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	125032	A. BUILDING _____ B. WING _____	10/13/2022

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 10/10/2022 to 10/13/2022. The facility was not in substantial compliance with 42 CFR 483 Subpart B. Survey dates: 10/10/2022 - 10/13/2022 Census: 56 Sample size: 14	F 000		
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 record review, interviews, and facility policy review, the facility failed to ensure planned fall prevention interventions were promptly and consistently implemented to minimize the risk of falls/fall-related injury for 1 (Resident #22) of 2 sampled residents reviewed for falls. Findings included: Review of a facility policy titled, "Fall Prevention and Management," revised 03/2022, revealed the steps for post-fall management included, "g. Complete post-fall huddle. h. First responder to	F 689	CORRECTIVE ACTION OF THE RESIDENT IDENTIFIED: The physician orders for Resident #22 were reviewed. There is an active order, placed on 8/28/2020 for, "alarm on at all times." Within the interventions text in the order it specifies "Bed and Body alarm". The results of the sleep pattern monitoring that was completed from 7/23/21-9/30-21 for Resident #22 was reviewed by the interdisciplinary team. It was noted that the resident slept better on nights when	11/29/22

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

Electronically Signed | 11/22/2022

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complete First Responder Form. i. Clinical follow-up for care plan additions/changes as indicated through outcomes of daily stand-up and falls meetings discussions."

Review of a quarterly Minimum Data Set (MDS), dated 10/13/2022, revealed Resident #22 was severely impaired in cognitive skills for daily decision-making, per a staff assessment for mental status. According to the MDS, the resident had active diagnoses including hypertension, Alzheimer's disease, and a history of falling. The MDS indicated the resident required extensive assistance with bed mobility and transfer, did not walk during the assessment period, was totally dependent with locomotion on and off the unit, and used a wheelchair for mobility. Per the MDS, the resident had experienced two falls with no injury since admission, reentry, or prior assessment.

A review of "Current Orders" revealed Resident #22 had a physician's order dated 07/22/2020 for, "Precautions: Fall Prevention Protocol ACTIVE." Additionally, the resident had a physician's order dated 08/28/2020 for alarms to be on "at all times." The order did not specify the type of alarms to be used.

Review of a care plan, dated as initiated 07/22/2020, revealed Resident #22 was at high risk for falls related to a history of falls and a diagnosis of dementia. The care plan indicated the resident had experienced falls on 07/10/2021, 07/23/2021, 07/29/2021, 09/16/2021, 10/17/2021, 01/30/2022, 05/06/2022, 06/11/2022, 07/23/2022, and 09/12/2022. Interventions included monitoring the resident's sleep patterns (07/23/2021); having the physician complete a

she was up out of her room during the day. On 11/17/22, Resident #22's falls care plan was updated to include the intervention, "Encourage me to get out of my room during the day in my wheelchair so that I sleep better at night."

The physician completed a medication evaluation and reviewed the psychotropic committee meeting notes from 8/3/21 on 11/21/22. Per MD/medical director, "No further changes recommended."

The "Psychotropic Committee Meeting" Note on 8/3/21 amended on 11/18/22 to include "correction last fall 7/29/21."

The CNA documenation for close watch for Resident #22 reamins at every 15 minutes at this time.

The intervention, "Make sure alarm is free and clear of resident's doll (or anything else that may hinder alarm from activating) while in bed" was inactivated from Resident #22s fall care plan due to an assessment that was conducted on 7/20/22 that states that it was determined the pillow was not heavy enough that removal of the pillow would trigger the alarm.

A post fall meeting was conducted on 11/18/22 to discuss the falls that occurred on 10/17/21 and 9/12/22 for Resident #22. The falls committee agreed that the interventions that were added to the falls care plan were "offer to go to bed when the resident appears tired" on 10/17/22

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F 689	Continued From page 2 medication evaluation (07/29/2021); having a staff member stay with the resident during periods of restlessness (01/30/2022); replacing the wheelchair alarm due to a malfunction and checking the alarms every shift to ensure they are activated (02/10/2022); placing the resident next to staff, due to the resident's tendency to stand without asking for help (05/06/2022); checking on the resident every 15 minutes (06/11/2022); ensuring the bed alarm is secured with Velcro to ensure proper placement (07/23/2022). Review of a "Nurse Note w/ [with] Vitals," dated 07/23/2021, revealed Resident #22 had an unattended, witnessed fall. The resident's alarm sounded, and staff saw the resident stand, attempt to sit down, and miss the wheelchair. The resident fell to the floor and landed on their buttocks. The wheelchair brakes were locked, the resident's shoes were on, and the floor was dry. The resident reported, "I am looking for my companions." No injuries were noted. Review of an "LTC [Long-Term Care] IDT [Interdisciplinary Team] Note," dated 07/23/2021, revealed a falls meeting was conducted, and an intervention to monitor the resident's sleep patterns was developed. Review of a "Monitoring Sleeping Pattern" form revealed the facility monitored Resident #22's sleep pattern from 07/23/2021 to 09/31/2021. There was no documentation in the resident's medical record of any conclusions or interventions that were developed as a result of the sleep pattern monitoring. Review of a "Nurse Note," dated 07/29/2021, revealed the resident had an "unattended fall."	F 689	and "please toilet me after meals" on 9/12/22 were appropriate. IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED, AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents have the potential to be affected by this deficiency. All falls that occurred within the last six months were reviewed to ensure that fall prevention interventions are promptly and consistently implemented to minimize the risk of falls/falls-related injuries. MEASURES AND SYSTEMIC CHANGES TO PREVENT RECURRENCE: Education will be provided to all nursing staff on the falls policy and procedure and care planning. A spreadsheet will be developed to track falls for all residents. The spreadsheet will be done after every fall to ensure that all follow-up is completed. The Director of Nursing or designee will be responsible for ongoing compliance. MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS Weekly audits of the falls spreadsheet will be completed by the Director of Nursing or designee for 90 days or until 100% compliance is met, in order to monitor the effectiveness of these changes and to ensure correction is achieved and	

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F 689	Continued From page 3 The note indicated a certified nursing assistant (CNA) heard the resident's bed alarm sound and upon entering Resident #22's room, found the resident on the floor between the bed and side drawer. The resident was supine (lying on back) with the right leg flexed upward and the left leg straight. The resident reported attempting to "check the food that I'm cooking." No injury was noted. The note indicated the bed was in the low position and locked at the time of the fall. Review of an "LTC IDT Note," dated 07/30/2021, revealed a falls meeting was conducted, and an intervention was developed to have the physician complete a medication evaluation and to assess the resident's medications during a psychotropic meeting. Review of a "Psychotropic Committee Meeting" note, dated 08/03/2021, incorrectly indicated Resident #22's last fall occurred on 04/13/2021. According to the note, Resident #22's physician did not attend the meeting. Review of a "Nurse Note," dated 01/30/2022, revealed Resident #22 had an unattended fall from the wheelchair. The note indicated the resident was found on the floor in the hallway in front of the wheelchair. The resident reported wanting to go back to bed. According to the note, the wheelchair alarm was on but did not sound. No injury was noted. Review of an "LTC IDT Note," dated 01/31/2022, revealed a falls meeting was conducted, and an intervention was developed to have a staff member stay with the resident during periods of restlessness if the assigned CNA had to attend to another resident; however, based on review of	F 689	sustained. The results of this audit will be reviewed in QAPI.	

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the Nurse Note below, the resident fell again 10 days later after exhibiting signs of restlessness.

Review of a "Nurse Note," dated 02/10/2022, revealed Resident #22 was found on the floor near the hallway, in front of the wheelchair. According to the note, the alarm was on but did not sound. The resident reported wanting to go home. Staff reported they had toileted the resident and placed the resident in bed, but the resident got up twice, so had been placed in the wheelchair.

Review of an "LTC IDT Note," dated 02/11/2022, revealed a falls meeting was conducted, and the wheelchair alarm was replaced due to malfunction. An intervention to check the alarms every shift was added.

Review of a "Nurse Note," dated 05/06/2022, revealed Resident #22 had an "attended fall." According to the note, the resident slipped from the chair to the floor. CNAs attempted to catch the resident but were unsuccessful. The resident reported wanting to go home. No injury was noted.

Review of a "Nurse Note," dated 05/10/2022, revealed a falls meeting was conducted, and an intervention was developed to place the resident next to staff due to the resident's tendency to stand without asking for assistance.

Review of a "Nurse Note," dated 06/11/2022, revealed Resident #22 had an "unattended witnessed fall." Staff heard the resident's alarm sounding and went out in the hall to see the resident sliding slowly to the floor, onto the buttocks. The wheelchair was at the resident's

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back, and the side table was upside down in front of the resident. The resident was unable to explain what they were attempting to do. No injury was noted.

Review of an "LTC IDT Note," dated 06/15/2022, revealed a falls meeting was conducted, and an intervention was developed to check on the resident every 15 minutes.

Review of CNA documentation for "close watch" revealed 15-minute checks were initiated on 06/26/2022, eleven days after the intervention was developed.

Review of a "Nurse Note," dated 07/23/2022, revealed Resident #22 had an unattended fall. According to the note, the resident was found on the floor, facing the door to the room, with the slippers under the resident's right leg. The note indicated the bed alarm did not trigger. The nurse noted that the resident's doll was under the large body pillow on the resident's bed, and when the doll was removed, the alarm sounded; therefore, the nurse surmised the combined weight of the doll and the pillow prevented the alarm from triggering.

Review of an "LTC IDT Note," dated 07/26/2022, revealed a falls meeting was conducted and an intervention was added to check the resident's alarms every shift to ensure they were activated. Additionally, the bed alarm was secured with Velcro to ensure proper placement. The note indicated the body pillow weight was considered; however, it was determined the pillow was not heavy enough that removal of the pillow would trigger the alarm.,

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Review of a "Nurse Note," dated 09/12/2022, revealed Resident #22 had an unattended fall. According to the note, the resident was found in the bathroom, soiled with urine, and lying on the right side with legs extended. No injury was noted. The CNA stated the resident's alarm was delayed and was not sounding when the CNA entered the resident's room and found the resident's wheelchair unoccupied. The note indicated the alarm would be replaced.

Review of a "Fall Risk Assessment," dated 09/12/2022, revealed Resident #22 had fall risk factors including confusion/dementia, unsteady gait, frequent toileting needs, a history of falls in the past three months, a language barrier, and poor hearing. The resident's fall risk assessment total score was 75. The form indicated a score of 15 or greater indicated a fall risk.

Observation on 10/11/2022 at 10:30 AM revealed Resident #22 in a wheelchair in their room, with an alarm in place. The resident's roommate stated the alarm sounded frequently.

During an interview on 10/12/2022 at 2:44 PM, CNA #1 stated he checked on Resident #22 every 15 minutes. CNA #1 stated he also checked to ensure Resident #22's bed and chair alarm were functioning by checking the batteries.

During an interview on 10/13/2022 at 8:50 PM, Licensed Practical Nurse (LPN) #1 stated the Director of Nursing could answer questions related to fall interventions for Resident #22.

During an interview on 10/13/2022 at 9:43 AM, the Director of Nursing (DON) stated she did not see a physician's note to indicate a medication

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review was conducted as indicated after the 07/29/2021 fall. The DON acknowledged the date of the last fall listed on the 08/03/2021 psychotropic meeting notes was incorrect. The DON stated she could not find documentation regarding a discussion about Resident #22's sleep monitoring and did not know what was determined from the monitoring. The DON was asked about the planned intervention to place the resident "next to staff" and when that intervention was discontinued. She stated, "What they do is they try to make sure [resident] is visible where staff can see [gender]." The DON stated for the 05/06/2022 fall, staff was "facing a different direction" and staff were told to keep the resident where they could see the resident. She stated if a staff member had to go in another resident's room, the resident might be left alone but "as much as possible" they preferred to "have eyes on" the resident. The DON was asked why, if staff were to keep the resident in sight, the 15-minute checks were put in place after the fall on 06/11/2022. She stated if the resident was with staff, "they are just checking" on the resident and, if staff had to go and help another resident, the expectation would be to do a visual check on the resident every 15 minutes. The DON stated this was documented on the "close watch" task. The DON stated "close watch" monitoring was only documented every 30 minutes until 06/26/2022 because, while the frequency had had been updated on the care plan, it also needed to be corrected in the task list.

During an interview on 10/13/2022 at 10:57 AM, Registered Nurse (RN) #1 stated she did not recall the results of the sleep review for Resident #22. The RN stated in addition to the alarms, staff were also with the resident when the resident was

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in the hallways, and if the resident was in bed, then the 15-minute checks were done.

During an interview on 10/13/2022 at 11:54 AM, the Administrator stated nurses on the floor were responsible for ensuring care planned interventions were carried out. The Administrator did not recall Resident #22's sleep pattern study and did not know the outcome. The Administrator did not know the details regarding the occasions when the resident's alarm failed to function. The Administrator stated there should be a fall meeting for each fall, during which the fall and the resident's chart were reviewed comprehensively. Based on this review, the team would gather data and look at the care plan to determine if new or different interventions were needed. Regarding the 15-minute checks, the Administrator indicated if staff were doing constant supervision of the resident and switched to 15-minute checks, there should have been clarification that the 15-minute checks were to be done while the resident was in bed.

During an interview with the DON and Administrator on 10/13/2022 at 1:33 PM, the DON stated there was no fall meeting documented after the 10/17/2021 or 09/12/2022 falls. She stated the team talked about the falls in stand-up meetings but must have forgotten to document. The Administrator stated she was not aware there was not a fall meeting after those falls.