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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation # 146866. This 25667 was electronically sent to the facility on 2/10/2020. A revision of this 2567 was electronically sent to the facility on 2/20/2020.	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. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/10/2020

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comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 47, with 13 selected for sample. Based on observation, interview and record review the facility failed to timely review and revise the plan of care for three of the sampled residents, including Resident (R) 42, R41, and R17, all related to revision of the care plans following falls.

Findings included:

- Review of Resident (R) 42's "Physician Orders," dated 01/15/2020, documentation included diagnoses of chronic kidney disease, senile degeneration of the brain, muscle weakness, difficulty walking, and need for assistance with personal care.

The admission "Minimum Data Set" (MDS) dated 01/18/20, documentation included the resident admitted date 01/13/2020, with the "Brief Interview for Mental Status" (BIMS) score of 12, which indicated moderate cognitive impairment. The resident required limited assistance of staff with activities of daily living (ADLS) and required supervision with walking in the corridor. Her balance during transition and walking was not steady but she was able to stabilize without staff assistance. The resident had no functional limitation in range of motion (ROM) in her upper or lower extremities and used a walker. She was always continent of urine and occasionally incontinent of bowel. The resident did not have a history of falls.

The "Falls Care Area Assessment" (CAA), dated

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01/23/2020, documentation included the resident needed assistance with ADL's and transfers related to impaired mobility and was at risk for falls.

The care plan, dated 01/13/2020, directed staff that the resident was at risk for falls related to an unsteady gate. Interventions included Ensure the call light was within reach. Provide appropriate footwear when transferring and ambulating. Provide assistive devices as needed. Ensure items are within reach.

Additions to the care plan included, on 01/22/2020, observe return demonstration of call light, remind resident to use call light for assistance and remind the resident to use her cane to prevent falls.

On 01/27/2020, request the pharmacy to review the resident's medication regimen related to medications that cause falls and perform frequent checks. Remind the resident that she will fall if she stands without assistance.

On 01/29/2020, Ensure the bathroom door remained unlocked when not in use. Instructions to the staff to discontinued use of her cane, remind the resident to use her walker, and request assistance to prevent falls.

Additionally, the care plan entries directed staff that the resident had falls on 01/21/2020, 01/25/2020, and 01/27/2020. The care plan did not reveal any immediate interventions implemented to prevent further falls following the falls on 01/21/2020 and on 01/25/2020.

The electronic medical record (EMR) "Nursing

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Note" (NN), dated 01/21/2020 at 08:16 PM, documentation included the resident fell while toileting herself. She stated she fell to the floor while turning to shut the bathroom door. The resident reported she hit her head against the wall when she fell. Assessment revealed a raised area to the right side of her head, which was tender to the touch. The care plan lacked revision, following this fall, with interventions implemented to prevent further falls for the resident.

The EMR NN, dated 01/25/2020 at 12:30 PM, documentation included the staff found the resident on the floor beside the bed, with her walker on the side by the sink. The assessment revealed the resident with an approximate 0.2 centimeter (cm) swollen area above her left eyebrow and a 0.2 cm. abrasion to her nose near the eyebrows. The call light lacked activation when found by the nurse aide. The resident stated she was trying to reach her briefs on the tops shelf of her closet. She lost her balance and fell to the floor. The staff removed the briefs from the top shelf and placed them in the dresser. The intervention to store the resident's briefs in the resident's dresser instead of the top self of her closet. This interventions was not communicated to the staff in the resident's care plan.

The EMR NN, dated 01/27/2020 at 01:44 PM, documentation included the resident was lying on her husband's floor (adjacent room) with the walker found upright at her feet. It appeared the resident fell backwards. She reported she hit her head on the floor. The assessment revealed an egg sized bump located at the left upper side of her head. The resident stated she attempted to go to her bathroom, found the door locked and

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proceeded to go out into the hallway and enter the bathroom from her husband's door since they share the same bathroom. Once she got into his room, she fell backward. The staff requested the pharmacist review the resident's medications. The intervention to make sure the bathroom door was kept unlocked was not communicated to staff on the care plan until 01/29/2020, two days after the resident's fall.

Review of the fall investigation reports for the resident's falls on 01/21/2020, 01/25/2020, and 01/27/2020, revealed the facility did not thoroughly investigate the cause or contributing factors of the falls to provide appropriate implemented interventions to prevent further falls.

On 01/29/2020 at 11:37 AM, the resident sat in a chair beside her husband in the adjacent room. She had her walker positioned in front of her and no slip grip socks were in place. The resident had a black discoloration beneath the left eye and a scratch/laceration on the left side of her nose. She stated she was visiting with her husband.

On 02/03/2020 at 05:09 PM, the resident walked unattended from her room using the front wheeled walker and wearing non-skid socks. The resident's gait was slow and leaning forward while using the walker.

On 02/04/20 at 11:59 AM, observation of the resident's closet revealed her briefs were directly on the floor of the closet and in the dresser drawer. She sat in her recliner with her cane on the left side of her chair and the walker on the right side of the chair. The bathroom door was unable to be opened and remained locked. The Durable Power of Attorney (DPOA) was present

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and left the room to go to the adjoining room to unlock the bathroom door from the inside when the resident got up and followed her into the adjacent room without using her walker.

On 02/04/2020 at 11:59 AM, the resident's DPOA stated the resident's bathroom door should be unlocked or she goes to the other room to get into the bathroom. The top shelf of the closet should not hold the resident's briefs. She stated the resident used her cane sometimes but should use the rolling walker. The last time the resident fell she had a folding walker by the door.

On 02/04/2020 at 12:05 PM, Certified Nursing Assistant (CNA) N, stated he forgot to unlock the resident's bathroom door as he should have after the resident in the adjacent room had used the toilet at around 10:30 AM.

On 02/03/2020 at 10:57 AM, CNA N reported the resident was a fall risk because when she walks, she leans backward, was unsteady, and she does not use her call light. Staff catch her walking around the room and in her husband's room (the room with the shared bathroom.) We redirect her to use the call light and to use her walker. She fell recently, her husband yelled out and I responded finding her on the floor on her back. The nurse assessed the resident and the resident stated she fell backwards. The black around her eye and the scratch on her nose was a result of the fall. CNA N explained he did not recall the intervention the staff put in place following that fall by the resident.

On 02/03/2020 at 03:55 PM, CNA O stated the nurse assesses the resident when they fall before the staff move them. The nurse should collect witness statements where the staff document

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everything that happened. A new intervention should be put in place after the fall to prevent further falls. The resident was at risk for falls. She woke up one time and was dizzy. Another time she fell because the bathroom door was locked. CNA O reported checking on her often and reminding her to use her call light. CNA O was not aware of any specifics about where the resident's stuff (briefs) should be located. She does not use her cane and should use her walker.

On 02/03/2020 at 11:29 AM, Licensed Nurse (LN) G stated the care plan directed the staff on the resident's needs and preferences. The charge nurse updated the residents' care plans with acute episodes like falls and then the Interdisciplinary Team (IDT) members reviewed it. LN G stated the fall protocol included implementing a new fall intervention following a fall. She reported the resident was a high fall risk due to her critical high potassium and renal failure. The staff must remind her constantly to call for assistance and use her walker and she was already working with therapy. LN G reported she redirected the resident at least five times already, today. LN G did not know if the interventions following the resident's falls were communicated to her or not.

On 02/03/2020 at 02:00 PM, LN J reported the director of nursing investigated the resident falls. The facility fall protocol started with the charge nurse initiating the risk tool in the electronic medical record (EMR), staff assessed for causes and then put an immediate intervention in place to prevent future falls. The IDT review the next morning for appropriateness of the new intervention. LN J verified the investigation

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reports for the resident's falls that occurred on 01/21/2020 and 01/25/2020, lacked analysis of findings to determine the cause or contributing factors related to the falls, lacked appropriate immediate interventions entered in the care plan.

On 02/03/2020 at 04:57 PM, LN K reported the individual needs and preferences of the residents are in the care plan. The charge nurses should revise the care plan with an immediate intervention after a resident fall to prevent further falls. Sometimes it was tough to come up with a new intervention if the person has multiple fall or has dementia. The director of nursing handles the investigation part of the fall. She reported the resident was a fall risk due to individual needs and preferences in the care plan and getting to know them better. The nurses can revise the care plan if they see something a little different. LN K stated she was present for the resident's falls. LN K confirmed the notes failed to reflect immediate interventions to prevent further falls and lacked analysis to determine the cause or contributing factors. The care plan failed to guide because reminding her to use the call light does not work if the resident was impatient or cognitive impaired. The resident was not going to tell the staff that she needs assistance because she wants to go home.

On 02/04/2020 at 01:49 PM, Administrative Nurse D agreed the fall investigations lacked analysis of data to determine the cause and contributing factors related to the fall and immediate interventions with care plan revisions when falls occurred to prevent further falls. She stated the care planned interventions communicate guidance to the staff to prevent falls. Staff should implement care planned interventions

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consistently. The staff should keep the bathroom door unlocked, remove the cane if the intervention was no longer appropriate, and revise the care plan with new interventions to effectively communicate guidance to the direct care staff in a timely manner to ensure the risks of falls are mitigated. The charge nurses should provide oversight to make sure the care planned interventions were consistently used.

The facility policy for "Fall Guidelines-Assessing Falls and Their Causes," dated 10/2010, documentation included the purposes of this procedure was to provide guidance for assessing a resident after a fall and to assist staff in identifying causes of the fall. If causes of a fall cannot be readily identified and if the fall is accompanied by other signs and symptoms (e.g., confusion or lethargy), the staff and physician will consider a possible underlying acute medical cause. The policy did not address the investigation, implementation of immediate interventions following a fall and monitoring for the provision of interventions as care planned to prevent further falls.

The facility failed to timely review and revise the resident's care plan following these falls to prevent further falls for the resident.

- Review of Resident (R) 41's "Physician Orders," dated 01/14/2020, documentation included diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbances and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and

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irrational fear) disorder.

The admission "Minimum Data Set" (MDS) dated 01/15/2020, documentation included the resident admitted on 01/10/2020, with the "Brief Interview for Mental Status" (BIMS) score of four, which indicated severe cognitive impairment. He required extensive assistance of staff with activities of daily living (ADLS) and did not walk. His balance during transition was not steady but he was able to stabilize with staff assistance moving on and off toilet and with surface to surface transfer. He had an indwelling catheter and was occasionally incontinent of bowel. The resident had a fall two to six months prior to admission.

The "Fall Care Area Assessment" (CAA), dated 01/23/2020, documentation included the resident admitted for end of life care and skilled services. He needed assistance with ADL's and transfers related to impaired mobility and weakness and was at risk for falls. The resident experienced incontinence.

The care plan (CP), dated 01/10/2020, directed staff the resident had impaired thought processes and required assistance with decision making related to dementia and he had difficulty understanding others. He was at risk for falls. Staff were to ensure items were within reach, ensure the call light was within reach and remind him to use the call light for safety. The staff were to provide assistive devices as needed and review information on his past falls and attempt to determine the cause of the falls. The care plan lacked additional interventions following the resident's falls on 01/17/2020 until 01/19/2020, two days following the accidents. The additional

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interventions included:
1) Provide comfort and reassurance.
2) Place a fall mat.
3) Offer a bed pan if agitated.
4) Assess pain every shift.
5) Ask if resident he would like his spouse to sit with him.

Review of the electronic medical record (EMR) revealed the "Orders-Administration Note Text," on 01/17/2020 at 07:50 PM, revealed the resident received Milk of Magnesia (MOM) Concentrate Suspension, 30 milligrams/milliliter, by mouth, as needed, for constipation.

The "Nursing Note Text/Primary Care Physician Communication," dated 01/17/2020 at 09:03 PM, (one hour and 13 minutes after the staff administered him the MOM) documentation included the staff called the nurse to the resident's room where the resident was lying on his back next to the bed. The resident stated that he was going to get up to mop and fell. The assessment at the time of the fall, revealed the resident was noticeably confused. The documentation did not include a root cause analysis of causes or contributing factors related to the fall and/or an immediate intervention provided to prevent further falls.

Review of the "Interdisciplinary Team (IDT) Review," in the EMR, dated 01/19/2020 at 10:23 PM, two days after the falls, documentation included the resident got out of bed and fell onto the floor, and within minutes (after being repositioned onto the bed) repeated that event. The team documented the Root Cause Analysis: He believed he was getting up to mop the floor. The IDT Recommendations/Interventions were as

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follows:
1) Provide comfort and reassurance.
2) Place a fall mat.
3) Offer a bed pan if agitated.
4) Assess pain every shift.
5) Ask if resident he would like his spouse to sit with him.

Review of the "Fall Investigation," dated 01/20/2020, revealed the facility failed to analyze the collected data to determine the cause or contributing factors resulting in the resident's fall. However, it identified interventions to include a mat added to the floor and to ensure the bed was in the lowest position when staff were not giving direct care.

On 01/28/2020 at 12:09 PM, the resident was lying quietly in the low bed, with the fall mat in place.

Observation on 02/04/2020 at 10:30 AM, revealed the resident was yelling out "I gotta go." He was sitting on the side of the bed with his feet on the fall mat next to his low bed. Administrative Staff A responded to a report of the resident yelling out. At 10:35 AM, Administrative Staff A and Certified Nurse Aide (CNA) N assisted the resident to the wheelchair using a gait belt and then assisted him to the toilet in the bathroom where the resident had a large bowel movement (BM).

On 02/4/2020 at 12:02 PM, AM, the resident rested in the low bed with his eyes closed, quietly. The fall mat was not in place beside the bed but instead folded and across the room. At that time, the resident's Durable Power of Attorney (DPOA), in the room, confirmed the resident's fall mat was not in place as it should be to prevent injuries

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from falls.

On 02/04/2020 at 12:05 PM, CNA N stated he forgot to replace the fall mat beside the resident's bed after assisting the resident from the bathroom earlier in the morning.

On 02/03/2020 at 10:57 AM, CNA N stated when a resident falls the staff nurse assessed the resident before being moved. He stated the nurse should initiate interventions for the residents immediately after a fall to prevent further falls. CNA N reported the resident yelled and tried to get out of bed when he knew he needed to have a BM. Furthermore, the resident usually mellowed out after having a BM. Current interventions included the bed in a low position next to the wall, a fall mat beside the bed, and the staff to reposition and monitor the resident frequently.

On 02/03/2020 at 11:29 AM, Licensed Nurse (LN) G stated the fall protocol included implementing a new fall intervention following a fall. She reported the resident was at high fall risk due to his confusion. Current fall interventions included keeping the bed in a low position next to the wall, a fall mat beside the bed, monitoring for pain and reposition and monitor frequently.

On 02/03/2020 at 03:55 PM, CNA O, stated the current fall interventions for the resident included keeping the bed in a low position next to the wall, a fall mat beside the bed, monitoring for pain and reposition and monitor frequently. The resident usually needed to use the bathroom when he became restless. He did not like the bed pan but would go to the toilet. He required assistance to transfer to the bed to chair and then to the toilet.

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He would calm down after he has a BM.

On 02/03/2020 at 04:57 PM, LN K reported the charge nurses should revise the care plan with an immediate intervention after a resident falls to prevent further falls. Sometimes it was tough to come up with a new intervention if the person has multiple fall or has dementia. The director of nursing handles the investigation part of the fall. She reported the resident was a fall risk due to his disease process and he has bad sundowning (increased confusion later in day) which improved with his medication adjustment.

On 02/04/2020 at 01:49 PM, Administrative Nurse D stated the resident had a fall and the staff no sooner got him comfortable in the bed and he flew off the bed again. She confirmed the progress note for 01/17/2020, as noted above did not address an additional fall and verified the staff administered MOM an hour before the fall occurred and that needing to have a bowel movement could be a contributing factor to his restlessness. She agreed the investigation lacked analysis of data to determine cause and contributing factors related to the fall and lacked an immediate intervention when the fall occurred. Administrative Nurse D stated the care planned interventions communicate guidance to the staff to prevent falls, and the expectation was for staff to place a fall mat next to the low bed in the low position prior to leaving the resident unattended.

The facility policy for "Fall Guidelines-Assessing Falls and Their Causes," dated 10/2010, documentation included the purposes of this procedure was to provide guidance for assessing a resident after a fall and to assist staff in identifying causes of the fall. If causes of a fall

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cannot be readily identified and if the fall is accompanied by other signs and symptoms (e.g., confusion or lethargy), the staff and physician would consider a possible underlying acute medical cause. The policy did not address the investigation, implementation of immediate interventions following a fall and monitoring for the provision of interventions as care planned to prevent further falls.

The facility failed to timely review and revise the resident's care plan to include appropriate interventions following this dependent confused resident's 2 falls to prevent further falls.

- The electronic medical record (EMR) indicated that Resident (R)17 admitted to the facility on 09/20/19.

The "Medication Review Report," dated 01/02/2020 revealed R17 had diagnoses of muscle weakness, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), restlessness, and agitation.

The admission "Minimum Data Set" (MDS), dated 09/27/19, assessed R17 with a Brief Interview of Mental Status Score (BIMS) of 11, indicating moderate cognitive impairment. He required extensive assistance of two or more staff for bed mobility, transfers, and toilet use, and extensive assistance of one for locomotion and ambulation in the corridor. His balance was not steady, and he was only able to stabilize with human assistance. He had a limitation to one side of his upper extremity range of motion. He used a

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walker and wheelchair for mobility. The assessment also indicated that he was occasionally incontinent of bowels and had an indwelling catheter present. He had a fall in the last month prior to admission and had no falls since admission. Physical therapy treated him for four days and 122 minutes and Occupational therapy treated him for six days and 309 minutes.

The quarterly "MDS," dated 12/14/19, assessed the resident with short and long term memory problem, no memory recall, and severely impaired decision making. He required extensive assistance of one staff for bed mobility, transfer, locomotion, and for toileting. He did not ambulate in the room or corridor. His balance was not steady, and he was only able to stabilize with human assistance. He used a wheelchair for mobility and was frequently incontinent of bladder and occasionally incontinent of bowel. He was not on a toileting program for his bowel and bladder. Furthermore, he did have falls since admission or the prior MDS assessment, which included one injury fall that was not a major injury. He received Physical Therapy during the seven day lookback period for the MDS, for five days and 42 minutes in group and 158 individual therapy minutes. Physical Therapy began treatment on 11/15/19.

Both the "Falls and Activities of Daily Living Care Area Assessments" (CAA), dated 10/04/19, revealed R17 was at risk for falls and needed assistance with activities of daily living (ADL's) and transfers related to impaired mobility and recent hospitalization.

The "Urinary Incontinence and Indwelling Catheter CAA," dated 10/04/19, revealed this CAA triggered for required extensive assistance

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for toileting and he required an indwelling catheter.

The "Cognitive Loss/Dementia CAA," dated 10/04/19, revealed R17 could not recall the day of the week or the word sock. He only was able to repeat 2 of the 3 words at the beginning of the assessment.

The care plan for incontinence, revised on 09/23/19, instructed the staff that R17 was incontinent of bowel and bladder at times, preferred to be assisted to the bathroom for his toileting needs when requested, and often required changing his briefs as he was unaware of incontinent episodes.

The care plan for falls, dated 09/20/19, instructed the staff that R17 was at risk for falls and to ensure the call light was within reach and encourage him to use it. Provide him with appropriate footwear when transferring and ambulating, provide assistive devices (which devices not identified) as needed, and remind him to use call light for safety (inappropriate as the resident experienced confusion so could not remember instructions). Review information on past falls and attempt to determine the cause of the falls as indicated. Provide a clutter free environment, free from spills and/or clutter, adequate lighting, and keep personal items within reach. Alarm pad for chair and bed per family request as safety awareness is poor and has history of not requesting assistance before arising. Discontinued on 10/24/19.

The facility reported the resident had falls on 09/28/19, 10/12/19, 10/18/19, 10/26/19, 10/27/19, 10/29/19, 11/05/19, 11/15/19, 12/09/19,

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F 657	Continued From page 17 01/11/2020, 01/17/2020, and 01/28/2020. 1. The progress note, dated 09/28/19 at 03:56 AM, documented that around 02:30 AM, staff found R17 on the floor at the foot of the bed. He was trying to go to the bathroom, the bed alarm was working, but the nearby television drowned out the alarm sounding. The resident received a 1.0 centimeter (cm) by 1.0 cm skin tear to his left elbow. The fall intervention was to toilet the resident at 02:00 AM even if asleep and to monitor area televisions for volume level. The facility failed to add the intervention to the care plan following the fall to inform the staff. 2. The progress note, dated 10/12/19 at 03:00 PM, revealed staff found R17 on the floor in the hallway in front of his room and lying face down. An abrasion was present to the right side of his forehead. His son reported that his had left R17 unattended in his room to go out to get his dad a shake. On this day, R17 required one on one monitoring for the majority of the day for safety due to his anxiousness and agitation, and his recent dose reduction on an antianxiety medication which added to this. The facility failed to implement a new intervention to the care plan to prevent further falls and inform the staff. 3. The progress note, dated 10/18/19 at 09:45 AM, revealed R17 experienced a fall at 12:45 AM, had a head laceration and a skin tear to his hand. The facility investigation, for the resident's fall on 10/18/19 and completed on 10/24/19, revealed the staff found the resident on the floor of the room in front of the bathroom door. The resident stated he was going to the bathroom and he had not activated the call light. The investigation	F 657		

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included interventions that R17 was relocated to a different room across from the nurse's station to improve visualization and increase sense of security, and staff were to make contact with R17 as they pass by. The facility failed to implement these interventions to inform the staff of the room change with adding them to the care plan and the intervention to make contact with him as the staff passed by until 10/29/19, which was 11 days after the resident's fall.

4. The progress note, dated 10/26/19 at 02:03 PM, revealed R17 was laying on floor in front of his recliner. He stated that he was attempting to take his jacket off and stood up to do so then fell to the floor. The facility failed to add a new intervention to the care plan to prevent further falls.

The interdisciplinary team (IDT) fall review note, dated 10/29/19 at 01:20 PM, revealed R17 had no safety awareness, was confused, impulsive, and does not remember to ask for help. The IDT recommendations included frequent checks, frequent toileting opportunities, reinforce the concept that nursing staff are always present to provide assistance by stopping to talk to him, and engage his son regarding ideas to keep R17 from attempting self transfers, and he responded that he would sit with him on the porch. The facility failed to add any of these recommendations to the care plan to inform the direct care staff.

5. The progress note, dated 10/27/19 at 01:20 AM, revealed the resident fell just after midnight trying to toilet self, had been toileted 15 minutes prior with no void and dry brief, and had a skin tear to his right hand. A repeated attempt to void was also not successful and staff requested an

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order for a straight catheter to check for residual of urine in the bladder and a urinalysis. The facility failed to add a new intervention to the care plan to prevent further falls.

6. The progress note, dated 10/29/19 at 09:21 PM, revealed staff found R17 lying on the floor in front of his wheelchair. He had stated he was just going to lay down and take a nap, then stated he thought it was time to go to his bed.

The IDT fall review note, dated 10/30/19 at 07:35 AM, revealed that the resident stated he was tired and wanted to lie down, and the IDT suspected a urinary tract infection. The interventions/recommendations included: assess for symptoms of urinary tract infection, remain within eyesight of staff members. The physician declined the order for the urinalysis and the "Durable Power of Attorney" (DPOA) chose and alternate physician and requested to be seen by a new physician.

7. The progress note, dated 11/05/19 at 07:12 PM, revealed R17 was on the floor and had two skin tears to his forehead, approximately 2.0 cm by 0.5 cm each. R17 had stated he was walking over to get himself in his bed from his recliner and ended up on his head. The facility failed to add a new intervention to prevent further falls.

The IDT note, dated 11/14/19 at 01:36 PM, which was 9 days after the fall, revealed the resident exhibited no safety awareness and believed he could transfer and ambulate at will but he lacked strength. The IDT team recommendations/interventions included that his medication list was sent to the pharmacist for review and recommended taking his blood

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pressure standing and lying to rule out orthostatic hypotension (blood pressure dropping with change of position) and a slow gradual dose reduction (GDR) of his anxiolytic (a medication used to treat anxiety) and the facility is in the midst of doing so. An order was obtained to resume Physical and Occupational Therapy for strengthening and balance. The care plan intervention for the pharmacy consultant review was added to the care plan on 11/15/19, which was 10 days after the fall. The anxiolytic GDR intervention was added to the care plan on 11/26/19, which was 21 days after the fall. The order for Physical and Occupational Therapy was not added to the care plan until 11/30/19. Physical therapy treatment started on 11/15/19, which was 10 days after the fall, and the intervention was added 25 days after the fall. The facility failed to add a new intervention in a timely manner to prevent R17 from having further falls.

The IDT review note, dated 11/15/19 at 09:45 AM, revealed the team was evaluating fall frequency. R17 had increased falls related to his deficiency of safety awareness, every attempt to self transfer he often stated he was just trying to "..... ". A return demonstration of the call light was successful, voices understanding, and was agreeable with requests to call for assistance. The nursing staff noticed increase in fatigue and somnolence. The facility contacted the pharmacy for med review-to identify meds that may contribute to falls. Staff would move R17 to an easy chair to within sight of the nursing desk, the call light barely reaches, so the staff would contact the maintenance for a call light extender. The pharmacy review of R17's medications was a prior IDT recommendation on 11/14/19 for the 11/05/19 fall. The intervention to ensure call light

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was in reach and encourage use was already in place on the care plan. Reminding R17 to use the call light for safety and observe return demonstration for call light use was not an appropriate intervention due the cognitive state of the resident. The notes regarding the past falls did not indicate that the resident used his call light when he was found on the floor, making the intervention ineffective.

8. The progress note, dated 11/15/19 at 04:26 PM, revealed R17 was sitting on the floor in front of the recliner, stated he heard talking outside of his room and was going to tell the people talking to quiet down. He denied the need to toilet.

The IDT review of the fall, dated 11/18/19 at 08:02 AM, had recommendations/interventions to maintain a quiet environment around the nurses station while R17 was resting, encourage him to call out or use a call light when needing assistance, monitor blood pressure standing or lying to determine a patten for fall risk due to orthostatic hypotension. The review included R17 did not realize he would fall if he arose unattended. The recommendation for orthostatic blood pressure monitoring was a duplicate intervention.

9. A Progress note, dated 01/11/20 at 10:20 PM, revealed R17 was sitting on the floor in his room near the foot of his bed. He stated he was going to the bathroom and did what the staff always told him to and he fell. The care plan lacked a new intervention following the fall to prevent further falls.

The IDT review note, dated 01/13/2020, revealed he needed to use the bathroom and forgot he

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could not walk. The team recommendations/interventions included to conduct a BIMS assessment for cognition, investigate changes in thought process pattern with the DPOA, discuss potential for dementia diagnosis related to current diagnosis of age related cognitive decline, discuss relocating to the memory care unit if diagnosis was appropriate, and request a Speech Therapy screening for safety awareness. The IDT recommendations were not on the care plan and the facility failed to add an immediate intervention to the care plan to prevent further falls.

10. The progress note, dated 01/28/2020 at 08:10 PM, revealed R17 was laying on the floor, stated he wanted to lay down on the floor, and that he got up out of his chair and fell to his buttocks. The care plan lacked a new intervention to prevent further falls.

The IDT review note, dated 01/29/2020, recommendation/intervention was to determine if it was a deliberate change in position or a fall. An intervention was revised on the care plan on 01/29/2020, to keep in eyesight of nursing (instead of just the nurse) while not in bed or sleeping in the recliner (instead of just when sleeping in the bed). The facility failed to add an immediate intervention to prevent further falls.

On 02/03/2020 at 10:28 AM, R17 reported he did not recall falling last week when questioned, which was five days after the most recent fall.

On 02/03/2020 at 10:39 AM, Certified Medication Aide (CMA) R, revealed that she just provides relief to the staff in the memory unit. R17 does not verbalize the need for the bathroom. CMA R

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was not aware of fall interventions other than a fall mat and to try to assist to toilet him every one to two hours. CMA R reported she was guessing there was a book that the interventions were in and would search until she found it. She usually passed medications and would have to ask the charge nurse if she had questions.

On 02/03/20 at 04:24 PM, Certified Nurse Aide (CNA) M, revealed that when a resident fell the charge nurse would get with the staff and tell them what the intervention was. If the fall occurred on a prior shift the intervention was given CNA to CNA by verbal report at shift change. R17's interventions included a fall mat, visual of staff at all times, place quiet sign on door when napping. He transfers with assist of one to two staff, depends on the moment. For toileting, the staff toilet everybody every two hours, except for one resident that was checked and changed every two hours. R17 could tell the staff when he needed to go to the bathroom or when he was wet. The staff try to offer to toilet him before meals and before he goes to bed, or if he was sitting on the side of the bed.

On 02/04/20 at 11:38 AM, Licensed Nurse (LN) I, revealed when a resident fell we come up with a intervention, we put the intervention in the note. LN I was not aware if the charge nurses added the intervention to the care plan or not, she did not know how to get into the care plan in the electronic medical record (EMR) to change things. The nurses had a huddle report sheet where they write the falls on and it was also passed on in report. The staff also fill out an incident report and any staff that have observed the fall fill out a report. The charge nurse verbally passes the fall information on to the CNA's and

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F 657	Continued From page 24 was not sure how CNA staff received information of falls that occurred on the staff's day off. On 02/04/20 at 12:11 PM, with Administrative Nurse D, revealed the nurses are to contact her and come up with an intervention for the fall, and that there was a recent in-service regarding that. Not all nurses were proficient at putting the interventions in the care plan, it usually falls on the IDT team. Administrative Nurse D confirmed that interventions were missing in the care plan and they should be immediately implemented to prevent further falls. The interventions should be added to the care plan. The facility policy "Fall Guidelines-Assessing Falls and Their Causes," revised 10/2010, lacked instruction to staff to implement a new intervention following a fall to prevent further falls. The facility failed to timely review and revise this resident's care plan to include effective appropriate interventions to prevent further falls.	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: The facility reported a census of 47 residents with 13 residents selected for review including	F 689		

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four residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to implement interventions following falls to prevent further falls for three of the four residents reviewed, Resident (R)42, R41, and R17.

Findings included:

- The electronic medical record (EMR) indicated that Resident (R)17 admitted to the facility on 09/20/19.

The "Medication Review Report," dated 01/02/2020 revealed R17 had diagnoses of muscle weakness, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), restlessness, and agitation.

The admission "Minimum Data Set" (MDS), dated 09/27/19, assessed R17 with a Brief Interview of Mental Status Score (BIMS) of 11, indicating moderate cognitive impairment. He required extensive assistance of two or more staff for bed mobility, transfers, and toilet use, and extensive assistance of one for locomotion and ambulation in the corridor. His balance was not steady, and he was only able to stabilize with human assistance. He had a limitation to one side of his upper extremity range of motion. He used a walker and wheelchair for mobility. The assessment also indicated that he was occasionally incontinent of bowels and had an indwelling catheter present. He had a fall in the last month prior to admission and had no falls since admission. Physical therapy treated him for four days and 122 minutes and Occupational therapy treated him for six days and 309 minutes.

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The quarterly "MDS," dated 12/14/19, assessed the resident with short and long term memory problem, no memory recall, and severely impaired decision making. He required extensive assistance of one staff for bed mobility, transfer, locomotion, and for toileting. He did not ambulate in the room or corridor. His balance was not steady, and he was only able to stabilize with human assistance. He used a wheelchair for mobility and was frequently incontinent of bladder and occasionally incontinent of bowel. He was not on a toileting program for his bowel and bladder. Furthermore, he did have falls since admission or the prior MDS assessment, which included one injury fall that was not a major injury. He received Physical Therapy during the seven day lookback period for the MDS, for five days and 42 minutes in group and 158 individual therapy minutes. Physical Therapy began treatment on 11/15/19.

Both the "Falls and Activities of Daily Living Care Area Assessments" (CAA), dated 10/04/19, revealed R17 was at risk for falls and needed assistance with activities of daily living (ADL's) and transfers related to impaired mobility and recent hospitalization.

The "Urinary Incontinence and Indwelling Catheter CAA," dated 10/04/19, revealed this CAA triggered for required extensive assistance for toileting and he required an indwelling catheter.

The "Cognitive Loss/Dementia CAA," dated 10/04/19, revealed R17 could not recall the day of the week or the word sock. He only was able to repeat 2 of the 3 words at the beginning of the assessment.

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The care plan for incontinence, revised on 09/23/19, instructed the staff that R17 was incontinent of bowel and bladder at times, preferred to be assisted to the bathroom for his toileting needs when requested, and often required changing his briefs as he was unaware of incontinent episodes.

The care plan for falls, dated 09/20/19, instructed the staff that R17 was at risk for falls and to ensure the call light was within reach and encourage him to use it. Provide him with appropriate footwear when transferring and ambulating, provide assistive devices (which devices not identified) as needed, and remind him to use call light for safety (inappropriate as the resident experienced confusion so could not remember instructions). Review information on past falls and attempt to determine the cause of the falls as indicated. Provide a clutter free environment, free from spills and/or clutter, adequate lighting, and keep personal items within reach. Alarm pad for chair and bed per family request as safety awareness is poor and has history of not requesting assistance before arising. Discontinued on 10/24/19.

The facility reported the resident had falls on 09/28/19, 10/12/19, 10/18/19, 10/26/19, 10/27/19, 10/29/19, 11/05/19, 11/15/19, 12/09/19, 01/11/2020, 01/17/2020, and 01/28/2020.

1. The progress note, dated 09/28/19 at 03:56 AM, documented that around 02:30 AM, staff found R17 on the floor at the foot of the bed. He was trying to go to the bathroom, the bed alarm was working, but the nearby television drowned out the alarm sounding. The resident received a

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1.0 centimeter (cm) by 1.0 cm skin tear to his left elbow. The fall intervention was to toilet the resident at 02:00 AM even if asleep and to monitor area televisions for volume level. The facility failed to add the intervention to the care plan following the fall to inform the staff.

2. The progress note, dated 10/12/19 at 03:00 PM, revealed staff found R17 on the floor in the hallway in front of his room and lying face down. An abrasion was present to the right side of his forehead. His son reported that his had left R17 unattended in his room to go out to get his dad a shake. On this day, R17 required one on one monitoring for the majority of the day for safety due to his anxiousness and agitation, and his recent dose reduction on an antianxiety medication which added to this. The facility failed to implement a new intervention to the care plan to prevent further falls and inform the staff.

3. The progress note, dated 10/18/19 at 09:45 AM, revealed R17 experienced a fall at 12:45 AM, had a head laceration and a skin tear to his hand. The resident was sent to the emergency room and returned at 06:45 AM with three sutures to the center of his forehead.

The facility investigation, for the resident's fall on 10/18/19 and completed on 10/24/19, revealed the staff found the resident on the floor of the room in front of the bathroom door. The resident stated he was going to the bathroom and he had not activated the call light. The investigation included interventions that R17 was relocated to a different room across from the nurse's station to improve visualization and increase sense of security, and staff were to make contact with R17 as they pass by. The facility failed to implement

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these interventions to inform the staff of the room change with adding them to the care plan and the intervention to make contact with him as the staff passed by until 10/29/19, which was 11 days after the resident's fall.

4. The progress note, dated 10/26/19 at 02:03 PM, revealed R17 was laying on floor in front of his recliner. He stated that he was attempting to take his jacket off and stood up to do so then fell to the floor. The facility failed to add a new intervention to the care plan to prevent further falls.

The interdisciplinary team (IDT) fall review note, dated 10/29/19 at 01:20 PM, revealed R17 had no safety awareness, was confused, impulsive, and does not remember to ask for help. The IDT recommendations included frequent checks, frequent toileting opportunities, reinforce the concept that nursing staff are always present to provide assistance by stopping to talk to him, and engage his son regarding ideas to keep R17 from attempting self transfers, and he responded that he would sit with him on the porch. The facility failed to add any of these recommendations to the care plan to inform the direct care staff.

5. The progress note, dated 10/27/19 at 01:20 AM, revealed the resident fell just after midnight trying to toilet self, had been toileted 15 minutes prior with no void and dry brief, and had a skin tear to his right hand. A repeated attempt to void was also not successful and staff requested an order for a straight catheter to check for residual of urine in the bladder and a urinalysis. The facility failed to add a new intervention to the care plan to prevent further falls.

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6. The progress note, dated 10/29/19 at 09:21 PM, revealed staff found R17 lying on the floor in front of his wheelchair. He had stated he was just going to lay down and take a nap, then stated he thought it was time to go to his bed.

The IDT fall review note, dated 10/30/19 at 07:35 AM, revealed that the resident stated he was tired and wanted to lie down, and the IDT suspected a urinary tract infection. The interventions/recommendations included: assess for symptoms of urinary tract infection, remain within eyesight of staff members. The physician declined the order for the urinalysis and the "Durable Power of Attorney" (DPOA) chose and alternate physician and requested to be seen by a new physician.

7. The progress note, dated 11/05/19 at 07:12 PM, revealed R17 was on the floor and had two skin tears to his forehead, approximately 2.0cm by 0.5cm each. R17 had stated he was walking over to get himself in his bed from his recliner and ended up on his head. The facility failed to add a new intervention to prevent further falls.

The IDT note, dated 11/14/19 at 01:36 PM, which was 9 days after the fall, revealed the resident exhibited no safety awareness and believed he could transfer and ambulate at will but he lacked strength. The IDT team recommendations/interventions included that his medication list was sent to the pharmacist for review and recommended taking his blood pressure standing and lying to rule out orthostatic hypotension (blood pressure dropping with change of position) and a slow gradual dose reduction (GDR) of his anxiolytic (a medication used to treat anxiety) and the facility is in the

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midst of doing so. An order was obtained to resume Physical and Occupational Therapy for strengthening and balance. The care plan intervention for the pharmacy consultant review was added to the care plan on 11/15/19, which was 10 days after the fall. The anxiolytic GDR intervention was added to the care plan on 11/26/19, which was 21 days after the fall. The order for Physical and Occupational Therapy was not added to the care plan until 11/30/19. Physical therapy treatment started on 11/15/19, which was 10 days after the fall, and the intervention was added 25 days after the fall. The facility failed to add a new intervention in a timely manner to prevent R17 from having further falls.

The IDT review note, dated 11/15/19 at 09:45 AM, revealed the team was evaluating fall frequency. R17 had increased falls related to his deficiency of safety awareness, every attempt to self transfer he often stated he was just trying to "..... ". A return demonstration of the call light was successful, voices understanding, and was agreeable with requests to call for assistance. The nursing staff noticed increase in fatigue and somnolence. The facility contacted the pharmacy for med review-to identify meds that may contribute to falls. Staff would move R17 to an easy chair to within sight of the nursing desk, the call light barely reaches, so the staff would contact the maintenance for a call light extender. The pharmacy review of R17's medications was a prior IDT recommendation on 11/14/19 for the 11/05/19 fall. The intervention to ensure call light was in reach and encourage use was already in place on the care plan. Reminding R17 to use the call light for safety and observe return demonstration for call light use was not an appropriate intervention due the cognitive state of

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the resident. The notes regarding the past falls did not indicate that the resident used his call light when he was found on the floor, making the intervention ineffective.

8. The progress note, dated 11/15/19 at 04:26 PM, revealed R17 was sitting on the floor in front of the recliner, stated he heard talking outside of his room and was going to tell the people talking to quiet down. He denied the need to toilet.

The IDT review of the fall, dated 11/18/19 at 08:02 AM, had recommendations/interventions to maintain a quiet environment around the nurses station while R17 was resting, encourage him to call out or use a call light when needing assistance, monitor blood pressure standing or lying to determine a patten for fall risk due to orthostatic hypotension. The review included R17 did not realize he would fall if he arose unattended. The recommendation for orthostatic blood pressure monitoring was a duplicate intervention.

9. A Progress note, dated 01/11/20 at 10:20PM, revealed R17 was sitting on the floor in his room near the foot of his bed. He stated he was going to the bathroom and did what the staff always told him to and he fell. The care plan lacked a new intervention following the fall to prevent further falls.

The IDT review note, dated 01/13/2020, revealed he needed to use the bathroom and forgot he could not walk. The team recommendations/interventions included to conduct a BIMS assessment for cognition, investigate changes in thought process pattern with the DPOA, discuss potential for dementia

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diagnosis related to current diagnosis of age related cognitive decline, discuss relocating to the memory care unit if diagnosis was appropriate, and request a Speech Therapy screening for safety awareness. The IDT recommendations were not on the care plan and the facility failed to add an immediate intervention to the care plan to prevent further falls.

10. The progress note, dated 01/28/2020 at 08:10 PM, revealed R17 was laying on the floor, stated he wanted to lay down on the floor, and that he got up out of his chair and fell to his buttocks. The care plan lacked a new intervention to prevent further falls.

The IDT review note, dated 01/29/2020, recommendation/intervention was to determine if it was a deliberate change in position or a fall. An intervention was revised on the care plan on 01/29/2020, to keep in eyesight of nursing (instead of just the nurse) while not in bed or sleeping in the recliner (instead of just when sleeping in the bed). The facility failed to add an immediate intervention to prevent further falls.

On 02/03/2020 at 10:28 AM, R17 reported he did not recall falling last week when questioned, which was five days after the most recent fall.

On 02/03/2020 at 10:39 AM, Certified Medication Aide (CMA) R, revealed that she just provides relief to the staff in the memory unit. R17 does not verbalize the need for the bathroom. CMA R was not aware of fall interventions other than a fall mat and to try to assist to toilet him every one to two hours. CMA R reported she was guessing there was a book that the interventions were in and would search until she found it. She usually

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passed medications and would have to ask the charge nurse if she had questions.

On 02/03/20 at 04:24 PM, Certified Nurse Aide (CNA) M, revealed that when a resident fell the charge nurse would get with the staff and tell them what the intervention was. If the fall occurred on a prior shift the intervention was given CNA to CNA by verbal report at shift change. R17's interventions included a fall mat, visual of staff at all times, place quiet sign on door when napping. He transfers with assist of one to two staff, depends on the moment. For toileting, the staff toilet everybody every two hours, except for one resident that wass checked and changed every two hours. R17 could tell the staff when he needed to go to the bathroom or when he was wet. The staff try to offer to toilet him before meals and before he goes to bed, or if he was sitting on the side of the bed.

On 02/04/20 at 11:38 AM, Licensed Nurse (LN) I, revealed when a resident fell we come up with a intervention, we put the intervention in the note. LN I was not aware if the charge nurses added the intervention to the care plan or not, she did not know how to get into the care plan in the electronic medical record (EMR) to change things. The nurses had a huddle report sheet where they write the falls on and it was also passed on in report. The staff also fill out an incident report and any staff that have observed the fall fill out a report. The charge nurse verbally passes the fall information on to the CNA's and was not sure how CNA staff received information of falls that occurred on the staff's day off.

On 02/04/20 at 12:11 PM, with Administrative Nurse D, revealed the nurses are to contact her

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and come up with an intervention for the fall, and that there was a recent in-service regarding that. Not all nurses were proficient at putting the interventions in the care plan, it usually falls on the IDT team. Administrative Nurse D confirmed that interventions were missing in the care plan and they should be immediately implemented to prevent further falls. The interventions should be added to the care plan.

The facility policy "Fall Guidelines-Assessing Falls and Their Causes," revised 10/2010, lacked instruction to staff to implement a new intervention following a fall to prevent further falls.

The facility failed to timely implement appropriate interventions to prevent further falls for the resident with multiple falls.

- Review of Resident (R) 41's "Physician Orders," dated 01/14/2020, documentation included diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbances and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder.

The admission "Minimum Data Set" (MDS) dated 01/15/2020, documentation included the resident admitted on 01/10/2020, with the "Brief Interview for Mental Status" (BIMS) score of four, which indicated severe cognitive impairment. He required extensive assistance of staff with activities of daily living (ADLS) and did not walk. His balance during transition was not steady but he was able to stabilize with staff assistance

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moving on and off toilet and with surface to surface transfer. He had an indwelling catheter and was occasionally incontinent of bowel. The resident had a fall two to six months prior to admission.

The "Fall Care Area Assessment" (CAA), dated 01/23/2020, documentation included the resident admitted for end of life care and skilled services. He needed assistance with ADL's and transfers related to impaired mobility and weakness and was at risk for falls. The resident experienced incontinence.

The care plan (CP), dated 01/10/2020, directed staff the resident had impaired thought processes and required assistance with decision making related to dementia and he had difficulty understanding others. He was at risk for falls. Staff were to ensure items were within reach, ensure the call light was within reach and remind him to use the call light for safety. The staff were to provide assistive devices as needed and review information on his past falls and attempt to determine the cause of the falls. The care plan lacked additional interventions following the resident's falls on 01/17/2020 until 01/19/2020, two days following the accidents. The additional interventions included:
1) Provide comfort and reassurance.
2) Place a fall mat.
3) Offer a bed pan if agitated.
4) Assess pain every shift.
5) Ask if resident he would like his spouse to sit with him.

Review of the electronic medical record (EMR) revealed the "Orders-Administration Note Text," on 01/17/2020 at 07:50 PM, revealed the resident

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received Milk of Magnesia (MOM) Concentrate Suspension, 30 milligrams/milliliter, by mouth, as needed, for constipation.

The "Nursing Note Text/Primary Care Physician Communication," dated 01/17/2020 at 09:03 PM, (one hour and 13 minutes after the staff administered him the MOM) documentation included the staff called the nurse to the resident's room where the resident was lying on his back next to the bed. The resident stated that he was going to get up to mop and fell. The assessment at the time of the fall, revealed the resident was noticeably confused. The documentation did not include a root cause analysis of causes or contributing factors related to the fall and/or an immediate intervention provided to prevent further falls.

Review of the "Interdisciplinary Team (IDT) Review," in the EMR, dated 01/19/2020 at 10:23 PM, two days after the falls, documentation included the resident got out of bed and fell onto the floor, and within minutes (after being repositioned onto the bed) repeated that event. The team documented the Root Cause Analysis: He believed he was getting up to mop the floor. The IDT Recommendations/Interventions were as follows:
1) Provide comfort and reassurance.
2) Place a fall mat.
3) Offer a bed pan if agitated.
4) Assess pain every shift.
5) Ask if resident he would like his spouse to sit with him.

Review of the "Fall Investigation," dated 01/20/2020, revealed the facility failed to analyze the collected data to determine the cause or

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contributing factors resulting in the resident's fall. However, it identified interventions to include a mat added to the floor and to ensure the bed was in the lowest position when staff were not giving direct care.

On 01/28/2020 at 12:09 PM, the resident was lying quietly in the low bed, with the fall mat in place.

Observation on 02/04/2020 at 10:30 AM, revealed the resident was yelling out "I gotta go." He was sitting on the side of the bed with his feet on the fall mat next to his low bed. Administrative Staff A responded to a report of the resident yelling out. At 10:35 AM, Administrative Staff A and Certified Nurse Aide (CNA) N assisted the resident to the wheelchair using a gait belt and then assisted him to the toilet in the bathroom where the resident had a large bowel movement (BM).

On 02/4/2020 at 12:02 PM, AM, the resident rested in the low bed with his eyes closed, quietly. The fall mat was not in place beside the bed but instead folded and across the room. At that time, the resident's Durable Power of Attorney (DPOA), in the room, confirmed the resident's fall mat was not in place as it should be to prevent injuries from falls.

On 02/04/2020 at 12:05 PM, CNA N stated he forgot to replace the fall mat beside the resident's bed after assisting the resident from the bathroom earlier in the morning.

On 02/03/2020 at 10:57 AM, CNA N stated when a resident falls the staff nurse assessed the resident before being moved. He stated the nurse should initiate interventions for the residents

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immediately after a fall to prevent further falls. CNA N reported the resident yelled and tried to get out of bed when he knew he needed to have a BM. Furthermore, the resident usually mellowed out after having a BM. Current interventions included the bed in a low position next to the wall, a fall mat beside the bed, and the staff to reposition and monitor the resident frequently.

On 02/03/2020 at 11:29 AM, Licensed Nurse (LN) G stated the fall protocol included implementing a new fall intervention following a fall. She reported the resident was at high fall risk due to his confusion. Current fall interventions included keeping the bed in a low position next to the wall, a fall mat beside the bed, monitoring for pain and reposition and monitor frequently.

On 02/03/2020 at 03:55 PM, CNA O, stated the current fall interventions for the resident included keeping the bed in a low position next to the wall, a fall mat beside the bed, monitoring for pain and reposition and monitor frequently. The resident usually needed to use the bathroom when he became restless. He did not like the bed pan but would go to the toilet. He required assistance to transfer to the bed to chair and then to the toilet. He would calm down after he has a BM.

On 02/03/2020 at 04:57 PM, LN K reported the charge nurses should revise the care plan with an immediate intervention after a resident falls to prevent further falls. Sometimes it was tough to come up with a new intervention if the person has multiple fall or has dementia. The director of nursing handles the investigation part of the fall. She reported the resident was a fall risk due to his disease process and he has bad sundowning

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(increased confusion later in day) which improved with his medication adjustment.

On 02/04/2020 at 01:49 PM, Administrative Nurse D stated the resident had a fall and the staff no sooner got him comfortable in the bed and he flew off the bed again. She confirmed the progress note for 01/17/2020, as noted above did not address an additional fall and verified the staff administered MOM an hour before the fall occurred and that needing to have a bowel movement could be a contributing factor to his restlessness. She agreed the investigation lacked analysis of data to determine cause and contributing factors related to the fall and lacked an immediate intervention when the fall occurred. Administrative Nurse D stated the care planned interventions communicate guidance to the staff to prevent falls, and the expectation was for staff to place a fall mat next to the low bed in the low position prior to leaving the resident unattended.

The facility policy for "Fall Guidelines-Assessing Falls and Their Causes," dated 10/2010, documentation included the purposes of this procedure was to provide guidance for assessing a resident after a fall and to assist staff in identifying causes of the fall. If causes of a fall cannot be readily identified and if the fall is accompanied by other signs and symptoms (e.g., confusion or lethargy), the staff and physician would consider a possible underlying acute medical cause. The policy did not address the investigation, implementation of immediate interventions following a fall and monitoring for the provision of interventions as care planned to prevent further falls.

The facility failed to timely implement appropriate

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interventions following this dependent confused resident's fall to prevent further falls.

- Review of Resident (R) 42's "Physician Orders," dated 01/15/2020, documentation included diagnoses of chronic kidney disease, senile degeneration of the brain, muscle weakness, difficulty walking, and need for assistance with personal care.

The admission "Minimum Data Set" (MDS) dated 01/18/20, documentation included the resident admitted date 01/13/2020, with the "Brief Interview for Mental Status" (BIMS) score of 12, which indicated moderate cognitive impairment. The resident required limited assistance of staff with activities of daily living (ADLS) and required supervision with walking in the corridor. Her balance during transition and walking was not steady but she was able to stabilize without staff assistance. The resident had no functional limitation in range of motion (ROM) in her upper or lower extremities and used a walker. She was always continent of urine and occasionally incontinent of bowel. The resident did not have a history of falls.

The "Falls Care Area Assessment" (CAA), dated 01/23/2020, documentation included the resident needed assistance with ADL's and transfers related to impaired mobility and was at risk for falls.

The care plan, dated 01/13/2020, directed staff that the resident was at risk for falls related to an unsteady gate. Interventions included Ensure the call light was within reach. Provide appropriate footwear when transferring and ambulating.

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Provide assistive devices as needed. Ensure items are within reach.

Additions to the care plan included, on 01/22/2020, observe return demonstration of call light, remind resident to use call light for assistance and remind the resident to use her cane to prevent falls.

On 01/27/2020, request the pharmacy to review the resident's medication regimen related to medications that cause falls and perform frequent checks. Remind the resident that she will fall if she stands without assistance.

On 01/29/2020, Ensure the bathroom door remained unlocked when not in use. Instructions to the staff to discontinued use of her cane, remind the resident to use her walker, and request assistance to prevent falls.

Additionally, the care plan entries directed staff that the resident had falls on 01/21/2020, 01/25/2020, and 01/27/2020. The care plan did not reveal any immediate interventions implemented to prevent further falls following the falls on 01/21/2020 and on 01/25/2020.

The electronic medical record (EMR) "Nursing Note" (NN), dated 01/21/2020 at 08:16 PM, documentation included the resident fell while toileting herself. She stated she fell to the floor while turning to shut the bathroom door. The resident reported she hit her head against the wall when she fell. Assessment revealed a raised area to the right side of her head, which was tender to the touch. The documentation lacked indication of immediate interventions implemented to prevent further falls.

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The EMR NN, dated 01/25/2020 at 12:30 PM, documentation included the staff notified the nurse that the resident was on the floor. The resident was found prone beside the bed, with her walker on the side by the sink. The assessment revealed the resident with an approximate 0.2 centimeter (cm) swollen area above her left eyebrow and a 0.2 cm. abrasion to her nose near the eyebrows. The call light lacked activation when found by the nurse aide. The resident stated she was trying to reach her briefs on the tops shelf of her closet. She lost her balance and fell to the floor. The staff removed the briefs from the top shelf and placed them in the dresser. The intervention to store the resident's briefs in the resident's dresser instead of the top self of her closet was not communicated to the staff in the resident's care plan.

The EMR NN, dated 01/27/2020 at 01:44 PM, documentation included the resident was lying supine on her husband's floor (adjacent room) with the walker found upright at her feet. It appeared the resident fell backwards. She reported she hit her head on the floor. The assessment revealed an egg sized bump located at the left upper side of her head. The resident stated she attempted to go to her bathroom, found the door locked and proceeded to go out into the hallway and enter the bathroom from her husband's door since they share the same bathroom. Once she got into his room, she fell backward. The staff requested the pharmacist review the resident's medications. The intervention to make sure the bathroom door was kept unlocked was not communicated to staff on the care plan until 01/29/2020, two days after the

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resident's fall.

Review of the fall investigation reports for the falls on 01/21/2020, 01/25/2020, and 01/27/2020, revealed the facility did not thoroughly investigate the cause or contributing factors of the falls to provide appropriate implemented interventions to prevent further falls.

On 01/29/2020 at 11:37 AM, the resident sat in a chair beside her husband in the adjacent room. She had her walker positioned in front of her and no slip grip socks were in place. The resident had a black discoloration beneath the left eye and a scratch/laceration on the left side of her nose. She stated she was visiting with her husband trying to start a conversation.

On 02/03/2020 at 05:09 PM, the resident walked unattended from her room using the front wheeled walker wearing non-skid socks. The resident's gait was slow leaning forward while using the walker.
On 02/04/20 at 11:59 AM, observation of the resident's closet revealed her briefs were on the floor of the closet and in the dresser drawer. She sat in her recliner with her cane on the left side of her chair and the walker on the right side of the chair. The bathroom door was unable to be opened and remained locked. The Durable Power of Attorney (DPOA) was present and left the room to go to the adjoining room to unlock the bathroom door from the inside and the resident got up and followed her into the adjacent room without using her walker.

On 02/04/2020 at 11:59 AM, the resident's DPOA stated the resident's bathroom door should be unlocked or she goes to the other room to get

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into the bathroom. The top shelf of the closet should not hold the resident's briefs. She stated the resident used her cane sometimes but should use the rolling walker. The last time the resident fell she had a folding walker by the door.

On 02/04/2020 at 12:05 PM, Certified Nursing Assistant (CNA) N, stated he forgot to unlock the resident's bathroom door after the resident in the adjacent room had used the toilet at around 10:30 AM, as he should have done.

On 02/03/2020 at 10:57 AM, CNA N reported the resident was a fall risk because when she walks, she leans backward, was unsteady, and she does not use her call light. Staff catch her walking around the room and in her husband's room (the room with the shared bathroom.) We redirect her to use the call light and to use her walker. She fell recently, her husband yelled out and I responded finding her on the floor on her back. The nurse assessed the resident and the resident stated she fell backwards. The black around her eye and the scratch on her nose was a result of the fall. CNA N explained he did not recall the intervention the staff put in place following that fall by the resident.

On 02/03/2020 at 03:55 PM, CNA O stated the nurse assesses the resident when they fall before the staff move them. The nurse should collect witness statements where the staff document everything that happened. A new intervention should be put in place after the fall to prevent further falls. The resident was at risk for falls. She woke up one time and was dizzy. Another time she fell because the bathroom door was locked. CNA O reported checking on her often and reminding her to use her call light. CNA O was not aware of any specifics about where the

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resident's stuff (briefs) should be located. She does not use her cane and should use her walker.

On 02/03/2020 at 11:29 AM, Licensed Nurse (LN) G stated the care plan directed the staff on the resident's needs and preferences. The charge nurse updated the residents' care plans with acute episodes like falls and then the Interdisciplinary Team (IDT) members reviewed it. LN G stated the fall protocol included implementing a new fall intervention following a fall. She reported the resident was a high fall risk due to her critical high potassium and renal failure. The staff must remind her constantly to call for assistance and use her walker and she was already working with therapy. LN G reported she redirected the resident at least five times already, today. LN G did not know if the interventions following the resident's falls were communicated to her or not.

On 02/03/2020 at 02:00 PM, LN J reported the director of nursing investigated the resident falls. The facility fall protocol started with the charge nurse initiating the risk tool in the electronic medical record (EMR), staff assessed for causes and then put an immediate intervention in place to prevent future falls. The IDT review the next morning for appropriateness of the new intervention. LN J verified the investigation reports for the resident's falls that occurred on 01/21/2020 and 01/25/2020, lacked analysis of findings to determine the cause or contributing factors related to the falls, lacked appropriate immediate interventions entered in the care plan.

On 02/03/2020 at 04:57 PM, LN K reported the individual needs and preferences of the residents

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are in the care plan. The charge nurses should revise the care plan with an immediate intervention after a resident fall to prevent further falls. Sometimes it was tough to come up with a new intervention if the person has multiple fall or has dementia. The director of nursing handles the investigation part of the fall. She reported the resident was a fall risk due to individual needs and preferences in the care plan and getting to know them better. The nurses can revise the care plan if they see something a little different. LN K stated she was present for the resident's falls. LN K confirmed the notes failed to reflect immediate interventions to prevent further falls and lacked analysis to determine the cause or contributing factors. The care plan failed to guide because reminding her to use the call light does not work if the resident was impatient or cognitive impaired. The resident was not going to tell the staff that she needs assistance because she wants to go home.

On 02/04/2020 at 01:49 PM, Administrative Nurse D agreed the fall investigations lacked analysis of data to determine the cause and contributing factors related to the fall and immediate interventions with care plan revisions when falls occurred to prevent further falls. She stated the care planned interventions communicate guidance to the staff to prevent falls. Staff should implement care planned interventions consistently. The staff should keep the bathroom door unlocked, remove the cane if the intervention was no longer appropriate, and revise the care plan with new interventions to effectively communicate guidance to the direct care staff in a timely manner to ensure the risks of falls are mitigated. The charge nurses should provide oversight to make sure the care planned

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F 689	Continued From page 48 interventions were consistently used. The facility policy for "Fall Guidelines-Assessing Falls and Their Causes," dated 10/2010, documentation included the purposes of this procedure was to provide guidance for assessing a resident after a fall and to assist staff in identifying causes of the fall. If causes of a fall cannot be readily identified and if the fall is accompanied by other signs and symptoms (e.g., confusion or lethargy), the staff and physician will consider a possible underlying acute medical cause. The policy did not address the investigation, implementation of immediate interventions following a fall and monitoring for the provision of interventions as care planned to prevent further falls. The facility failed to ensure the timely appropriate interventions implemented to prevent repeated falls for the resident following	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: The facility reported a census of 47 residents. The 13 residents selected for review included two reviewed for respiratory care. Based on	F 695		

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observation, interview, and record review, the facility failed to provide appropriate cleaning and storage of one of the two, Resident (R)32's nebulizer (device which changes liquid medication into a mist easily inhaled into the lungs) administration kit, to prevent further respiratory infections.

Findings included:

- The signed physician orders from the hospital for Resident (R)32, dated 12/24/19, included a primary diagnosis of exacerbation of chronic obstructive pulmonary disease (COPD, progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing.)

The annual "Minimum Data Set" (MDS), dated 04/12/19, assessed R32 with a Brief Interview of Mental Status (BIMS) score of 14, indicating cognitively intact, and shortness of breath with exertion and when lying flat.

The quarterly "MDS," dated 12/15/19, assessed R32 with a BIMS score of 11, indicating moderately impaired cognition and no shortness of breath present.

The care plan, dated 12/31/19, instructed staff that R32 was at risk for infection related to pneumonia (inflammation of the lungs) and was in the hospital for pneumonia and exacerbation of COPD. The staff were to monitor for signs and symptoms of worsening infection and administer medications as ordered. The care plan also included that he was at risk for complications related to a compromised respiratory system related to COPD. The staff were to encourage

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him to be out of bed as tolerated, monitor for signs and symptoms of respiratory infection, and that he has a history of recurrent pneumonia.

The hospital discharge instructions, dated 12/24/19, included orders for Ipratropium bromide-Albuterol sulfate (combination medication used to relax and open air passages in the lungs to make breathing easier), 0.5 milligrams (mg) per 3 milliliter (ml) inhalation four times a day and as needed every six hours.

On 01/29/2020 at 09:29 AM, the nebulizer administration kit remained connected, in a plastic bag, and connected to the nebulizer machine that was sitting on top of the bedside table.

On 01/29/2020 at 11:07 AM, Licensed Nurse (LN) G administered the ordered Ipratropium-Albuterol nebulizer treatment. Once the treatment completed, LN G removed the mask and set it on the bedside table with gloved hands, wiped the mask with a pre-moistened wipe and dried the mask with a facial tissue, then placed the connected kit in a plastic bag.

On 02/03/2020 at 10:25 AM, the nebulizer administration kit was on top of the bedside table, the kit remained connected, and stored in a plastic bag.

On 02/04/2020 at 09:04 AM, the nebulizer administration kit was on top of the bedside table, the kit remained connected, condensation was present in the medicine cup of the kit, and with the kit stored in a plastic bag.

On 02/04/2020 at 09:08 AM, LN H revealed the

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nebulizer kit should be rinsed with tap water, sat out to dry, and stored in a bag. Furthermore, she reported that she dries the kit with a paper towel and then reconnects the kit and places it in the bag.

On 02/04/2020 at 11:47 AM, LN I, revealed that she left the nebulizer kit to air dry on a paper towel on the bedside table by the nebulizer machine, then rinsed the pieces with water, and laid the pieces out on a paper towel to air dry. When the kit was dry, she would place it in the bag. Furthermore, she revealed she was not sure of what the procedure was here, but that that was the procedure she used in the past.

On 02/04/2020 at 11:56 AM, Administrative Nurse D revealed after the nebulizer treatment was complete, the nurse should rinse the kit with water and place the kit back in the bag along with the tubing, and she was not sure if the nebulizer kit should air dry or not.

The facility policy for "Administering Medications through a Small Volume (Handheld) Nebulizer," revised October 2010, instructed that post administration the staff was to rinse and disinfect the nebulizer equipment according to facility protocol, or: wash pieces with warm, soapy water; rinse with hot water, place all the pieces in a bowl and cover with isopropyl (rubbing) alcohol. Then soak the pieces for five minutes, rinse all the pieces, and allow the pieces to air dry on a paper towel. When the equipment is completely dry, store it in a plastic bag with the resident's name and the date on it.

The facility failed to clean and store the nebulizer administration kit appropriately for R32, to

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F 695	Continued From page 52 prevent further respiratory infections.	F 695		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: The facility reported a census of 47 residents,	F 755		

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with 13 sampled which included 5 reviewed for medication administration. Based on observation, interview, and record review the facility failed to follow the physician orders for one of the five sampled residents, Resident (R) 41, when the staff failed to administer insulin as ordered on 12 occasions and failed to notify the physician as ordered when the blood sugar was above 350 on one occasion in one month.

Findings included:

- Review of Resident (R) 41's "Physician Orders," dated 01/14/2020, documentation included diagnoses of type 2 diabetic mellitus (DM)-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), multiple myeloma (cancerous blood cells which can damage the bones), and chronic kidney disease.

The admission "Minimum Data Set" (MDS) dated 01/15/2020, documentation included the resident admitted date 01/10/20, with the "Brief Interview for Mental Status" (BIMS) score of four, which indicated severe cognitive impairment. He received injections and insulin for six days of the look back period, had one new insulin order.

The "Nutritional Status Care Area Assessment" (CAA), dated 01/23/2020, documentation included admitted for end of life skilled services for diagnoses which included multiple myeloma, dementia, and diabetes mellitus.

The care plan (CP), dated 01/17/2020, directed staff to administer medications as ordered. Provide finger stick blood sugar checks as ordered or as indicated. The staff should monitor

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for signs and symptoms of hyperglycemia (high blood sugar) such as excessive thirst, frequent urination, clammy skin, and altered mental status. As well as monitor for signs and symptoms of hypoglycemia (low blood sugar) such as sweating, tremors, increased heart rate, pallor, nervousness, confusion, slurred speech, lack of coordination, staggering gait.

The physician orders included:

1. Blood glucose/sugar (BG/BS) monitoring fasting and two hours post parietal (PP-after meal) in the morning for DM, ordered 01/10/2020.

2. Insulin Lispro Solution 100 UNIT/Milliliters (ML) Inject 12 units subcutaneous (fat layer of skin) before meals for DM. Notify primary care physician (PCP) if BG is less than 50 or greater than 350, ordered 01/10/2020.

The physician orders, dated 01/14/2020, did not include an order for blood sugar parameters to hold the resident's insulin medication.

Review of the medication administration record (MAR), dated 01/10/2020 through 01/28/2020. revealed the resident's blood sugars (BS) range was 77-385. Insulin Lispro Solution 100 units/ML, 12, units was not given as ordered on 12 occasions, without physician notification for further instructions of the insulin. The staff failed to notify the physician when the resident experienced an elevated BS of 385 on 01/12/2020 at 11:00 AM.

Review of the electronic medical records (EMR) "Orders-Administration Note Text," dated 01/11/2020 at 11:52 AM, included documentation

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that Insulin Lispro Solution 100 units/milliliters (ML), 12 units subcutaneously before meals for DM, was held due to the resident choosing to eat. Additionally, the EMR lacked follow-up or notification of the facility notifying the physician for guidance related to the staff holding the medication.

Review of the EMR "Orders-Administration Note Text," dated 01/18/2020 at 12:31 PM, included documentation that Insulin Lispro Solution 100 units/milliliters (ML), 12 units subcutaneous before meals for DM, was held due to the resident not eating. Additionally, the EMR lacked follow-up or notification of the facility notifying the physician for guidance related to the staff holding the medication.

Review of the EMR "Orders-Administration Note Text," dated 01/18/2020 at 5:06 PM, included documentation that Insulin Lispro Solution 100 units/milliliters (ML), 12 units subcutaneous before meals for DM, was held due to the resident not eating. Additionally, the EMR lacked follow-up or notification of the facility notifying the physician for guidance related to the staff holding the medication.

Review of the EMR "Orders-Administration Note Text," dated 01/19/2020 at 09:20 AM, included documentation that Insulin Lispro Solution 100 units/milliliters (ML), 12 units subcutaneous before meals for DM, was held due to the resident not eating. Additionally, the EMR lacked follow-up or notification of the facility notifying the physician for guidance related to the staff holding the medication.

Review of the EMR "Orders-Administration Note

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Text," dated 01/20/2020 at 10:08 AM, included documentation that Insulin Lispro Solution 100 units/milliliters (ML), 12 units subcutaneous before meals for DM, was held due to the resident not eating. Additionally, the EMR lacked follow-up or notification of the facility notifying the physician for guidance of the staff holding the medication.

On 01/29/2020 at 09:10 AM, Certified Medication Aide (CMA) R assisted the resident with a house supplement. The resident drank 100% of the supplement. CMA R reported that the resident usually drank 100% of his supplement even when he did not eat otherwise.

On 01/29/2020 at 11:37 AM, Licensed Nurse (LN) I checked the resident's BS with a result of 106.

On 02/03/2020 at 10:57 AM, CNA N stated the resident ate about 25% of his breakfast meal. The resident eats breakfast late because he wakes up late. The resident required the staff to feed him his meals. He gets a mighty shake from the medication aide and the staff serve one with his meals. He usually drinks his mighty shake.

On 02/03/2020 at 02:30 PM, Certified Nurse Aide (CNA) O reported the resident liked iced tea, and his favorite dessert was chocolate pudding. She stated the resident eats 25-30% of his meal but would eat pudding and mighty shakes 90% of the time. CNA O fed the resident four bites of chocolate pudding and two glasses of iced tea.

On 2/3/2020 at 11:29 AM, LN G reported the resident had a very poor appetite most of the time. The staff provide him with his favorite foods. Most of the time, he says he is not hungry,

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but will drink health shakes quickly. She stated she did not believe the resident had blood sugar parameters for holding the Insulin but the staff used nursing judgement. LN G stated the physician should be notified of concerns if the insulin was held. She verified the insulin was held, as noted above, without physician orders and notification. LN G verified the physician was not notified of the elevated blood sugar on 01/12/2020.

On 02/03/2020 at 04:97 PM, LN K reported the resident barely eats, but eats better in the afternoon. She verified the resident's blood sugar at 04:00 PM, was 315, which was high but below the parameter to notify the physician of 350. She verified the insulin was held, without physician orders and notification. LN G verified the physician was not notified of the elevated blood sugar on 01/12/2020.

On 02/04/2020 at 08:35 AM, Administrative Nurse D stated that individual physicians set parameters for notification and or when to notify the physician of BS. The nurse should not hold insulin without first notifying the physician of the concern and receiving orders for follow-up care. She verified the physician was not notified of a BS of 385, on 01/12/2020, as ordered by the physician. As well, nurses held insulin without notifying the physician, as expected. Administrative Nurse D stated that resident's BS could be affected by other things rather than meal intake, that the resident's disease process with multiple myeloma and chronic kidney disease could affect the BS and should be considered when treating the resident.

The facility policy "Administering Medications," dated 12/2012, documentation included

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F 755	Continued From page 58 medications shall be administered in a safe and timely manner as prescribed. Medication must be administered within one hour of their prescribed, unless otherwise specified (for example, before and after meals). If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences the person preparing or administering the medication shall contact the resident's attending physician or the facility's Medical Director to discuss the concerns. The facility failed to follow the physician orders for this resident with blood sugar parameters of when to notify the physician and failed to follow the physician order by holding the resident's insulin on 12 occasions using nursing judgement when the physician ordered the staff to administer the resident's insulin.	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph	F 756		

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F 756	Continued From page 59 (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: The facility reported a census of 47 residents, with 13 residents sampled which included five residents reviewed for unnecessary medications. Based on interview and record review, the facility pharmacist failed to identify medication monitoring irregularities for two of the five sampled residents, including Resident (R) 13 received anti-hypertensive medications without adequate blood pressure monitoring as the physician ordered and for R41 when the nursing staff held R41's insulin without a physician order to hold it. Findings included:	F 756		

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- Review of Resident (R) 13's "Physician Orders," dated 01/07/2020, documentation included diagnoses, of hypertension (high blood pressure), atrial fibrillation (irregular heart rhythm), and atherosclerotic heart disease (a build-up of plaque in the arteries causing obstruction to blood flow).

The admission "Minimum Data Set" (MDS) dated 04/22/19, documentation included the resident admitted on 04/15/19, with the "Brief Interview for Mental Status" (BIMS) score of 14, which indicated cognitively intact.

The quarterly MDS, dated 12/01/19, lacked relevant changes in the assessment.

The care plan, dated 01/06/2020, directed the staff that the resident was at risk for adverse side effects related to the use of medications, which included antihypertensive. The pharmacy consultant would review monthly and PRN the medication regimen. The staff should monitor for the following adverse side effects related to the medications: Dizziness, especially during initiation of medication or with dosage changes. Monitor for hypotension when taking Losartan to avoid any episodes of loss of consciousness and accidental falls. Monitor vital signs as ordered.

Review of the physician orders, dated 01/07/2020, revealed the resident received the following anti-hypertensive and diuretics medication which could cause hypotension [low blood pressure- defined by the Mayo Clinic as systolic blood pressure (SBP) less than 90 and/or diastolic blood pressure (DBP) less than 60] as an adverse side effect the resident's affect the

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medications.

1. Amlodipine Besylate, 10 milligrams (MG), by mouth, in the morning for hypertension (HTN,) ordered 04/15/19.

2. Losartan Potassium, 50 MG, by mouth, in the morning for HTN, ordered 04/15/19.

3. Lasix 20 MG, by mouth, in the morning for HTN, ordered 04/15/19.

The undated facility policy for, "Facility Blood Pressure Protocol," documentation included to notify the "MD/Provider on call if outside of parameters if the Diastolic BP is less than 55.

Review of the resident's 01/2020, medication administration record (MAR) revealed the resident received the above medication while experiencing hypotensive DBP, without advising the physician as directed by the facility protocol.

1. On 01/05/2020, with DBP of 55.
2. On 01/11/2020, with DBP of 52.
3. On 01/16/2020, with DBP of 58.
4. On 01/21/2020, with DBP of 42.
5. On 01/24/2020, with DBP of 51.
6. On 01/28/2020, with DBP of 52.

Review of the pharmacist monthly drug regimen reviews from 05/09/19, through 11/06/29, with the exceptions of 07/10/19 and 08/13/19, which the facility staff failed to find for review, revealed the pharmacist failed to identify any problems with the resident's blood pressures being below the parameters and the staff administered the medication and did not contact the physician for further guidance on the situation.

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On 02/03/2020 at 04:57 PM, Licensed Nurse (LN) K reported the residents that received medications for their blood pressure received monitoring for hypotension in accordance with the facility protocol, which required staff to notify the physician if the DBP was less than 55. She stated she was not aware of the resident having hypotensive episodes as reflected on the MAR. LN K confirmed the staff should have notified the physician of the above low DBP to receive guidance regarding administration of the medication.

On 02/02/2020 at 09:15 AM, Administrative Nurse D stated that if a resident received medications for their blood pressure (BP), and did not have individual blood pressure parameters, hypotension would be monitored in accordance with the facility protocol, which required staff to notify the physician if the DBP was less than 55. She verified the resident experienced hypotensive DBPs as indicated above, received multiple medications for the treatment of hypertension without notifying the physician of irregularities. Administrative Nurse D reported the charge nurse should recheck the resident's blood pressure when it was outside of the parameters to verify abnormalities and document the additional BP. She verified there were not any follow-up on the reported low DBP as required by the facility protocol.

The undated "Facility Blood Pressure Protocol," documentation included to notify the "MD/Provider on call if outside of parameters if the Diastolic BP is less than 55.

The facility pharmacist failed to identify the

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irregularities of the facility failure to monitor the resident's blood pressures for adverse side effects and effectiveness of anti-hypertensive medication and diuretics.

- Review of Resident (R) 41's "Physician Orders," dated 01/14/2020, documentation included diagnoses of type 2 diabetic mellitus (DM)-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), multiple myeloma (cancerous blood cells which can damage the bones), and chronic kidney disease.

The admission "Minimum Data Set" (MDS) dated 01/15/2020, documentation included the resident admitted date 01/10/20, with the "Brief Interview for Mental Status" (BIMS) score of four, which indicated severe cognitive impairment. He received injections and insulin for six days of the look back period, had one new insulin order.

The care plan (CP), dated 01/17/2020, directed staff to administer medications as ordered. Provide finger stick blood sugar checks as ordered or as indicated. The staff should monitor for signs and symptoms of hyperglycemia (high blood sugar) such as excessive thirst, frequent urination, clammy skin, and altered mental status. As well as monitor for signs and symptoms of hypoglycemia (low blood sugar) such as sweating, tremors, increased heart rate, pallor, nervousness, confusion, slurred speech, lack of coordination, staggering gait.

The physician orders included:

1. Blood glucose/sugar (BG/BS) monitoring

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fasting and two hours post parietal (PP-after meal) in the morning for DM, ordered 01/10/2020.

2. Insulin Lispro Solution 100 UNIT/Milliliters (ML) Inject 12 units subcutaneous (fat layer of skin) before meals for DM. Notify primary care physician (PCP) if BG is less than 50 or greater than 350, ordered 01/10/2020.

The physician orders, dated 01/14/2020, did not include an order for blood sugar parameters to hold the resident's insulin medication.

Review of the medication administration record (MAR), dated 01/10/2020 through 01/28/2020. revealed the resident's blood sugars (BS) range was 77-385. Insulin Lispro Solution 100 units/ML, 12, units was not given as ordered on 12 occasions, without physician notification for further instructions of the insulin. The staff failed to notify the physician when the resident experienced an elevated BS of 385 on 01/12/2020 at 11:00 AM.

Review of the electronic medical records (EMR) "Orders-Administration Note Text," dated 01/11/2020 at 11:52 AM, included documentation that Insulin Lispro Solution 100 units/milliliters (ML), 12 units subcutaneously before meals for DM, was held due to the resident choosing to eat. Additionally, the EMR lacked follow-up or notification of the facility notifying the physician for guidance related to the staff holding the medication.

Review of the pharmacist monthly drug regimen review, dated 01/14/2020, failed to identify the irregularity that the facility staff failed to notify the physician when the resident's blood sugar was

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too low on 01/11/2020, and the nursing staff decided to hold the resident's insulin. Additionally the nursing staff then lacked any follow-up documentation or notification to the physician for further guidance related to the staff holding the medication.

The facility staff lacked a physician order to hold the insulin at their desecration. This irregularity of the staff holding the resident's insulin continued following the pharmacist review as follows:

Review of the EMR "Orders-Administration Note Text," dated 01/18/2020 at 12:31 PM, included documentation that Insulin Lispro Solution 100 units/milliliters (ML), 12 units subcutaneous before meals for DM, was held due to the resident not eating. Additionally, the EMR lacked follow-up or notification of the facility notifying the physician for guidance related to the staff holding the medication.

Review of the EMR "Orders-Administration Note Text," dated 01/18/2020 at 5:06 PM, included documentation that Insulin Lispro Solution 100 units/milliliters (ML), 12 units subcutaneous before meals for DM, was held due to the resident not eating. Additionally, the EMR lacked follow-up or notification of the facility notifying the physician for guidance related to the staff holding the medication.

Review of the EMR "Orders-Administration Note Text," dated 01/19/2020 at 09:20 AM, included documentation that Insulin Lispro Solution 100 units/milliliters (ML), 12 units subcutaneous before meals for DM, was held due to the resident not eating. Additionally, the EMR lacked follow-up or notification of the facility notifying the

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physician for guidance related to the staff holding the medication.

Review of the EMR "Orders-Administration Note Text," dated 01/20/2020 at 10:08 AM, included documentation that Insulin Lispro Solution 100 units/milliliters (ML), 12 units subcutaneous before meals for DM, was held due to the resident not eating. Additionally, the EMR lacked follow-up or notification of the facility notifying the physician for guidance of the staff holding the medication.

On 01/29/2020 at 09:10 AM, Certified Medication Aide (CMA) R assisted the resident with a house supplement. The resident drank 100% of the supplement. CMA R reported that the resident usually drank 100% of his supplement even when he did not eat otherwise.

On 02/03/2020 at 10:57 AM, CNA N stated the resident ate about 25% of his breakfast meal. The resident eats breakfast late because he wakes up late. The resident required the staff to feed him his meals. He gets a mighty shake from the medication aide and the staff serve one with his meals. He usually drinks his mighty shake.

On 2/3/2020 at 11:29 AM, LN G reported she did not believe the resident had blood sugar parameters for holding the Insulin but the staff used nursing judgement. LN G stated the physician should be notified of concerns if the insulin was held. She verified the insulin was held, as noted above, without physician orders and notification. LN G verified the physician was not notified of the elevated blood sugar on 01/12/2020.

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On 02/03/2020 at 04:97 PM, LN K reported the resident barely eats, but eats better in the afternoon. She verified the resident's blood sugar at 04:00 PM, was 315, which was high but below the parameter to notify the physician of 350. She verified the insulin was held, without physician orders and notification. LN G verified the physician was not notified of the elevated blood sugar on 01/12/2020.

On 02/04/2020 at 08:35 AM, Administrative Nurse D stated that individual physicians set parameters for notification and or when to notify the physician of BS. The nurse should not hold insulin without first notifying the physician of the concern and receiving orders for follow-up care. She verified the physician was not notified of a BS of 385, on 01/12/2020, as ordered by the physician. As well, nurses held insulin without notifying the physician, as expected. Administrative Nurse D stated that resident's BS could be affected by other things rather than meal intake, that the resident's disease process with multiple myeloma and chronic kidney disease could affect the BS and should be considered when treating the resident.

The facility policy "Administering Medications," dated 12/2012, documentation included medications shall be administered in a safe and timely manner as prescribed. Medication must be administered within one hour of their prescribed, unless otherwise specified (for example, before and after meals). If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences the person preparing or administering the medication shall contact the

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F 756	Continued From page 68 resident's attending physician or the facility's Medical Director to discuss the concerns. The facility pharmacist failed to identify medication irregularities when the nursing staff held R41's insulin without a physician order to hold it.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility reported a census of 47 residents, with 13 residents sampled which included five residents reviewed for unnecessary medications. Based on observation, interview, and record	F 757		

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review, the facility failed to ensure the medication regimen was free of unnecessary medications for two of the five residents sampled when the facility failed to effectively monitor blood pressures for adverse side effects and effectiveness with administration of anti-hypertensive medications for Resident (R) 13 and R19.

Findings included:

- Review of Resident (R) 13's "Physician Orders," dated 01/07/2020, documentation included diagnoses, of hypertension (high blood pressure), atrial fibrillation (irregular heart rhythm), and atherosclerotic heart disease (a build-up of plaque in the arteries causing obstruction to blood flow).

The admission "Minimum Data Set" (MDS) dated 04/22/19, documentation included the resident admitted on 04/15/19, with the "Brief Interview for Mental Status" (BIMS) score of 14, which indicated cognitively intact.

The quarterly MDS, dated 12/01/19, lacked relevant changes in the assessment.

The care plan, dated 01/06/2020, directed the staff that the resident was at risk for adverse side effects related to the use of medications, which included antihypertensive. The pharmacy consultant would review monthly and PRN the medication regimen. The staff should monitor for the following adverse side effects related to the medications: Dizziness, especially during initiation of medication or with dosage changes. Monitor for hypotension when taking Losartan to avoid any episodes of loss of consciousness and accidental falls. Monitor vital signs as ordered.

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Review of the physician orders, dated 01/07/2020, revealed the resident received the following anti-hypertensive and diuretics medication which could cause hypotension [low blood pressure- defined by the Mayo Clinic as systolic blood pressure (SBP) less than 90 and/or diastolic blood pressure (DBP) less than 60] as an adverse side effect the resident's affect the medications.

1. Amlodipine Besylate, 10 milligrams (MG), by mouth, in the morning for hypertension (HTN,) ordered 04/15/19.

2. Losartan Potassium, 50 MG, by mouth, in the morning for HTN, ordered 04/15/19.

3. Lasix 20 MG, by mouth, in the morning for HTN, ordered 04/15/19.

The undated facility policy for, "Facility Blood Pressure Protocol," documentation included to notify the "MD/Provider on call if outside of parameters if the Diastolic BP is less than 55.

Review of the residents 01/2020, medication administration record (MAR) revealed the resident received the above medication while experiencing hypotensive DBP, without advising the physician as directed by the facility protocol.

1. On 01/05/2020, with DBP of 55.
2. On 01/11/2020, with DBP of 52.
3. On 01/16/2020, with DBP of 58.
4. On 01/21/2020, with DBP of 42.
5. On 01/24/2020, with DBP of 51.
6. On 01/28/2020, with DBP of 52.

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On 01/29/20 at 11:50 AM, the resident was sitting at the dining room table, denied dizziness on inquiry, and stated he felt good today.

On 02/03/2020 at 04:57 PM, Licensed Nurse (LN) K reported the residents that received medications for their blood pressure received monitoring for hypotension in accordance with the facility protocol, which required staff to notify the physician if the DBP was less than 55. She stated she was not aware of the resident having hypotensive episodes as reflected on the MAR. LN K confirmed the staff should have notified the physician of the above low DBP to receive guidance regarding administration of the medication.

On 02/02/2020 at 09:15 AM, Administrative Nurse D stated that if a resident received medications for their blood pressure (BP), and did not have individual blood pressure parameters, hypotension would be monitored in accordance with the facility protocol, which required staff to notify the physician if the DBP was less than 55. She verified the resident experienced hypotensive DBPs as indicated above, received multiple medications for the treatment of hypertension without notifying the physician of irregularities. Administrative Nurse D reported the charge nurse should recheck the resident's blood pressure when it was outside of the parameters to verify abnormalities and document the additional BP. She verified there were not any follow-up on the reported low DBP as required by the facility protocol.

The undated "Facility Blood Pressure Protocol," documentation included to notify the "MD/Provider on call if outside of parameters if

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the Diastolic BP is less than 55.

The facility failed to ensure the resident's medication regimen was free of unnecessary medications as exhibited by the facility failure to monitor the resident's blood pressures for adverse side effects and effectiveness of anti-hypertensive medication and diuretics.

- Resident (R) 19 admitted to the facility on 03/19/18, with the following diagnoses: Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), hypertension (elevated blood pressure), cerebral infarction (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage), Atrial fibrillation (rapid, irregular heart rate), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), congestive heart failure (a condition with low heart output and body becomes congested with fluid), and chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

The annual "Minimum Data Set" (MDS), dated 12/15/19, revealed the Brief Interview for Mental Status (BIMS) score of 10, indicating impaired cognition.

The Physician's Order Sheet dated, 01/02/2020 included a medication order, dated 08/16/17, for Lisinopril (a medication to treat high blood pressure) and 01/07/2020, Sotalol (a medication to treat and prevent abnormal heart rhythms).

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The Lisinopril order lacked blood pressure parameters to monitor the medication. The Sotalol order included blood pressure parameters with instructions to the staff to hold the medication, if the resident's systolic blood pressure was less than 90 or diastolic blood pressure was less than 55.

R19's "Medication Administration Record" from 01/01/2020 through 01/28/2020, identified the resident received these blood pressure medications on 01/08/2020 with a blood pressure reading of 120/50, on 01/10/2020 with a blood pressure reading of 111/54, on 01/21/2020 with a blood pressure reading of 136/52, and on 01/27/2020 with a blood pressure reading of 120/50.

Interview on 02/04/2020 at 08:57 AM, with Certified Medication Aide (CMA) S confirmed that R19's blood pressure was outside of the physician ordered monitoring parameters and the medications should have been held per the physician's orders.

Interview on 02/04/2020 at 01:24 PM, with Administrative Nurse D verified the staff administered the resident the medication when the blood pressure was outside of the parameters and the staff should have been held the medication.

The facility's policy, "Facility Blood Pressure Protocol," undated, documented instructions for the staff to notify the MD (medical doctor/Provider) on call, if the blood pressure was outside of the parameters. If systolic blood pressure is less than 90 or greater than 170, or if diastolic blood pressure is less than 55 or greater

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F 757	Continued From page 74 than 110. The facility failed to adequately monitor the resident's blood pressures on four occasions when the blood pressure was outside of the ordered parameters, to ensure no unnecessary medication usage for this resident.	F 757		