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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 12/15/2021 through 12/16/2021. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint (VA00051084 substantiated with deficiencies) was investigated during the survey. The census in this 120 certified bed facility was 103 at the time of the survey. The survey sample consisted of 7 resident reviews.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 657		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical record review, the facility staff failed to review and revise the care plan for one Resident (Resident #1103) following multiple falls, in a survey sample of 7 Residents.

The findings included:

The facility staff failed to review and revise the care plan for Resident #1103 to implement interventions to prevent future fall incidents.

On 12/15/21 at approximately 2:10 PM, Resident #1103 was observed by Surveyor C in the presence of Employee C, the maintenance director. Resident #1103 resided on the memory care unit and cognitive impairments were noted. Facility staff were observed encouraging and assisting Resident #1103 to use her rollator while they ambulated out of the dayroom. Employee C inspected the rollator and determined that despite the brakes being locked the rollator was able to easily roll across the floor.

On 12/15/21 and 12/16/21, a review of the electronic health record (EHR) and the facility provided incident tracking list was performed. This review revealed that Resident #1103 had been determined on 10/14/21, to be a high risk for falling. Resident #1103 had 8 falls within the past 30 days. The falls occurred on 11/15/21, 11/18/21, 11/21/21, 11/24/21, 11/30/21, 12/6/21, and two on 12/7/21.

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Review of the nursing notes and incident reports for the above falls revealed the following:
1. The fall on 11/15/21, indicated no details of a contributing cause or events. On 11/16/21, Resident #1103 was discussed by the IDT (interdisciplinary team) with "no new interventions" being implemented.

2. For the fall on 11/18/21, the nursing notes read, "Resident was walking out the day room without walking [sic] [walker] and had a fall". Another entry this same day read, "Was can [sic] called in room resident right leg was swollen purplish color warm to touch c/o [complained of] pain notified [Nurse practitioner name redacted] new order obtained send to ED [emergency department] for eval treat call 911. Resident #1103 returned and was seen by wound care services for the leg injury, later had to be put on an antibiotic and also had a surgical consult for the injury.

3. Fall on 11/21/21, noted Resident #1103 was "coming towards her room door, knees buckled and she went down to the floor". Resident #1103 was discussed by the IDT 11/22/21, with "no new interventions noted at this time".

4. Fall on 11/24/21, "slid off bed".

5. Fall on 11/30/21, another Resident was holding Resident #1103's hand as she was about to reach the floor and staff intervened and assisted Resident to a chair. The IDT discussed this fall on 12/1/21, and implemented no new interventions.

6. On 12/6/21, Resident #1103 was noted on the floor in her room.

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7. On 12/7/21, Resident #1103 was in the dayroom, while using her walker she fell.

8. On 12/7/21, the Resident was ambulating in the hallway using her rollator and lost her balance and fell. She hit her head on the wall, sustained an open area to her head with bleeding noted and a skin tear to her hand. She was sent to the emergency room for evaluation.

Review of the care plan for Resident #1103 revealed on 11/24/21, an intervention was added that indicated "OT [occupational therapy] as needed". Therapy notes provided reveal that on 11/24/21, she was evaluated and put on therapy caseload due to her fall. No other care plan revisions were noted until 12/15/21, when Resident #1103 was assigned a wheelchair following Surveyor intervention.

On 12/15/21, during an end of day meeting Resident #1103 was discussed with the facility staff. The discussion included Resident #1103's repeated falls and continued use of the rollator, which had been identified by Employee C as needing repairs.

On 12/16/21, the facility Administrator reported to the survey team that Resident #1103 had been determined to not be safe to use the rollator, and had been assigned a wheelchair with a bucket seat and anti-rollbacks on the night of 12/15/21.

On 12/16/21, the facility Administrator provided Surveyor C with the therapy screens and notes for Resident #1103. Review of these documents revealed that Resident #1103 was screened by therapy staff on 12/2/21 and 12/7/21. Both

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F 657	Continued From page 4 screens indicated the Resident was on therapy case load and staff need to remind the Resident to use her assistive device/rollator. The therapy records also contained a screening completed on 12/15/21, and noted, "Removed patient's rollator from room. Secondary to poor safety and unsteady gait. Patient will be given a wc [wheelchair] with anti-rollback and a dumped seat. Patient will work on wc safety and mobility". No further information was provided.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, clinical record review, facility documentation review and in the course of a complaint investigation, the facility staff failed to provide supervision to prevent accidents/falls for one Resident (#1103) in a survey sample of 7 Residents. The findings included: 1. For Resident #1103, the facility staff failed to provide supervision to prevent recurrent falls.	F 689		

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F 689	Continued From page 5	F 689		

On 12/15/21 and 12/16/21, a review of the electronic health record (EHR) and the facility provided incident tracking list was performed. This review revealed that Resident #1103 had been determined on 10/14/21, to be a high risk for falling. Resident #1103 had 8 falls within the past 30 days. The falls occurred on 11/15/21, 11/18/21, 11/21/21, 11/24/21, 11/30/21, 12/6/21, and two on 12/7/21.

Review of the nursing notes and incident reports for the above falls revealed the following:
1. The fall on 11/15/21, indicated no details of a contributing cause or events. On 11/16/21, Resident #1103 was discussed by the IDT (interdisciplinary team) with "no new interventions" being implemented.
2. Fall on 11/18/21, nursing notes read, "Resident was walking out the day room without walking [sic] [walker] and had a fall".
3. Fall on 11/21/21, noted Resident #1103 was "coming towards her room door, knees buckled and she went down to the floor".
4. Fall on 11/24/21, "slid off bed".
5. Fall on 11/30/21, another Resident was holding Resident #1103's hand as she was about to reach the floor and staff intervened and assisted Resident to a chair.
6. On 12/6/21, Resident #1103 was noted on the floor in her room.
7. On 12/7/21, Resident #1103 was in the dayroom, while using her walker she fell.
8. On 12/7/21, the Resident was ambulating in the hallway using her rollator and lost her balance and fell. She hit her head on the wall, sustained an open area to her head with bleeding noted and a skin tear to her hand. She was sent to the emergency room for evaluation.

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F 689	Continued From page 6 Review of the care plan for Resident #1103 revealed on 11/24/21, an intervention was added that indicated "OT [occupational therapy] as needed". Therapy notes provided reveal that on 11/24/21, she was evaluated and put on therapy caseload due to her fall. On 12/15/21 at 3 PM, an interview was conducted with Employee D, the therapy director. Employee D said that when a Resident falls therapy services will screen the Resident to see if any therapy interventions are needed. On 12/15/21, during an end of day meeting Resident #1103 was discussed with the facility staff. On 12/16/21, the facility Administrator reported to the survey team that Resident #1103 had been evaluated to not be safe to use the rollator and had been assigned a wheelchair with a bucket seat and anti-rollbacks on the night of 12/15/21. No further information was provided. Complaint related deficiency.	F 689		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on clinical record review, the facility staff failed to ensure that one Resident (Resident #1103) was free from significant medication errors, in a survey sample of 7 Residents.	F 760		

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F 760	Continued From page 7	F 760		

The findings included:

On 12/15/21 and 12/16/21, the electronic health record for Resident #1103 was conducted.

Resident #1103 had physician orders that read, Clonazepam Tablet 0.5 MG Give 0.5 tablet by mouth two times a day related to schizoaffective disorder, bipolar type and Warfarin Sodium Tablet 4 MG Give 1 tablet by mouth in the evening related to chronic atrial fibrillation.

Further review revealed that on multiple occurrences, Resident #1103 was not administered significant medications as ordered by the physician. The details are as follows:

1. On 11/18/21, twice on 11/19/21, and on 11/20/21, Resident #1103 missed scheduled doses of "Clonazepam". A progress note written on 11/18/21, read "Medication not in cart, called pharmacy, stated script is needed, placed call to md for script". Two progress notes on 11/19/21 and another dose on 11/20/21, for the Clonazepam administration read, "On order".

Resident #1103 was noted with an increase in behaviors. On 11/19/21, nursing notes read, "very fidgety". On 11/20/21, it stated, "Very restless and anxious and aggressive". On 11/20/21, an order for Ativan as needed was obtained from the doctor and administered on 11/20/21, 11/21/21, and 11/22/21.

2. On 11/25/21, 11/26/21, and 12/6/21, Resident #1103 was not administered Warfarin/Coumadin. Progress notes on each of these dates read, "On order".

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F 760	Continued From page 8 No further information was received.	F 760		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, facility documentation review and in the course of a complaint investigation, the facility staff failed to maintain Resident equipment in a safe operating condition for 1 Resident (Resident #1102) in a survey sample of 7 Residents. The findings included. 1. For Resident #1102 the facility staff failed to maintain the wheelchair brakes, which resulted in the Resident falling. Resident #1102 was admitted to the facility on 2/25/2021, and discharged to another nursing facility on 3/2/2021. On 12/15/21, a closed clinical record review was conducted. This review revealed the following: * On 2/25/21, Resident #1102 was assessed for fall risk and was identified to be at "moderate risk for falling". * On 3/1/21, a progress note was entered that read, "Resident discussed due to recent fall with no injuries noted. Care plan reviewed and updated at this time". No further details of the fall were noted in the clinical record.	F 908		

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On 12/15/21 at 2:46 PM, Surveyor C received the incident report regarding Resident #1102's fall from the Facility Administrator. Review of this document indicated in the incident description..."Resident said he was trying to transfer from the wheelchair to the bed. The wheelchair brakes were not properly used at the time of the fall". In the section titled "predisposing environmental factors", equipment was checked.

On 12/15/21 at 3:00 PM, Surveyor C met with Employee D, the therapy director. Employee D was able to recall Resident #1102. Employee D indicated that equipment is assigned by nursing and/or therapy upon admission, it just depends on who provides the equipment first. Employee D indicated that following a Resident having a fall, therapy performs a screening, regardless if they are already on therapy caseload or not.

On 12/15/21 at 3:02 PM, Surveyor C inquired if Employee D knew if Resident #1102 had failed to use the wheelchair brakes properly or if the brakes were malfunctioning. Surveyor C said the incident report was not clear. Employee D, the therapy manager was able to provide Surveyor C with a "rehabilitation Screening Form" for Resident #1102, which was conducted following his fall on 3/1/21. This document read, "Patient wc [wheelchair] locks were not working. Therapy issued a new wc. Patient currently on PT/OT [physical therapy/occupational therapy]. Patient c/o [complained of] R [right] hip pain. Nursing to get x-ray".

On 12/16/21, a review of the facility policy titled, "Maintenance Service" was conducted. This policy read, "Maintenance service shall be provided to all areas of the building, grounds and

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F 908	Continued From page 10 equipment". No further information was provided. Complaint related deficiency.	F 908		