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S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b)4)5) 300.1210d)6) 300.2090b) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which	S9999		

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allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

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6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.2090 Food Preparation and Service
b) Foods shall be attractively served at the proper temperatures and in a form to meet individual needs.

This REQUIREMENT is not met as evidenced by:

Failures at this level require more than one Deficient Practice Statement.

A. Based on observation, interview, and record review the facility failed to supervise a resident after providing the resident with a hot pureed food. This failure affects one (R31) of six residents reviewed for accidents in the sample of 33. This failure resulted in R31 spilling hot liquid on R31's lap sustaining redness and 3 blistered areas to R31's bilateral lower extremities requiring subsequent treatment which is ongoing.

B. Based on observation, interview, and record review the facility failed to remove a tripping hazard to prevent a fall and failed to implement fall interventions and complete a root cause analysis for two residents (R133, R20) of six residents reviewed for accidents in the sample of 33. This failure resulted in R133 sustaining an unwitnessed fall leading to hospitalization for a Subdural Hematoma.

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C. Based on observation, interview, and record review the facility failed to prevent siderail entrapment for one of six residents (R54) reviewed for accidents in a sample list of 33 residents.

Findings Include:

a.1.) R31's Care Plan dated 12/17/24 includes the following diagnoses: Psychotic Disorder, Cerebral Infarction with Dominant Right sided Hemiparesis/Hemiplegia, Anxiety, Major Depression. Dysphagia, Muscle Weakness, and Reduced Mobility.

R31's Minimum Data Set (MDS) dated 12/17/24 documents R31 is Severely Cognitively Impaired, has Bilateral Decreased Range of Motion to Lower and Upper Extremities, is Wheelchair Bound, and Totally Dependent on staff for eating.

R31's Progress Note dated 1/19/2025 at 2:53 PM documents (R31) "spilled beets on lap Administrator, Power of Attorney, Nurse Practitioner on call, and Hospice notified. Administered Morphine for pain and cool compress. Hospice nurse will see (R31) tomorrow. (Physician) ordered Antibiotic Ointment to be applied."

On 1/22/25 at 11:00 AM V1 (Administrator) stated "We did not initiate an incident investigation for (R31's) burn. I didn't feel like we needed to. There wasn't a serious injury."

On 1/23/25 at 12:00PM V7 (Certified Nursing Assistant/CNA) stated I was working on 1/19/25 in the dining room. I was feeding another resident when they brought (R31's) lunch tray out

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and set it in front of (R31). (R31) is anxious and she will grab at things. The next thing I knew (R31) hit the hot beets in (R31's) lap. I went ahead and fed (R31). (R31) was wearing slacks and a top and I covered the spill. I didn't have any idea those beets were so hot. Then when I got (R31) back to bed 25 minutes or so later and removed (R31's) pants I discovered (R31) had been burned. I got the nurse right away."

On 1/23/25 at 12:10 PM V5 (Licensed Practical Nurse/LPN) stated I knew (R31) had spilled the beets in her lap on 12/19/25, but I wasn't aware until (V7) took (R31) to bed and took off (R31's) pants, (R31) had been burned. (R31's) thighs were red and tender and later blisters came up and burst. I notified (V1), the Nurse Practitioner on Call, Hospice, and resident's representative. We got an order for Antibiotic Ointment, and I applied that and cool compresses."

On 1/21/25 at 12:00 PM and on 1/22/25 at 11:45 AM R31 was observed sitting at the dining room table with uneaten hot foods in front of (R31). There were no staff visible directly assisting R31. R31 was muttering and moving hands back and forth.

On 1/23/25 at 2:00 PM R31 was lying in bed. V5 (LPN) pointed out an open area on R31's left outer thigh appearing as a sloughing blister approximately 1/2" in diameter, another sloughing blister on R31's Left inner thigh approximately 1" in diameter, and another sloughing blister on R31's Right inner thigh approximately 1/2" in diameter with a separate area on R31's right thigh measuring approximately 1/2" in diameter.

On 1/23/25 at 12:30 PM V13 (Dietary Manager) stated "The beets went out on 1/19/25 at a

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temperature of 180 degrees Fahrenheit. I had no idea those little insulated bowls keep the temperature so hot. I was wrong and I will not let that happen again."

On 1/24/25 at 11:00 AM V1 (Administrator) denied the facility has a policy for incident reporting or investigation. V1 stated now we are making sure (R31) does not have the food in front of (R31) before (R31) is fed." When notified R31 had hot food in front of R31 unsupervised on 1/21/25 and 1/22/25, V1 stated "I'll look into that" and verified (R31) should not have been unsupervised with hot food in front of (R31).

b. 1.) The facility's investigation report for R133 dated 1/12/25 no time given documents "(R133) had an unwitnessed fall in his room. Roommate was not in the room at the time of the fall. (R133) was transferred to Emergency Room at the local hospital who transferred (R133) to another hospital for care."

R133's Physician's Order Sheet (POS) dated January 2025 documents the following diagnoses: Parkinson Disease, Schizophrenia, Depression, Diabetes and Epileptic Seizures. R133 is able to be interviewed and walks with his walker.

On 1/21/25 at 11:00 AM R133 stated "Yes, I fell in my room, I got up from bed to go to the bathroom and I tripped on the fall mat that was next to my bed. I had to go to the hospital, and they transferred me to another hospital. I came back home on 1/10/25." R133 continue to say "My fall mat next to my bed was torn, I had that fall mat for a long time. I have a new fall mat now."

On 1/23/25 at 11:30 AM the fall mat which was

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removed from R133's room was torn on the bottom. The netting on the bottom of the fall mat was ripped from the bottom of the mat and was hanging down off the mat.

The hospital emergency department Radiology Results records dated 1/5/25 document R133 arrived at the Emergency Department on 1/5/25 at 2:05 PM and a CT (computed tomography) Scan without Contrast was completed which documented "Left frontoparietal Subdural Hematoma is slightly higher attenuation than previously suggesting interval rebleeding." The emergency documentation dated 1/5/25 documents "RN called to NH (nursing home) to notify facility (R133) will need to be transferred to higher level of care facility due to CT results."

Hospital records document "(R133) transferred to another hospital for care on 1/5/25." The records document the receiving hospital decision was R133 need to have an embolization procedure, which was performed on 1/8/25. Hospital records document "Impression after the procedure. Successful intracranial portion of the left middle meningeal artery embolization without immediate procedure complications." The records document R133 was discharged back to the facility on 1/10/25.

V10 (CNA) stated per phone interview on 1/23/25 at 10:22 AM "I was sitting at the nurses desk charting when I heard yelling and I went to check and found (R133) face down on his stomach, hands under his chin and (R133) stated 'I tripped on my mat going to the bathroom.'" V10 stated the nurse was notified and came to the room and assessed R133 and stated she was going to call EMS (Emergency Medical Services) for R133 and R133 was taken to the hospital.

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On 1/23/25 at 1:08 PM V11 (Nurse Practitioner) stated "According to my information from the hospital records I have in front of me (R133) received a Subdural Hematoma from the fall. I understand he did not lose consciousness but still needed the embolization procedure to be done."

R133's investigation report dated 1/5/25 no time available, documented the root cause analysis for R133's fall was due to frayed safety mat by R133's bed.

b2.) R20's Care Plan revised 1/13/25 includes the following diagnoses: Closed Fracture Left Radius, Moyamoya Disease, Age Related Physical Disability, Generalized Anxiety Disorder.

R20's Minimum Data Set (MDS) dated 12/17/24 documents R20 has a history of falls.

R20's Care Plan includes a problem first initiated 12/29/23 and continued since then documenting "(R20) is unsafe with transfers and often attempts to transfer self. (R20) has had numerous falls related to self-transferring." This Care Plan also states "1/7/2025: Actual Fall: 15-minute checks for safety and positioning. Date Initiated: 01/07/2025. Although 15 Minute checks were check marked as complete in the electronic medical record, there was no documentation of resident's location or activity at the time of the check or interventions initiated to prevent falls.

The facility's final report to the state agency dated 1/20/25 documents "(R20) had an unwitnessed fall in room. (R20) stated to staff (R20) slid off the bed and complained of pain in the left wrist. (R20) was sent to (local hospital) Emergency Room. X-rays to Left wrist were completed and

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revealed fracture to Left Distal Radius." There is no root cause analysis documented as to the cause of (R20's) fall.

On 1/24/25 at 3:00PM V3 (Registered Nurse/RN) stated "I did the investigation. I don't recall what the root cause was." V3 verified a root cause must be determined to decide appropriate interventions to initiate to prevent more falls.

The facility's policy Fall Prevention revised 11/10/18 states "Policy: To provide for resident safety and to minimize injuries related to falls; decrease falls and still honor resident's wishes/desires for maximum independence and mobility. Procedure: Conduct fall assessments on day of admission, quarterly, and with a change in condition. Identify, on admission, the resident's risk for falls. Assessment of fall risk will be completed by the admission nurse at the time of admission. Appropriate interventions will be implemented for residents determined to be at high risk at the time of admission for up to 72 hours. The admitting nurse will assign a temporary category."

c.1.) R54's undated Face Sheet documents medical diagnoses as Dementia, Psychosis, Sensorineural Hearing Loss, Dependence on wheelchair, unsteady on feet and Dysphagia.

R54's Minimum Data Set (MDS) dated 11/15/24 documents R54 as severely cognitively impaired. This same MDS documents R54 is dependent on staff for toileting, transfers, and maximum assistance for bathing, dressing and personal hygiene.

R54's Physician Order Sheet (POS) dated

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S9999	Continued From page 9 January 2025 documents a physician order starting 6/24/24 with no end date for R54 to use Left siderail when R54 is in bed to enhance bed mobility. R54's Bed Rail/Transfer Bar consent dated 7/7/23 documents R54 has been assessed to benefit from a Left half siderail to be used at all times when resident is in bed. R54's Nurse Progress Note dated 12/13/24 at 4:01 AM documents R54 was calling out. R54 was in her bed, laying across the bed. R54's head was closer to the right side of the bed. R54's Lower extremities on the left side of the bed. R54's Left Lower Extremity (LLE) was caught in between the first and second bar on her half siderails. R54 stated she was trying to get up. No new injuries to LLE noted. On 1/21/25 at 10:00 AM R54 was laying in her bed with two half siderails in the up position. On 1/23/25 at 1:15 PM R54 was laying in her bed with two half siderails in the up position. On 1/22/25 at 2:45 PM V1 Administrator stated she was unaware that R54 had gotten her LLE stuck in the siderail. V1 Administrator further stated R54 is not supposed to use two siderails. V1 (Administrator) stated R54 could have easily been injured. "A"	S9999		