to the handrails. She said he pulls himself forward out of Resident #1's wheelchair . She said she was not updated on new interventions for Resident #1. She said she was in the morning meeting on 9/16/2024 but was not present for the full meeting and was not sure if new fall interventions were discussed for Resident #1.</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>Note: The nursing home is disputing this citation.</p>	<p>Interview on 9/17/2024 at 1:17 p.m. MDS A, said one of her responsibilities was to update care plans quarterly for residents with Medicare and without a payer source. She said a MDS nurse that quit the previous week. MDS A said she could not remember if it was last Wednesday or Thursday [9/11/24 or 9/12/24]. She said the former MDS nurse was responsible for updating the care plans for the long-term care residents that included Resident #1. MDS A said the DON, ADON or unit manager should update the care plans when there was an acute issue like a new fall. MDS A said she was not aware of Resident #1's last two falls.</p> <p>Interview on 9/17/2024 at 1:35 pm the ADON said Resident #1 had two witnessed falls on 9/14/2024 and 9/15/2024. She said after the fall on 9/14/2024 they were instructed by the DON to make more frequent rounding and make sure he was visible. She said she did not update Resident #1's care plan after the last two falls. She said care plans should be updated to ensure interventions are documented and put in place. The ADON said the MDS nurses take the workload and update the care plans and the ADMIN said a Corp. MDS nurse would update care plans since a MDS nurse quit last week (9/11/24 or 9/12/24). She said it was her understanding MDS A and MDS B would update care plans. She said she was not told it was her responsibility to update the care plan. She said Resident #1's last two falls were discussed in the morning meeting on 9/16/2024 with the IDT. The ADON said MDS A, MDS B and DON were in the morning meeting held on 9/16/2024. She said interventions were discussed related to Resident #1 with the IDT. She said she expected MDS A and MDS B to update Resident #1's care plan interventions. She said care plan interventions for Resident #1 should have been updated to address his recent falls and Resident #1's behavior of pulling up on handrails. She said the interventions are carried over to the cna's plan of care after the care plan is updated.</p> <p>Interview on 9/17/2024 at 2:06 p.m. with the DON, said the care plan for Resident #1 should have been updated by any nurse and care management (MDS nurses). She said the MDS nurse who was responsible for Resident #1's care plan quit last week on Thursday or Friday (9/11/24 or 9/12/24). She said she was told by the Admin. the Corp. MDS would monitor after the MDS nurse quit. She said Resident #1's fall interventions should have been update by care management (MDS A and MDS B). She said after a fall the IDT, which consisted of nurses, MDS nurses, DON and ADON, should discuss if interventions should be modified or new ones implemented. She said interventions were discussed in the morning meeting (9/16/2024) and the care management team was present. The DON said the care plan interventions should be updated so they can be seen in the cna's point of care. She said the care plan interventions should have been specific to Resident #1's needs after his two recent falls. She said Resident #1's care plan was not updated after the falls or the morning meeting (9/16/2024) where his falls were discussed. She said Resident #1 was at risk of injury because his interventions were not available to facility staff. She said the interventions she gave to LVN A and LVN B after Resident #1's falls were to monitor him closer and frequently.</p> <p>Interview on 9/17/2024 at 2:23 p.m. the ADMIN said the Corp. MDS was supposed to take over for the MDS nurse that quit. She said the Corp. MDS kept in contact with the care management team (MDS A and MDS B) by email. The ADMIN said she was at a conference and was not a part of the morning meeting (9/16/2024) after Resident #1's falls.</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>Note: The nursing home is disputing this citation.</p>	<p>Interview on 9/17/2024 at 3:08 p.m. with CNA A (via contracted Spanish interpreter) said she was Resident #1's aide. She said she was not told he had two falls during the past weekend. She said she was not informed of any updates to Resident #1's interventions. She said there was not a mat placed at the bedside earlier in the morning when the resident was in the bed. She said a mat was placed at Resident #1 bedside today at approximately 2:00 p.m. She checked the POC for any new updates related to resident interventions and she did not see new fall interventions for Resident #1.</p> <p>Interview on 9/18/2024 at 12:36 p.m. the ADMIN said there was not a time frame to update the care plan. She said she was not able to answer when an intervention needed to be updated and that would be a question for the DON and nursing staff. She said the issue with Resident #1 happened over the past weekend and they were not able to update the care plan. She said Resident #1's care plan was not updated after his fall, but the staff should have verbally communicated any new interventions put in place after the falls.</p> <p>Interview on 9/18/2024 at 1:22 p.m. with the Corp. MDS A nurse said she reviewed Resident #1's care plan. She said resident care plans should be a working document to mitigate what happened. She said Resident #1's care plan should be individualized to address his falls in his room and outside of his room. She said she was not the responsible for taking over for the MDS nurse that quit.</p> <p>Interview on 9/18/2024 at 1:51 p.m. with the Corp. MDS B said she was a traveling MDS nurse and helped out 1 to 2 days a week when needed at a facility. She said care plans are blueprints of what the resident needs. She said an acute issue, like a recent fall, should have been updated by the facility MDS nurses. She said her responsibility was to help update quarterly and annual care plans.</p> <p>Observation and Interview on 9/18/2024 at 3:45 p.m. revealed Resident #1 was lying in bed and his bed was not in the low position. CNA B said she was not sure why the bed was not in the low position. She said Resident #1 may have used the remote control for the bed. She removed the bed remote that was wedged between the mattress and bed frame. She said Resident #1 has used the remote before, but she had not notified a nurse of this behavior. She said the bed should be in the low position because Resident #1 is a high fall risk.</p> <p>Interview on 9/19/2024 at 12:34 p.m. the DON said Resident #1 was discussed in the morning meeting on 9/16/2024. She said a different wheelchair was discussed but was ruled it out because it would have been restrictive. She said a helmet was discussed but ruled out because they felt he would not wear it. She said they had not tried deterring him from pulling up on the handrails by not sitting him on the hall next to the handrails. She said the care management team (MDS nurses) should have updated the care plan right there in the meeting, but it was missed. She said she thought the failure happened over the weekend and she was not on her computer, so she provided verbal interventions. She said she told staff to monitor Resident #1 more frequently and that meant more rounding than the normal every 2 hours. She said the care plan was not updated timely for the interventions to care over to the CNAs POC, which would have made them aware of fall interventions for Resident #1.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Mememorial City Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1341 Blalock Houston, TX 77055	
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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>Note: The nursing home is disputing this citation.</p>	<p>Interview on 9/19/2024 at 7:30 p.m. with LVN B, said CNA C notified her Resident #1 was in his room, fell forward out of his wheelchair, fell on the floor and hit his head (on 9/14/2024). LVN B said she went to the Resident #1's room and he had a tear on his right elbow, skin tear to his fifth digit, an abrasion to his right thigh and top of his head. LVN B said the DON told her to fill out the incident report, fall assessment and treat his injuries. LVN B said she was not instructed to update Resident #1's care plan. LVN B said the DON instructed her to complete additional rounding (q 4 hours) and add a fall mat. She said she did not update Resident #1's interventions. LVN B said care management (MDS nurses) was responsible for updating the care plans.</p> <p>Interview on 9/19/2024 at 12:47 a.m. with MDS A said Resident #1's care plan was not updated until 9/18/2024 after surveyor intervention. She said the care plan interventions are carried over to the POC for CNAs to have access as to what the interventions were. She said the intervention was to keep Resident #1 at the nurses' station while he was awake so the nurse could see him.</p> <p>Record review of facility policy Care Plan Revision upon Status Change dated 10/24/2022 revealed in part the following:</p> <p>Policy:</p> <p>The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change.</p> <p>Policy Explanation and Compliance Guidelines:</p> <ol style="list-style-type: none"> <li>1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change.</li> <li>2. Procedure for reviewing and revising the care plan when a resident experiences a status change: <ol style="list-style-type: none"> <li>a. Upon identification of a change in status, the nurse will notify the MDS Coordinator, the physician, and the resident representative, if applicable.</li> <li>b. The MDS Coordinator and the Interdisciplinary Team will discuss the resident condition and collaborate on intervention options.</li> <li>c. The team meeting discussion will be documented in the nursing progress notes.</li> <li>d. The care plan will be updated with the new or modified interventions.</li> <li>e. Staff involved in the care of the resident will report resident response to new or modified interventions.</li> <li>f. Care plans will be modified as needed by the N (nurse), DS Coordinator or other designated staff member.</li> <li>g. The Unit Manager or other designated staff member will communicate care plan interventions to all staff involved in the resident's care.</li> </ol> </li> </ol> <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>Note: The nursing home is disputing this citation.</p>	<p>h. The Unit Manager or other designated staff member will conduct an audit on all residents experiencing a change in status, at the time the change in status is identified, to ensure care plans have been updated to reflect current resident needs.</p> <p>Record review of facility policy Fall Prevention Program dated 8/15/2022 revealed the following in part:</p> <p>High Risk Protocols:</p> <p>5.</p> <p>a. Provide interventions that address unique risk factors measured by the risk assessment tool: medications, psychological, cognitive status, or recent change in functional status .</p> <p>8. When any resident experiences a fall, the facility will: .E. Review the resident's care plan and update as indicated.</p> <p>An Immediate Jeopardy (IJ) situation was determined due to the above failures. The ADMIN and DON were notified and provided with the IJ template on 9/18/2024 at 12:46 p.m.</p> <p>The following Plan of Removal submitted by the facility was accepted on 09/18/2024 at 4:51 p.m. and included:</p> <p>September 18, 2024</p> <p>[facility]</p> <p>LETTER OF CREDIBLE ALLEGATION FOR REMOVAL OF IMMEDIATE JEOPARDY</p> <p>Attention Sir or Madam:</p> <p>On September 18, 2024, the Facility was notified by the surveyor that immediate jeopardy had been called and the Facility needed to submit a letter of removal. The Facility respectfully submits this Letter for a Plan of Removal pursuant to Federal and State regulatory requirements.</p> <p>The immediate jeopardy is as follows:</p> <p>Issue:</p> <p>F 656 - Develop/Implement Comprehensive Care Plan</p> <p>The facility failed to update or modify fall interventions after falls. Falls: Fall 7/12/24 - Left elbow. Unwitnessed fall. Fall- 9/14/2024 - Hematoma to left side of head. Witnessed fall. Fall- 9/15/24 - Hematoma to right side of head. Witnessed fall.</p> <p>Done for those affected:</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>Note: The nursing home is disputing this citation.</p>	<p>On 9/17/2024, Resident #1 was reassessed by Director of Nursing head to toe for injury and pain. The MD was notified of the findings with no new orders received.</p> <p>On 9/17/2024, Resident #1 was reassessed by the Director of Nursing and/ or designee related to use of Plavix and potential side effects, as well as falls, fall risk and fall interventions with no concerns noted. The MD was notified with no new orders were received.</p> <p>On 9/17/2024, the IDT reviewed Resident #1's plan of care related falls, injuries, pain and use medication Plavix. The plan of care was updated to reflect interventions regarding falls, injuries, pain and pharmacy consult medication as indicated and the RP was notified.</p> <p>To Identify Other Residents:</p> <p>Beginning 9/17/2024, the Director of Nursing and/ or designee reassessed residents who sustained falls 9/1/2024 through 9/17/2024 head to toe for pain and injury with no new concerns. By 9/17/2024.</p> <p>Beginning 9/17/2024, the Director of Nursing and/ or designee reviewed the status of resident injuries sustained from falls with no concerns in the last 30 days for appropriate treatment, care plan interventions and resolutions. By 9/17/2024.</p> <p>Beginning 9/17/24, the Director of Nursing and/ or designee reviewed the fall risk assessments for current residents for timely completion where indicated fall risk was reassessed and updated. By 9/17/2024.</p> <p>Beginning 9/17/2024, the IDT reviewed the falls care plans for residents identified to be at high risk for falls and/ or residents with physician orders for an anticoagulant for appropriate interventions and implementation. By 9/17/2024. There were updates completed as indicated.</p> <p>Beginning 9/17/2024, the Director of Nursing and/ or designee reviewed the progress notes for the last 30 days to ensure resident falls and/ or changes in condition related to falls were identified and addressed. By 9/17/2024. There were no concerns noted.</p> <p>Beginning 9/17/2024, the Director of Nursing and/or designee educated staff on updated care plans. Care Plans and/or interventions will be updated by the nursing staff at the time of occurrence. Care Plan policy was reviewed and there were no updates. The Kardex and tasks will be updated to ensure DCS are aware of interventions placed in the care plans. Nursing staff were reeducated on reviewing the Kardex and task for updated interventions. Completed 9/17/2024.</p> <p>Beginning 9/17/2024, the Director of Nursing and/ or designee reviewed the care plans for current residents who sustained falls in the last 30 days for implementation of interventions to address the fall. Where applicable the care plans were modified for individualization. By 9/17/2024.</p> <p>Education/ System Change:</p> <p>On 9/17/2024, the Regional Clinical Specialist reeducated the Administrator (Abuse Coordinator) and Director of Nursing on Abuse and Neglect and Abuse Policy to include prompt implementation and documentation of interventions to address resident falls and fall risk. By 9/17/2024.</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>Note: The nursing home is disputing this citation.</p>	<p>On 9/17/2024, the Regional Clinical Specialist reeducated the Administrator (Abuse Coordinator) and Director of Nursing on fall prevention and the Fall Prevention Policy to include prompt implementation and documentation of interventions, as well as reassessment of falls risks and adequate supervision to prevent resident falls. By 9/17/2024.</p> <p>On 9/17/2024, the Regional Clinical Specialist reeducated the Director of Nursing on the Incident and Accident Policy. By 9/17/2024.</p> <p>On 9/17/2024, the Administrator/ DON and/ or designee began reeducation to 100% of facility staff on the following: By 9/17/2024</p> <p>Abuse and Neglect and Abuse Policy to include prompt implementation and documentation of interventions to address resident falls and fall risk.</p> <p>Fall Prevention Policy to include prompt implementation and documentation of interventions, as well as reassessment of falls risks and adequate supervision to prevent resident falls.</p> <p>Resident changes in condition to include new and/ or repeat falls, changes in cognition and/ or gait and ADL status.</p> <p>On 9/17/2024, the Director of Nursing and/ or designee began reeducation for the IDT (Administrator, Licensed Nurses, Social Work, Care Management Nurses, Activities Director, Director of Rehab, Dietary Manager) on the policy for comprehensive care plans. Re-education included timely care planning, care plan accuracy, personalized interventions, care plan documentation and implementation of care plan interventions. By 9/17/2024.</p> <p>On 9/17/2024, the Director of Nursing and/ or designee began reeducation with 100% of Licensed Nurses on the Incident and Accident policy to include: By 9/17/2024.</p> <p>Accident and Incident report completion and documentation requirements e.g. immediate actions/ interventions to prevent a fall and supervise residents.</p> <p>Resident fall risk and fall risk reassessment, fall interventions and timeliness, resident supervision related to falls, as well as risk for injury from falls related to use of anticoagulant medication.</p> <p>Resident monitoring and PN documentation post fall (minimum of 72 hours).</p> <p>Changes in condition, to include notifications, interventions, documentation, monitoring and follow-up.</p> <p>Completion of resident skin evaluations, wound assessment forms, pain assessments, treatment orders, monitoring and care plans.</p> <p>Effective 9/18/2024, any facility staff on FMLA, Leave of Absence, non-scheduled workday or PTO will be reeducated by the Administrator, DON and/or designee prior to the start of their next scheduled shift.</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>Note: The nursing home is disputing this citation.</p>	<p>The Director of Nursing/ designee will review the 24-hour report for any changes in condition related to new falls or risk for falls. Ensure the physician is notified timely and that actions are taken timely to address the change in condition, actual fall and/ or fall risk. By 9/17/2024.</p> <p>An Ad Hoc QAPI was conducted on 9/18/2024, attended by the Administrator, DON, Medical Director and Regional Clinical Specialist to discuss the Immediate Jeopardy concerning F 656- Develop/Implement Comprehensive Care Plan.</p> <p>Monitoring:</p> <p>The Director of Nursing will monitor the following daily for 30 days, then three times weekly for two months, effective 9/18/2024.</p> <p>Changes in condition, to include resident falls. DON will ensure falls are promptly addressed by reviewing the 24-hour report and residents clinical records during the Morning Clinical Meeting</p> <p>Accident and Incidents for completion, immediate interventions and care planning, completion of assessments and notifications.</p> <p>Resident falls and anticoagulant medication are care planned for new falls and new orders for anticoagulants.</p> <p>Skin evals, wounds assessments forms and orders for injuries resulting from Incidents and Accidents.</p> <p>The surveyor confirmed the facility implemented their plan of removal and Monitoring began on 9/19/2024.</p> <p>Interviews on 9/19/2024 10:00 a.m. - 1:08 p.m. with 1 RN, 4 LVN, 1 Med aide and 4 CNAs the staff were not aware of the care plan updates, how interventions new and current are located and the process of which staff was responsible for updating the care plans. ADMIN and DON said they would in-service the staff again.</p> <p>Re-interviews after additional in-services:</p> <p>Interviews on 9/19/2024 at 2:22 p.m. - 9/23/2024 12:54 p.m. with ADMIN, DON, MDS nurses, Therapy Director, Activity Director, SW, OT/PT staff said they were reeducated on resident care plans, timely care planning, care plan accuracy, personalized interventions, care plan documentation and implementation of care plan interventions. They said they would ensure falls are promptly addressed by reviewing the 24-hour report and residents. They said they would ensure anticoagulant medications are care planned for new falls and new orders for anticoagulants.</p> <p>Interviews on 9/19/2024 at 2:22 p.m. - 9/23/2024 12:54 p.m. CNAs A,B,C, D, E, F, G and MA A (7a-7p, 7p-7a, 3p-11p) said they were reeducated on the POC and they are aware of interventions placed in the care plans. The staff said they were aware of Resident #'s updated fall interventions. The staff said Resident #1 had a fall mat placed on the right side of his bed and the bed in the lowest position. The staff said Resident #1 should be monitored to ensure he does not try to stand without assistance and he should not be left alone in his room until he is placed in bed.</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>Note: The nursing home is disputing this citation.</p>	<p>Interviews on 9/19/2024 at 2:22 p.m. - 9/23/2024 12:54 p.m. with LVN A, B, C, D, E, F and G (shifts 8a-8p, 8p-8a) said they were reeducated on the policy for comprehensive care plans. Re-education included timely care planning, care plan accuracy, personalized interventions, care plan documentation and prompt implementation of care plan interventions. Nursing staff said they were reeducated on reviewing the POC and task for updated interventions. Nursing staff said they were reeducated on reviewing the Kardex and task for updated interventions. The nursing staff said the [TRUNCATED]</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>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37059</p> <p>Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 4 residents (Resident #1) reviewed for free of accidents, hazards, supervision, and devices., in that:</p> <p>The facility failed to ensure precautionary interventions in place Resident #1, while he was prescribed an anticoagulant, who was a known fall risk that resulted in falls with injuries to the head and hospitalization .</p> <p>An IJ was identified on 9/17/2024. The IJ template was provided to the AIT and DON on 9/17/2024 at 5:06 p. m. While the IJ was removed on 9/20/2021 at 12:31 p.m., with the ADMIN and DON. The facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not an immediate jeopardy and a scope of pattern due to the facility staff had not been trained on identifying residents at risk for fall, preventions, and interventions, and modification and care plan falls.</p> <p>This failure placed facility residents who were fall risk at risk of serious harm and injury.</p> <p>Findings included:</p> <p>Resident #1</p> <p>Record review of Resident #1's face sheet dated 9/17/2024 revealed a [AGE] year-old male who admitted to the facility originally on 2/9/2021 and last admitted on [DATE] with the following diagnoses: Fragile X syndrome (genetic disorder and one of the most common causes of inherited intellectual disability), muscle weakness, unspecified falls, lack of coordination and cognitive communication deficit.</p> <p>Record review of Resident #1's Annual MDS revealed he had a BIMS score of 0 which indicated severe cognitive impairment. He used a wheelchair for mobility. Resident #1 requires total assistance (helper does all the support) for sit to stand and bed transfers. Section J1900 - Number of Falls since admission/entry or reentry or prior assessment was left balnk.</p> <p>Record review of facility Incidents by Resident fall report dated 9/17/2024 revealed the following in part:</p> <ul style="list-style-type: none"> <li>o [Resident #1] - Fall on 7/21/2024 at 9:40 p.m.</li> <li>o [Resident #1] - Fall on 9/14/2024 at 7:34 p.m.</li> <li>o [Resident #1] - Fall on 9/15/2024 at 12:15 p.m.</li> </ul> <p>Record review of Resident #1's care plan dated 9/17/2024 revealed the following:</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>Note: The nursing home is disputing this citation.</p>	<p>Problem: [Resident #1] receives anticoagulant/antiplatelet (medications that help reduce blood clotting) therapy (Plavix medication) Date initiated: 2/2021. Revision: 4/18/2024</p> <p>Goal: [Resident #1] will be free from discomfort or adverse reactions related to anticoagulant use through the review date. Date initiated: 2/10/2021. Revision on: 6/20/2024. Target date 11/3/2024.</p> <p>Interventions: Administer anticoagulant medications as ordered by physician .Daily skin inspection. Document any abnormalities .Observe/document/report PRN adverse reactions of anticoagulant therapy . bruising. Revision on 8/6/2023, Resident/family /caregiver teaching to include the following: . avoid activities that could result in injury, take precautions to avoid falls .</p> <p>Problem: [Resident #1] is high risk for falls r/t impaired mobility. Date initiated 2/11/2021. Revision on: 4/18/2024.</p> <p>Goal: [Resident #1] risks and injury potential will be minimized through the next review date. Date initiated: 2/11/2021. Revision on: 6/20/2021. Target date: 11/3/2024.</p> <p>Interventions: Anticipate and meet the resident's needs. Dated initiated: 2/11/2021. Follow facility fall protocol. Date initiated 2/19/2021. PT evaluate and treat as ordered or PRN. 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; side rails as ordered, handrails on walls, person items within reach. Date initiated 2/19/2021. Revision on 8/7/2023.</p> <p>Problem: [Resident #1] has had an actual fall with (Specify: no injury, On 12/28/2022) Poor Balance, Unsteady gait [the way a person walks]. 7/12/2023: actual fall, no injury. Date initiated: 1/9/2023. Revision on: 7/12/2023.</p> <p>Goal: [Resident #1] will resume usual activities without further incident through the review date. Date initiated: 1/9/2023. Revision on 6/20/2024. Target date: 11/3/2024.</p> <p>Interventions: Continue interventions on the at-risk plan. Date initiated: 1/9/2023. PT consult for strength and mobility. Date initiated: 1/9/2023 .Staff will round frequently and try to anticipate his needs. Date initiated: 7/21/2024. Staff will start offering [Resident #1] to stand and relieve pressure throughout the day. Date initiated 4/1/2024.</p> <p>Record review of Resident #1's Fall Risk Evaluations dated 7/21/2024 - 9/14/2024 revealed the following:</p> <p>Effective Date: 7/21/2024 - Score 13. Category High Risk. Scoring: If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. A prevention protocol should be initiated immediately and documented on the care plan.</p> <p>Effective Date: 9/14/2024 - Score 15. Category High Risk. Scoring: If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. A prevention protocol should be initiated immediately and documented on the care plan.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Effective Date: 9/15/2024 - Score 16. Category High Risk. Scoring: If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. A prevention protocol should be initiated immediately and documented on the care plan.</p> <p>Record review of Resident #1's Order Summary Report dated 9/17/2024 revealed the following in part:</p> <p>. May transfer to [Hospital] and clinical ER for CT of head r/t witness fall with head injury (order date 9/15/2024) .Transfer to .ER for CT of head and X-ray of L [left] shoulder r/t fall (order date 7/22/2024). Clopidogrel Bisulfate oral tablet 75 mg - Give 1 tablet by mouth one time a day for blood thinner (order date 2/10/2021).</p> <p>Record review of facility nursing notes dated 9/14/2024 at 10:06 p.m. revealed the following in part:</p> <p>Change of Condition: Signs/Symptoms Details: witnessed fal [sic], started 09/14/2024 .</p> <p>9/15/2024 02:00 [2:00 a.m.] NURSING - Nurse Note</p> <p>Note Text: Res arrived back to facility via . Ambulance transport. x2 assist by city ambulance personnel to transfer res from stretcher to bed via slide method. Res arrived back to facility a&amp;o x1 with 0 s/s of distress or discomfort. CT scan of head negative of any new/acute findings. No new orders received with res discharge paperwork from hospital. [name of on call service] oncall contact and notified of situation and res return to facility; spoke with [NAME], NP. [NAME], NP ordered to hold Plavix [keeps blood from coagulating (clotting)] until Monday; order implemented. POC conts [sic] as ordered. Res in bed with bed in lowest position, call light in place and all safety measures in place at this time.</p> <p>9/15/2024 12:15 .Res in Bistro area in WC eating lunch and witnessed falling on floor r/t leaning forward in WC after numerous attempts of assistance from staff to reposition him in WC so that res can sit back comfortably. Upon assessment SN (LVN A) noted bleeding and swelling from previous head injury to res forehead. res states it hurts but unable to give pain scale rating .</p> <p>Record review of Resident #1's hospital discharge summary dated 9/14/2024 revealed the following:</p> <p>Visit Summary - discharge diagnoses: tear of skin - primary, closed injury of head - primary, contusion (bruise) of right elbow - primary .</p> <p>Record review of Resident #1's hospital discharge summary dated 9/15/2024 revealed the following:</p> <p>Visit Summary - discharge diagnoses: Scalp injury, Fall. CT head without contrast. Findings: Right frontal scalp swelling is demonstrated.</p> <p>Observation and attempted Interview and on 9/17/2024 at 9:12 a.m. revealed Resident #1 was lying in bed on a pressure reducing air mattress. Resident #1 had on a brief, no shirt and no pants, glasses and a baseball style cap. Resident #1's call light was not in reach. The call light was on the floor. The floor on both sides of Resident #1's bed did not have a mat. The Residents bed was in a low position.</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>Note: The nursing home is disputing this citation.</p>	<p>Interview on 9/17/2024 at 1:35 pm with ADON, said Resident #1 had two witnessed falls on 9/14/2024 and 9/15/2024. She said after the fall on 9/14/2024 they were instructed by the DON to make more frequent rounding and make sure he was visible. She said she did not update Resident #1's care plan after the last two falls. She said care plans should be updated to ensure interventions are documented and put in place. The ADON said the MDS nurses take the load and the ADMIN said a Corp. MDS nurse would update care plans since a MDS nurse quite last week (9/11/24 or 9/12/24). She said it was her understanding MDS A and MDS B would update care plans. She said she was not told it was her responsibility to update the care plan. She said Resident #1's last two falls were discussed in the morning meeting on 9/16/2024 with the IDT. The ADON said MDS A, MDS B and DON were in the morning meeting held on 9/16/2024. She said interventions were discussed related to Resident #1 with the IDT. She said she expected MDS A and MDS B to update Resident #1's care plan interventions. She said care plan interventions for Resident #1 should have been updated to address his recent falls and Resident #1's behavior of pulling up on handrails. She said the interventions are carried over to the cna's plan of care after the care plan is updated.</p> <p>Interview on 9/17/2024 at 2:06 p.m. with the DON said she was aware of Resident #1's last two falls. She said she was notified and instructed the staff to monitor him more frequently. She said Resident #1 should have had fall mat placed on the side of his bed. She said she could not explain why the mat was not there. Surveyor explained earlier observations revealed Resident #1 did not have a mat while he laid in bed. She said she was not sure why he did not have a mat and they would put one out. She said a helmet was not considered because, Resident #1 did not like to take off his caps. She said another type of wheelchair was not considered because the IDT felt it would be restrictive. She said Resident #1's care plan was not updated after the falls or the morning meeting (9/16/2024) where his falls were discussed. She said Resident #1 was at risk of injury because his interventions were not available to facility staff.</p> <p>Interview on 9/17/2024 at 3:08 p.m. with CNA A (via contracted Spanish interpreter) said she was Resident #1's aide. She said she was not told he had two falls during the past weekend. She said she was not informed of any updates to Resident #1's interventions. She said there was not a mat placed at the bedside earlier in the morning when the resident was in the bed. She said a mat was placed at Resident #1 bedside today at approximately 2:00 p.m. She said she would check in the POC for any new updates related to resident interventions and she did not see new fall interventions for Resident #1.</p> <p>Interview on 9/18/2024 at 1:22 p.m. with the Corp. MDS A nurse said she reviewed Resident #1's care plan and said it needed to be cleaned up and we should have showed each fall that occurred. She said resident care plans should be a working document to mitigate what happened. She said Resident #1's care plan should be individualized to address his falls in his room and outside of his room. She said she was not aware that Resident leaned out of his chair on both falls and that he pulls himself up when he is positioned along the handrails in the hallways.</p> <p>Interview on 9/18/2024 at 1:51 p.m. with the Corp. MDS B said she was a traveling MDS nurse and helped out 1 to 2 days a week when needed at a facility. She said care plans are blueprints of what the resident needs. She said an acute issue, like a recent fall, should have been updated by the facility MDS nurses.</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>Note: The nursing home is disputing this citation.</p>	<p>Interview on 9/18/2024 at 2:40 p.m. with LVN A, said she worked with Resident #1 while he ate lunch on 9/15/2024. She said Resident #1 leaned forward and pushed back from the table, which was his normal behaviors. She said this was his normal behavior. She said Resident #1 pushed back from the table, while in the wheelchair, leaned forward, fell to the floor and hit his head. She said Resident #1 yelled out his head hurts. She said she was not told to update Resident #1's care plan. She said she was told by the DON keep a closer eye on him, which meant to keep him in our eyesight. She said Resident #1's leaning was not new, but it was more exaggerated. She said she was aware Resident #1 had a fall the day prior but was not told about new or updated interventions in his care plan. She said his normal interventions were to anticipate his needs and follow the fall protocol. She said the ADON said we needed to update his care plan because this behavior was not new, but it was more frequent. LVN A said the DON and ADON was responsible for updating the care plans.</p> <p>Interview on 9/18/2024 at 3:12 p.m. with Resident #1's PCP, said she was notified Resident #1 had a fall on 9/14 and he was in his wheelchair, had a hematoma to his head and the nurse [LVN B] said the hematoma was expanding. The PCP said she was at the facility when Resident #1 had the second fall on 9/15/2024 around lunch time. She said he had a raised bump on his head. She said he had tears rolled down his face. She said she observed him today (9/18/2024) in his wheelchair trying to get up using the hand railing. She said she was not sure who updated the care plans but said it was important to include behaviors that caused a risk to the resident's safety and to implement interventions to help to prevent injuries.</p> <p>Observation and Interview on 9/18/2024 at 3:45 p.m. revealed Resident #1 was lying in bed and his bed was not in the low position. CNA B said she is not sure why the bed was not in the low position. She said Resident #1 may have used the remote control for the bed. She removed the bed remote that was wedged between the mattress and bed frame. She said Resident #1 has used the remote before, but she had not notified a nurse of this behavior. She said the bed should be in the low position because Resident #1 is a high fall risk.</p> <p>An interview was attempted on 9/18/2024 at 4:22 p.m. with LVN B by phone.</p> <p>Interview on 9/19/2024 at 8:35 a.m. with Therapy Director said all residents are evaluated after every fall. She said due to Resident #1's cognition, he could not learn new things and the therapy performed would maintain skills he had. She said he had poor safety awareness. She said he required queuing because he will attempt to get up, and it is not safe for him to do so. She said therapy was not effective for preventing fall for Resident #1 and it was for maintenance.</p> <p>Interview on 9/19/2024 at 7:30 p.m. with LVN B, said CNA C notified her Resident #1 was in his room, fell forward out of his wheelchair, fell on the floor and hit his head (on 9/14/2024). LVN B said she went to the Resident #1's room and he had a tear on his right elbow, skin tear to his fifth digit, an abrasion to his right thigh and top of his head. LVN B said the DON told her to fill out the incident report, fall assessment and treat his injuries. LVN B said she was not instructed to update Resident #1's care plan. LVN B said the DON instructed her to complete additional rounding (q 4 hours) and add a fall mat. She said she did not update Resident #1's interventions. LVN B said care management (MDS nurses) was responsible for updating the care plans.</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>Note: The nursing home is disputing this citation.</p>	<p>Interview on 9/19/2024 at 7:52 p.m. with CNA C said he took Resident #1 to his room. CNA C said he turned to adjust the bed and Resident #1 fell out of his wheelchair onto the floor (on 9/14/2024. CNA C said Resident #1 fell face first and did not make a sound. CNA C said Resident #1 was sent the hospital. CNA C said when the resident returned, he was told to sit with the resident while he laid in bed. He said he was not aware of new interventions for Resident #1 because he was not working with him today.</p> <p>* Record review of facility policy Fall Prevention Program dated 8/15/2022 revealed the following in part:</p> <p>High Risk Protocols:</p> <p>5.</p> <p>a. Provide interventions that address unique risk factors measured by the risk assessment tool: medications, psychological, cognitive status, or recent change in functional status .</p> <p>8. When any resident experiences a fall, the facility will: .E. Review the resident's care plan and update as indicated.</p> <p>September 17, 2024</p> <p>[facility]</p> <p>LETTER OF CREDIBLE ALLEGATION FOR REMOVAL OF IMMEDIATE JEOPARDY</p> <p>Attention Sir or Madam:</p> <p>On September 17, 2024, the Facility was notified by the surveyor that immediate jeopardy had been called and the Facility needed to submit a letter of removal. The Facility respectfully submits this Letter for a Plan of Removal pursuant to Federal and State regulatory requirements.</p> <p>The immediate jeopardy is as follows:</p> <p>Issue:</p> <p>F 689 - Accidents/Supervision</p> <p>The facility failed to provide Resident #1 who is on an anticoagulant medication, adequate supervision and interventions to prevent falls causing head injury.</p> <p>The facility failed to ensure Resident #1's care plan was updated with interventions after 3 falls that resulted in hematomas to the forehead.</p> <p>Done for those affected:</p> <p>o On 9/17/2024, Resident #1 was reassessed by Director of Nursing head to toe for injury and pain. The MD was notified of findings with no new orders received.</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>Note: The nursing home is disputing this citation.</p>	<p>o On 9/17/2024, Resident #1 was reassessed by the Director of Nursing and/ or designee related to use of Plavix and potential side effects, as well as falls, fall risk and fall interventions with no concerns noted. The MD was notified with no new orders received.</p> <p>o On 9/17/2024, the IDT reviewed Resident #1's plan of care related falls, injuries, pain and use medication Plavix. The plan of care was updated to reflect interventions regarding falls, injuries, pain and pharmacy consult medication as indicated and the RP was notified.</p> <p>To Identify Other Residents:</p> <p>o Beginning 9/17/2024, the Director of Nursing and/ or designee reassessed residents who sustained falls 9/1/2024 through 9/17/2024 head to toe for pain and injury with no new concerns. By 9/17/2024.</p> <p>o Beginning 9/17/2024, the Director of Nursing and/ or designee reviewed the status of resident injuries sustained from falls with no concerns in the last 30 days for appropriate treatment, care plan interventions and resolutions. By 9/17/2024.</p> <p>o Beginning 9/17/24, the Director of Nursing and/ or designee reviewed the fall risk assessments for current residents for timely completion where indicated fall risk was reassessed and updated. By 9/17/2024.</p> <p>o Beginning 9/17/2024, the IDT reviewed the falls care plans for resident identified to be at high risk for falls and/ or residents with physician orders for an anticoagulant for appropriate interventions and implementation. By 9/17/2024. There were updates completed as indicated.</p> <p>o Beginning 9/17/2024, the Director of Nursing and/ or designee reviewed the progress notes for the last 30 days to ensure resident falls and/ or changes in condition related to falls were identified and addressed. By 9/17/2024. There were no concerns noted.</p> <p>o Beginning 9/17/2024, the Director of Nursing and/or designee educated staff on updated care plans. Care Plans and/or interventions will be updated by the nursing staff at the time of occurrence. Care Plan policy was reviewed and there were no updates. The Kardex and tasks will be updated to ensure DCS are aware of interventions placed in the care plans. Nursing staff were reeducated on reviewing the Kardex and task for updated interventions. Completed 9/17/2024.</p> <p>Education/ System Change:</p> <p>o On 9/17/2024, the Regional Clinical Specialist reeducated the Administrator (Abuse Coordinator) and Director of Nursing on Abuse and Neglect and Abuse Policy to include prompt implementation and documentation of interventions to address resident falls and fall risk. By 9/17/2024.</p> <p>o On 9/17/2024, the Regional Clinical Specialist reeducated the Administrator (Abuse Coordinator) and Director of Nursing on fall prevention and the Fall Prevention Policy to include prompt implementation and documentation of interventions, as well as reassessment of falls risks and adequate supervision to prevent resident falls. By 9/17/2024.</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 - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>o On 9/17/2024, the Regional Clinical Specialist reeducated the Director of Nursing on the Incident and Accident Policy. By 9/17/2024.</p> <p>o On 9/17/2024, the Administrator/ DON and/ or designee began reeducation to 100% of facility staff on the following: By 9/17/2024</p> <p>Abuse and Neglect and Abuse Policy to include prompt implementation and documentation of interventions to address resident falls and fall risk.</p> <p>Fall Prevention Policy to include prompt implementation and documentation of interventions, as well as reassessment of falls risks and adequate supervision to prevent resident falls.</p> <p>Resident changes in condition to include new and/ or repeat falls, changes in cognition and/ or gait and ADL status.</p> <p>o On 9/17/2024, the Director of Nursing and/ or designee began reeducation for the IDT (Administrator, Licensed Nurses, Social Work, Care Management Nurses, Activities Director, Director of Rehab, Dietary Manager) on resident care plans, timely care planning, care plan accuracy, personalized interventions, care plan documentation and implementation of care plan interventions. By 9/17/2024.</p> <p>o On 9/17/2024, the Director of Nursing and/ or designee began reeducation with 100% of Licensed Nurses on the Incident and Accident policy to include: By 9/17/2024.</p> <p>Accident and Incident report completion and documentation requirements e.g. immediate actions/ interventions to prevent a fall and supervise residents.</p> <p>Resident fall risk and fall risk reassessment, fall interventions and timeliness, resident supervision related to falls, as well as risk for injury from falls related to use of anticoagulant medication.</p> <p>Resident monitoring and PN documentation post fall (minimum of 72 hours).</p> <p>Changes in condition, to include notifications, interventions, documentation, monitoring and follow-up.</p> <p>Completion of resident skin evaluations, wound assessment forms, pain assessments, treatment orders, monitoring and care plans.</p> <p>o Effective 9/18/2024, any facility staff on FMLA, Leave of Absence, non-scheduled workday or PTO will be reeducated by the Administrator, DON and/or designee prior to the start of their next scheduled shift.</p> <p>o The Director of Nursing/ designee will review the 24-hour report for any changes in condition related to new falls or risk for falls. Ensure the physician is notified timely and that actions are taken timely to address the change in condition, actual fall and/ or fall risk. By 9/17/2024.</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 - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>An Ad Hoc QAPI was conducted on 9/17/2024, attended by the Administrator, DON, Medical Director and Regional Clinical Specialist to discuss the Immediate Jeopardy concerning F 689-Accidents/ Supervision.</p> <p>Monitoring:</p> <p>The Director of Nursing will monitor the following daily for 30 days, then three times weekly for two months, effective 9/18/2024.</p> <ul style="list-style-type: none"> <li>o Changes in condition, to include resident falls. DON will ensure falls are promptly addressed by reviewing the 24-hour report and residents clinical records during the Morning Clinical Meeting</li> <li>o Accident and Incidents for completion, immediate interventions and care planning, completion of assessments and notifications.</li> <li>o Resident falls and anticoagulant medication are care planned for new falls and new orders for anticoagulants.</li> <li>o Skin evals, wounds assessments forms and orders for injuries resulting from Incidents and Accidents.</li> </ul> <p>Surveyor monitored the plan of removal for effectiveness as follows:</p> <p>Interviews on 9/19/2024 10:00 a.m. - 1:08 p.m. with 1 RN, 4 LVN, 1 Med aide and 4 CNAs the I.J. was not able to be lowered based on staff interviews revealed they were not aware of the care plan updates, how interventions new and current are located and the process of which staff was responsible for updating the care plans.</p> <p>Interviews on 9/19/2024 at 2:22 p.m. - 9/23/2024 12:54 p.m. with ADMIN, DON, MDS nurses, Therapy Director, Activity Director, SW, OT/PT staff said they were reeducated o resident care plans, timely care planning, care plan accuracy, personalized interventions, care plan documentation and implementation of care plan interventions. They said they would ensure falls are promptly addressed by reviewing the 24-hour report and residents. They said they would ensure anticoagulant medications are care planned for new falls and new orders for anticoagulants.</p> <p>Interviews on 9/19/2024 at 2:22 p.m. - 9/23/2024 12:54 p.m. CNAs A,B,C, D, E, F, G and MA A (7a-7p, 7p-7a, 3p-11p) said they were reeducated on the POC and they are aware of interventions placed in the care plans. The staff said Resident #1 had a fall mat placed on the right side of his bed and the bed in the lowest position. The staff said Resident #1 should be monitored to ensure he does not try to stand without assistance and he should not be left alone in his room until he is placed in bed.</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>Note: The nursing home is disputing this citation.</p>	<p>Interviews on 9/19/2024 at 2:22 p.m. - 9/23/2024 12:54 p.m. with LVN A, B, C, D, E, F and G (shifts 8a-8p, 8p-8a) said they were reeducated on the policy for comprehensive care plans. Re-education included timely care planning, care plan accuracy, personalized interventions, care plan documentation and prompt implementation of care plan interventions. Nursing staff said they were reeducated on reviewing the POC and task for updated interventions. Nursing staff said they were reeducated on reviewing the Kardex and task for updated interventions. The nursing staff said they were aware to update acute care plan interventions and they did not have to wait for the MDS nurse to update the care plans. The nursing staff said they understood it was important to update the care plan interventions so the POC for CNAs was updated. The nursing staff said the interventions should be updated and put in place immediately to ensure the residents' safety. The nursing staff said they understood care plan interventions should be individualized to meet specific resident needs.</p> <p>Observation on 9/19/2024 at 11:17 a.m. revealed Resident #1 was in his wheelchair and being pushed by a nurse and she offered him coffee.</p> <p>Observation on 9/20/2024 at 11:03 a.m. revealed Resident #1 was in bed in the lowest position and the fall mat was on the door side (left side as surveyor looked at bed).</p> <p>Observation on 9/20/2024 at 2:56 a.m. revealed Resident #1 was next to the nurse's station with a cup of coffee. There was a nurse standing next to him and talking with him periodically.</p> <p>Observation on 9/23/2024 at 9:40 a.m. revealed Resident #1 was across from station #3 with a coffee cup in his hand. A nurse was at the nurses station within a few steps of the resident.</p> <p>Record review of facility head to toe assessments for high fall risk residents with falls from 9/1/2024 - 9/17/2024 (12 residents).</p> <p>Record review of fall risk assessments for current resident for timely completion where indicated fall risk was reassessed and updated. Resident #2's fall risk assessment indicated he was low risk (7 falls between 7/18/24 and 9/7/24) and he was was not indicated on the high risk for falls reassessment intially, but was corrected after surveyor intervention and review.</p> <p>Record review was conducted of the facility's In-services Training Report dated 9/17/24 conducted by DON to Licensed Nurses (LVNs, RNs) revealed the topic was Incident and Accident Policy - .fall interventions and timeliness, supervision related to falls, and risk for injury from falls related to anticoagulant medications . All in attendance voiced understanding.</p> <p>Record review was conducted of the facility's In-services Training Report dated 9/17/24 conducted by DON to All Staff revealed the topic was Fall and Fall Management Policy - Review Fall Prevention Program and Policy and Reeducated IDT members on Fall Prevention Program and Policy as attached. All in attendance voiced understanding.</p> <p>The Administrator was informed that the Immediate Jeopardy was removed on 9/20/2024 at 12:31 p.m. The facility remained out of compliance at the severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope identified as pattern due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37059</p> <p>Based on observation, interview, and record review, the facility failed to maintain an effective pest control program for 4 (Resident #4, Resident #2, Resident #1 and Resident #3) of 4 residents and 1 of 4 nurses' stations reviewed for pests, in that:</p> <ol style="list-style-type: none"> <li>1. Numerous gnats were observed in a resident room on Hall 300 (Resident #4, Resident #2, Resident #1 and Resident #3 rooms).</li> <li>2. There was live medium size roach at hall 300's nurses' station.</li> </ol> <p>This deficient practice could place residents at risk of residing in an environment with pests and decrease quality of life.</p> <p>The findings were:</p> <p>Observation of room [ROOM NUMBER] and interview on 9/17/2024 at 9:02 a.m. revealed there were numerous gnats around Resident #4's bed and cup of coffee she was drinking out of. Resident #4 said she has gotten use to the gnats but does not like them flying around her cup.</p> <p>Observation of room [ROOM NUMBER] and interview on 9/17/2024 at 9:12 a.m. revealed gnats in the room. Resident #3 was on his back in his bed and gnats flew around his head. Resident #3 said the gnats were frustrating because he spends most of his time in his room and does not leave the room often. Resident #1 did not respond to questions.</p> <p>Observation of room [ROOM NUMBER] and interview on 9/17/2024 at 10:50 a.m. revealed numerous gnats in the room and bathroom. Resident #2 said he has seen pest control spray, but it does not get rid of the gnats. He said he was not comfortable in his room because of the gnats.</p> <p>Observation and interview on 9/23/2024 at 9:40 am a.m. revealed a roach (approximately 1 inch) came out of pest control book for station 300. Resident #1 had his coffee cup on the same counter. There was a tray of resident snacks. Some snacks were wrapped in a wax or plastic wrap was not fully sealed. MDS A stepped on the roach after it fell on the floor. She said she had seen roaches at the station previously and documented in the pest control book.</p> <p>Interview on 9/23/2024 at 11:47 a.m. with the Maintenance Dir. said residents should not have gnats or any pest in their rooms. He said he did weekly checks of random rooms weekly. He said roaches could get into snacks that are left at the nurse's station.</p> <p>Interview on 9/23/2024 at 12:11 p.m. with the DON, said roaches or any insect was not acceptable. She said staff should put an entry in the pest control binder at the nurse's station. She said pest control came monthly.</p> <p>Interview on 9/23/2024 at 12:50 p.m. with the ADMIN said the facility did not have a pest control policy. She provided the pest control company's program specifications.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/23/2024
NAME OF PROVIDER OR SUPPLIER  Mememorial City Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1341 Blalock Houston, TX 77055	

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 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 9/23/2024 at 12:54 p.m., ADMIN said the facility was very proactive when dealing with pest. She said pest in resident rooms or at the nurses' station was not a risk to the residents. She said the pest control came weekly.</p> <p>Record review of facility pest control service report dated 9/18/2024 - 9/19/2024 and 9/11/2024 revealed the following in part:</p> <p>9/18/2024 - 9/19/2024</p> <p>Spoke with CNA [name], she mentioned wanting the whole 300 wing treated, and can schedule when to have the residents out of the rooms .</p> <p>Products application summary: Target Pest: small cockroaches</p> <p>9/11/2024</p> <p>Spoke with [name] about notebooks at nurses stations and cockroach activity in the 300 wing .</p> <p>Record review of facility Pest control Program Specifications dated 4/1/2017 revealed the following in part:</p> <p>Service Program Specifications - Interior crawling insect .Interior flying insect program (if applicable) Frequency - Every Month .Service log sightings (Each Service).</p>