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	265365	A. BUILDING _____ B. WING _____	C 09/19/2024

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F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement timely and appropriate interventions to prevent potential falls and injury for one resident (Resident #1) who had one fall mat next to the left side of the bed. Resident #1 had a fall from the right side of the bed that did not have a fall mat, which resulted in injury. The facility additionally failed to adequately assess resident falls by ensuring residents received treatment and care in accordance with acceptable standards of practice when the facility failed to complete post (after) fall 72 hour monitoring report (neurological (neuro) checks - pulse (P), respiration (R), and blood pressure (BP) measurements; assessment of pupil size and reactivity; and equality of hand grip strength) if the fall was unwitnessed or if the resident had an incident in hitting their head for three residents (Residents #2, #3 and #4), post fall initial clinical assessments for four residents (Resident #1, #2, #3 and #4), skin assessments for two residents (Resident #2 and #4), complete incident follow up documentation (IFU) for 72 hour post fall in the progress notes each shift for five residents (Residents #1, #2, #3, #4 and #5), document notification to physician for one resident (Resident #4), document notification of resident	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Donna Cooper TITLE: Licensed Nursing Home Admin (X6) DATE: 10-10-24

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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representative (RR) for two residents (Residents #4 and #5), update the residents' care plan with interventions for two residents (Residents #1 and #2), and update the kardex (nursing worksheet that includes a summary of patient information such as how many staff is needed to assist with care, if a fall risk would include interventions for falls, information on any specialized equipment resident may use, and other daily care information) binder located at the nurses' station with interventions for the nursing staff for four residents (Residents #1, #2, #3 and #4). The sample was 5. The census was 82.

Review of the facility's Managing Falls and Fall Risk policy, revised 12/19, showed:
-Policy statement: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling;
-Prioritizing approaches to managing falls and fall risk:
-1. The staff, with the input of the attending physician, will identify appropriate interventions to reduce the risk of falls. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions (i.e., to try one or a few at a time, rather than many at once);
-2. Examples of initial approaches might include exercise and balance training or a rearrangement of room furniture. If a medication is suspected as a possible cause of a resident's falling, the initial intervention might be to taper or stop that medication;
-3. In conjunction with the consultant pharmacist and nursing staff, the attending

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physician will identify and adjust medications that may be associated with an increased risk of falling, or indicate why those medications could not be tapered or stopped, even for a trial period;

-4. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant;

-5. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable;

-6. In conjunction with the attending physician, staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis (condition in which bones become weak and brittle), as applicable) to try to minimize serious consequences of falling;

-Monitoring subsequent falls and fall risk:

-1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling;

-2. If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention (e.g., dizziness or weakness) has resolved;

-3. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified;

-4. The staff and/or physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk

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for falling or injury due to falls.

Review of the facility's Fall Documentation Policy, undated, showed:
-Whenever a resident has a fall, the following must occur:
-A. An initial full body assessment, including neurological, must be documented;
-B. 72 hr. follow-up must be completed;
-C. The Initial post fall assessment must be initiated;
-a. The link for this assessment is in the risk report, and, or, it can be found under the resident assessment tab: Post Fall Initial Assessment V5-to be completed one time, directly after each fall. All questions must be completed;
-b. Post Fall 72 hr. Monitoring version (V) three is to be completed once each shift post fall for three days if witnessed fall. Please see attachment for appropriate assessment to complete after a fall;
-D. An updated fall risk assessment must be completed after each fall;
-E. All Interventions must be placed on the care plan;
-F. Interventions must be placed on the resident kardex for floor staff knowledge;
-When following up on falls, please ensure the above process in being followed by staff. If you are requiring a hard copy of the post fall neuro assessment, know and follow your plan for monitoring for completion, and uploading into medical records. Follow your process for ensuring direct care staff are aware of any new interventions implemented for your residents;
-Post fall step by step:
-1. Incident description:
-Complete a full body (head to toe) assessment prior to moving the resident off the

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floor. This will ensure the resident does not have severe injuries. This includes pupillary response. Example: No injuries noted. Pupils are equal, round and reactive to light and accommodation (PERRLA). Full range of motion (ROM) to all extremities. Legs equal in length. Hand grips and foot pushes/pulls equal in strength. No complaints of (c/o) pain. BP (Is read in milliliters of mercury (mmHg) when referring to Systolic (SBP, top number, normal is below 140), diastolic (DBP, bottom number, normal is below 90) 122/64, R (breaths per minute, normal is 12 - 18) 16, T (normal 98.6 degrees Fahrenheit (F)) 98.6, oxygen saturation (Sp02, measures amount of oxygen in the blood, normal SpO2 is between 90 and 100 percent (%)) 97% on room air. No c/o shortness of breath (SOB). Capillary refill (used for assessing the blood flow through peripheral (away from the center) tissues by compressing the nail bed until it blanches (temporary whitening of the skin) and record the time taken for the color to return to the nail bed. Normal capillary refill is less than 3 seconds) less than three sec. No edema (swelling) noted to any extremities. No other abnormalities noted;

-Please include the last time staff laid eyes on the resident, last time toileted, if the call light was on or off, where the resident's walker, cane, or wheelchair was located at the time of the fall. We have to have a very complete story on what occurred;

-Describe exactly how the resident's body was when you were alerted to fall, if the fall was or was not witnessed, what the resident and/or others say occurred, and any other information you may know that contributed to the fall. This includes exact location. Do not just write resident's room. Example: Resident on left side facing bed with blanket wrapped around legs and

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still connected to end of bed, Wheelchair to right of resident's face not coming in contact with resident. Breaks still locked on wheelchair. Call light was in reach of resident and not turned on. Staff last assisted resident to bathroom 30 minutes prior to fall. Resident states he/she rolled out of bed. Roommate states he/she saw resident roll out of bed.

-2. Resident's Description: Ask the resident:
-1. What were you trying to do when you fell? Where were you trying to go?;
-2. What made you fall? Did you trip, loose your balance, slide, etc.?;

-Chart whatever the resident says even if it doesn't make sense to you. This is their reality and will show what they were trying to do;

-3. Immediate Action Taken: This means what immediate action did you take to prevent this fall from occurring again. Immediate action taken does not refer to: got resident up off floor. This is not an intervention. If anything, the resident was safer on the floor. Examples:

-Resident attempting to go to the bathroom - Assisted resident to bathroom. If they are alert and oriented (A&O) times (x) 4 (Level of awareness of (1) self, (2) place, (3) time, and (4) situation. The higher the number, the better oriented a person is considered. Healthcare providers score a person's orientation on a scale of 1 to 4.) A & O x 3 - 4, educate them to call for assistance for the next few days as they are more likely to fall again in the next few days. If resident is not alert- take them to the bathroom and then have the aids assist them to the bathroom every 1-2 hours. Anticipate their needs. If it is new for the resident to wake up for the bathroom, maybe it is a urinary tract infection (UTI). Assess their urine;

-Is it their footwear? Are they having

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increased edema so their shoes are too tight, or they can't feel their feet as well? If so, intervention would be to address the edema and remove the shoes for the time being. Give them slipper/gripper socks for now;

-Is the resident having increased confusion causing increased falls? Ask for labs and/or urine analysis (UA). Has there been a recent medication change that could be causing the confusion related to the side effects?;

-Resident rolled out of bed-request a bed with bolstered edges, low bed, floor mats. If the fall is occurring at night and there is no one to get a different bed from, utilize pillows under the sheet to act as a bolstered edge;

-Find the root cause and fix it or the falls will continue. It is never ok to do nothing and wait for others to "fix" the problem. Do not utilize any type of personal alarm or bed rail. Only the Director of Nursing (DON) and Administrator can authorize the use of a positioning device as a very last resort. It is used to help the resident reposition, not to keep them in bed as that is a restraint;

-Injuries:

-1. Injuries observed at time of incident: A full body assessment must be completed. Even if there are no injuries, you must chart the level of pain, level of consciousness, mobility, and mental status. This will show if they have a change in mental status and how alert they were at the time of the fall to tell us what happened. Utilize the notes box to chart if any finding is different from their baseline;

-All injuries must be measured and described fully. Example: Bruise to left upper arm. 3 x 3 centimeters (cm) dark purple in color 100% intact skin. pain scale 0 -10 (0 = No pain, 1 - 3 mild pain, 4 - 7 moderate pain, 8 - 9 is severe

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pain, 10 = Worst pain possible) 4 out of 10 pain with touch. Ice applied. Pain relieved with ice;

-2. Injuries report post incident: This is where staff should chart all injuries that become visible after the initial assessment and are related to the fall;

-Factors: All sections need completed. Check all that apply. If you check the box "other" on any of these sections, you must type in the other information box what you mean by other;

-1. Predisposing environmental - This is looking at the environment where they fell. If you chart anything negative such as poor lightening, please explain as every room should have adequate lighting. Ex. Resident failed to turn light on in bathroom prior to entering;

-2. Predisposing physiological - This is looking at the resident's condition prior to the fall that could have contributed to the fall. If they have a diagnosis of advanced dementia, confused and impaired memory should be checked;

-3. Predisposing situation - This section looks at what situation could have contributed to the fall such as being new;

-Witnesses: If anyone (staff, resident, visitor, etc.) witnessed the fall a statement should be obtained and charted here;

-Check the box to show incident was witnessed and then click on the "new" box. Use the drop-down boxes to fully fill in: Relation, name, position, date, and who took the statement. If they are not a staff member, you will need to type in their full name and phone number as it will not be listed in the name section. We will need the full name and number in case further follow up is needed at a later date;

-Action: This is where we bring everything together:

-1. Agency/People notified: It does not matter

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the time of day/night. It is the nurse's responsibility on duty, when the fall occurred, to alert the responsible party (RP, or RR resident representative) and physician. If the fall does not have a major injury, the DON or a nurse manager can be notified during regular office hours. If the resident is their own RP, ask the resident if they want their emergency contact called and chart what they request. Everyone notified must have the full first and last name charted;

-2. Progress Note: This is where you chart the fall. This progress note connects with the resident's chart. All other sections of the risk management are not in the resident's chart. Therefore, this progress note must bring the complete fall together. Who, what, when, where, why, outcome/intervention all must be listed. Please make sure to include your body assessment here along with neuros (PERRLA). Recommend: Copy and paste your description note from the first tab as it should have the full picture charted there as well;

-3. Triggered user defined assessments (UDAs) - This will list any triggered assessments. You do not need to chart anything here;

-4. Care plan reviewed - every fall should have the care plan reviewed box checked as this is done in the initial fall assessment;

-5. Unusual occurrence report (completed for all injuries/accidents or any situation/occurrence that could pose a safety risk to patients or staff) - this box is checked if a claims report is completed;

-6. Care Conference Required- check this box if it applies;

-Notes: This is where you can chart any concerns or things you would not want in the chart. Example: call light was on for extended time. CNA, John Doe, counseled on answering call lights more promptly;

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-Signatures: The nurse on duty at the time of the fall must sign Licensed Nurse section of every fall. The DON and Administrator will also sign this section after they have reviewed the fall. Once the fall is completed with all charting done, the risk management incident is printed to the QA Reader and closed;
-Post Fall Assessments: Follow the following steps:
-Clinical tab - resident- assessment tab under resident's name- New-
-1st: Post Fall Initial Clinical Assessment V5 (SPN}: completed one time directly after each fall
------2nd: Post Fall 72-hour monitoring V3: If no head injury-complete once a shift x 3 days post fall,
-With head injury - complete assessments in order (b through i and then j for 72 hours: b= 15 min post, c=30 min post, d=45 min post, e= 1 hr post, f= 90 min post, g= 2 hr post, h=3 hr post, i= 4 hr post, j=Q shift x 72 hours);
-Post Fall Initial Clinical Assessment- V5: All questions must be completed:
-1. Description of fall - if checking other, you must describe in box that pops up;
-2. Clinical Assessment - do not use old vitals from prior to fall;
-3. Notification and Communication - if charting no to notified, please explain Why;
-4. Baseline neurological checks;
-5. Care planning- this will appear on the care plan. All falls need this section completed. If there is an option to edit a box you select, you need to edit to make it resident specific;
-6. Additional information - only section that can be left blank, if needed;
-Save, Sign, Lock, and Exit as soon as you complete this assessment;
-Post Fall 72-hour monitoring V3 - change type of

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assessment to b-j (depending on the time assessment you are completing)- Edit:
-a. Assessment: complete all questions except: 21, 22, 23, 24, ZS, 25a, 25b do not have to be completed if there is no change in condition;
-c) Additional Comment: may be left blank if you have nothing new to add;
-Save, Sign, lock, and exit as soon as you complete this assessment.

1. Review of Resident #1's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/30/24, showed:
-Moderate cognitive impairment;
-Upper and lower extremity impairment on both sides;
-Always incontinent of bladder and bowel;
-No falls since admission or the prior assessment;
-Diagnoses included traumatic brain injury (TBI), quadriplegia (paralysis of all four limbs), insomnia (sleep disorder of trouble falling asleep or staying asleep), seizure disorder, contracture (chronic loss of joint motion due to structural changes in non-bony tissue. These non-bony tissues include muscles, ligaments and tendons) of left hand, left wrist, right hand right wrist.

Review of the resident's progress notes, showed:
-9/13/24 at 12:09 A.M., resident noted lying on the floor next to low bed and wall on right side of bed. Resident appears to have a bruise on right cheek measuring 2 x 2 cm and an abrasion to left side of lower lip. Complaints of pain and discomfort. Tylenol given as ordered. ROM tolerated to all extremities;
-9/13/24 at 6:47 A.M., resident requested to be sent to hospital for further observation. RR and

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physician aware. Ambulance called for transportation. Emergency Medical Technicians (EMTs) arrived and transported resident to hospital;
-9/13/24 3:23 P.M., resident returned from hospital, diagnosis fall, acute (sudden in onset) pain of right knee, spastic quadriparesis (muscles appear unusually stiff, tight, or unable to move freely, loss of motor control). Resident has bruising noted to right cheek with slight swelling;
-No documentation of progress notes each shift for 72 hours after fall.

Review of the resident's care plan, on 9/16/24 at 12:15 P.M., showed:
-Focus: Activities of daily living (ADLs, activities related to personal care bathing, toileting, dressing, etc.) Resident requires total assist per staff with ADLs and mobility to actively participate related to weakness and fatigues easily;
-Goal: Resident's needs will be met per staff daily with some participation as tolerated this review period;
-Interventions:
-Assist resident with dressing grooming;
-Resident is a feeder with all meals and needs total assistance;
-Focus: Resident had actual falls on 10/13/23 and 10/21/23 with no injury;
-Goal: Identify possible contributing factors and reduce the risk of additional falls;
-Interventions:
-Check ROM (specify #) times daily;
-Keep bed in low position;
-Fall mat was not listed on the resident's care plan.

Review of the resident's assessments, dated 9/12/24 through 9/16/24, showed no post fall

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initial clinical assessment completed.

Review of the resident's MDS kardex report located in a binder at the nurses' station, dated 9/15/24 at 1:45 P.M., showed:
-Accidents/Fall Risk: falls since admission or prior assessment not marked, no assistive devices listed;
-No interventions were listed.

During an observation and interview on 9/16/24 at 10:39 A.M., the resident lay in a flat position on the bed on a low air loss mattress with four bolsters (raised area on outer edge of mattress to limit the likelihood of rolling off the bed), one bolster on each side of the head of the bed on right and left and one on each side of the foot of the bed one on left and right. The bed height was positioned with the bottom of the bed approximately two feet high and was not in lowest position. A fall mat lay on the floor on the right side of the resident's bed between the bed and the window, no fall mat was on the left side of the resident's bed. Certified Nursing Assistant (CNA) A was in the resident's room and said the resident did have a fall recently. He/She was unsure how the resident fell. CNA A said the resident fell on the floor on the right side of the bed. CNA A said he/she would know what interventions are in place for a resident by looking in the resident binder at the nurse's station that have all the resident's kardexes printed out. CNA A said the resident has one fall mat and it was located on the left side of the resident's bed but after the resident fell out of the right side of the bed the one fall mat was moved to the right side of the bed. CNA A said if a resident fell, he/she would make sure the resident is alright and not bleeding. CNA A would not move the resident and

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he/she would notify the nurse, and then provide any assistance the nurse needs. CNA A said he/she would fill out a witness statement if needed but a witness statement is not filled out for every fall.

During an observation and interview on 9/16/24 at 12:54 P.M., the resident lay flat in bed, with the bed in the lowest position with one fall mat on the right side of the bed and no fall mat on the left side of the resident's bed. CNA A said it is the responsibility of the staff who moves the fall mat to put the fall mat back in place. CNA A said he/she was not sure why the resident only had one fall mat. CNA A said the resident has only had one fall mat since he/she started, and it was always on the left side of the bed until the resident had the recent fall and then it was moved to the right side. CNA A said he/she would not know which side of the bed the resident would fall from. CNA A said he/she was not at the facility when the resident had the fall. CNA A said the resident can turn himself/herself in bed without assistance.

Observation on 9/17/24 at 8:39 A.M., showed the resident reclined in a Broda chair (a specialized reclining chair propelled by staff). One fall mat was on the right side of the resident's bed, no fall mat on the left side of the resident's bed.

During an interview on 9/17/24 at 8:54 A.M., CNA B said he/she would know a resident is a fall risk and what interventions are in place for a resident by looking in the kardex binder at the nurse's station. CNA B retrieved the kardex binder from behind the nurse's station. In the kardex binder, the resident had an MDS kardex report dated 9/15/24 at 1:45 P.M. The sections for

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"Accidents/Fall Risk" had no falls since admission or prior assessment marked, no assistive devices listed. No interventions were listed on the MDS kardex report. CNA A said the Maintenance Director (MD) was responsible for placing fall mat/mats in resident rooms. After the fall mat/mats are placed in the resident's room, it is the responsibility of the staff who moves the fall mat to put the fall mat back in place. CNA B said he/she does not know what side of the bed the resident would fall from. CNA B said if a resident's bed is not against the wall, then the resident should have a fall mat on both sides of the bed. CNA B said the resident did not have two fall mats. The DON told the MD this morning to get the resident a second fall mat and he/she is getting a second fall mat for the resident's room and will be placing it in the resident's room.

During an observation and interview on 9/17/24 at 9:27 A.M., CNA B said the MD just put the second fall mat in the resident's room. The resident was reclined in Broda chair. Fall mats were located on both sides of the resident's bed.

During an interview and observation on 9/17/24 at 9:57 A.M., Licensed Practical Nurse (LPN) C said he/she would know a resident is a fall risk when they are admitted to the facility and by the fall risk assessment. CNAs know when they finish providing care, all residents' beds should be placed in the lowest position. LPN C said he/she informs the CNAs who is a fall risk. LPN C said nursing informs the MD to get the fall mats and then it is nursing's responsibility to move the mats and then put them back in place after care is provided. LPN C thought the resident had two fall mats in his/her room. LPN C said he/she relieved the night nurse, LPN D, the morning after the

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resident fell on night shift. LPN D informed LPN C the resident fell out of bed on the right side. LPN D said the resident's low air loss mattress had deflated and the resident rolled off the right side of the bed. LPN D said he/she noticed the low air loss mattress was only partially plugged into the wall. LPN C said it is not typical for residents to only have one fall mat. LPN C said he/she does not believe the resident has rolled out of the bed prior to the last time because the resident has bolsters on the mattress. LPN C said the fall mats would have been put in place for a fall intervention. LPN C would not know which side a resident would fall from. If one fall mat was placed, it may be because a resident was getting out of bed on one side, staff could put a fall mat on that side and then if the resident starts to get out on the other side, they would put a second fall mat down on that side. LPN C said CNAs would know what interventions the residents have in place by looking in the kardex binder at the nurse's station. LPN C said if a resident has a fall he/she would go to the resident and do an assessment that included a head to toe assessment, looking for any redness, tenderness, bruising, bleeding, vital signs that would include blood pressure (BP), pulse, respirations, temperature, pain, ROM, and if the resident hit their head or it was an unwitnessed fall, would do neuro checks. If the resident was alright, he/she would transfer the resident into the resident's bed. LPN C would call the resident's physician and RR. All assessments, vital signs and notifications would be documented in risk management and a progress note. Neuros would be documented on a paper neuro sheet for 72 hours. Incident follow up (IFU) fall documentation should also be completed each shift in a progress note for 72 hours. The IFU progress notes should include the

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vital signs and if the resident had any changes like bruising that showed up after the fall, new pain, change in neuro checks. If a change was noted the physician and RR would to be notified and this would be documented in a progress note. LPN C said the resident had bruising on his/her right cheek and a small laceration to the lower right lip after the fall.

During an interview on 9/17/24 at 11:05 A.M., the DON said she was aware of the resident falling the night of 9/12/24. DON said instead of moving the fall mat from the left side to the right side, the staff should have requested an additional fall mat for the other side of the bed. The DON said the RR called after the fall, on 9/13/24, and requested the resident's bed to be placed against the wall or to have a second fall mat put between the bed and the wall. The intervention that was put in place was a second fall mat because the resident is total care and the bed against the wall would make resident care difficult. The DON requested the MD to make sure the second fall mat was in place yesterday on 9/16/24 and to follow up on it. The second fall mat should have been put in the resident's room on 9/13/24. Fall mats are placed to mitigate a serious injury. The DON said you do not know what side of the bed the resident will fall from so there should be a fall mat on both sides of the bed if the bed is not against a wall.

During an interview on 9/18/24 at 12:54 P.M., the MD said he was asked to place a second fall mat in the resident's room. The MD did not recall who instructed him to do it because it was text to him. He was unsure when it was texted to him, but when he noticed the text, he placed the mat in the resident's room at that time.

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During an interview on 9/19/24 at 7:45 A.M., LPN D said he/she worked the night the resident fell out of bed. The resident only had one fall mat at the time of the fall. The resident fell out of the right side of the bed, and this was the side without a fall mat. The resident sustained injuries from the fall that included a 2 x 2 cm bruise to his/her right cheek and an abrasion to his/her lip. When LPN D entered the room after the resident fell, he/she noticed the resident's low air loss mattress was deflated, and LPN D believed this is why/how the resident fell out of bed. LPN D said the low air loss mattress was partially unplugged from the wall and this caused the low air loss mattress to deflate. After he/she plugged the low air loss mattress completely in, the low air loss mattress reinflated. When a resident falls, the nurse should assess the resident for any injuries, take vial signs, ROM, and do neuro checks if it was an unwitnessed fall or if the resident hit their head, notify the physician and RR. The fall, assessment and notifications should be documented in risk management and in a progress note. The progress note should also list if there was any abnormality in the neuro check and the vital signs that were taken should be listed in the progress note. A skin assessment should be completed to document if the resident had any injuries. IFU 72 hour follow up documentation is completed in a progress note once per shift for 72 hours listing if there is any change in condition with the resident like new pain, new bruising, or change in mental status, the resident's current vital signs for that shift would also be listed in the progress note. LPN D said residents with fall mat's need a fall mat on both sides of the bed if the bed is not against a wall. There is no way to know what side the resident could fall from. LPN D said the resident should have had two fall mats.

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2. Review of Resident #2's quarterly MDS, dated 8/19/24, showed:
-Severe cognitive impairment;
-Upper and lower impairment on one side;
-Frequently incontinent of bladder and bowel;
-Falls since admission or the prior assessment, yes;
-Number of falls since admission or the prior assessment, two or more with no injury;
-Diagnoses included stroke, heart failure, high blood pressure, aphasia (loss of ability to understand or express speech, caused by brain damage), hemiplegia (paralysis on one side of the body) affecting right side, seizures, unsteadiness on feet, reduced mobility, repeated falls, and need for assistance with personal care.

Review of the resident's care plan during the survey, showed:
-Focus: Resident requires assist per staff with ADLs and mobility with ability to actively participate related to stroke and right sided weakness;
-Goal: Mobility status will improve as evidence by increased independence and mobility participation this review period;
-Interventions: Transfer assist x one to two staff;
-Focus: Resident has history of falls and remain at risk for future falls due to hemiparesis post stroke and cognitive deficits. Interdisciplinary team (IDT) unable to educate due to resident inability to recall education;
-Goal: Be free from minor/major injury through the review date;
-Interventions:
-8/11/24 referred to therapy for physical therapy (PT) and occupational therapy (OT) evaluation;

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-8/9/24 staff to ask resident if he/she wants to be toileted routinely after meals to mitigate falls related to self-transfer attempts;
-Ensure resident is wearing appropriate footwear (specify and describe correct client footwear: brown leather shoes, bedroom slippers, black nonskid socks) when ambulating or mobilizing in wheelchair;
-Focus: Risk for injury: fall occurred on 11/4/23 and on 1/22/24;
-Goal: Resident will resume daily activities without further incidents;
-Interventions:
-Assess resident and identify any injuries from fall;
-Educate on importance of maintaining a safe environment, free of potential fall hazards;
-One fall mat on left side of resident bed not listed in care plan.

Review of Post fall 72-hour monitoring report, dated 8/8/24, showed:
-No date or time listed in baseline (B) x one, every (q) 15 minutes (min) x four, q 30 min x two, q 1 hour (hr) x two, once per shift for 72 hours x three;
-No BP documented once per shift x three;
-No eyelid responses (4 = opens eyes spontaneously, 3 = opens eyes only in response to speech, 2 = opens eyes only in response to pain, 1 = does not open eyes when painfully stimulated, U = untestable (not capable of being tested)) documented in B x 1, q 15 min x four, q 30 min x two, q 1 hr x 2;
-No Post fall-72 hour monitoring report completed for second fall on 8/11/24.

Review of the resident's progress notes, dated 8/8/24 through 8/14/24, showed:

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F 689	Continued From page 20 -8/8/24 at 11:51 A.M., resident fell, no documentation physician or RR was notified of fall; -8/8/24, Night shift (7:00 P.M. - 7:00 A.M.), no IFU documentation for fall; -8/9/24, Night shift, no IFU documentation for fall; -8/10/24, Night shift, no IFU documentation for fall; -8/11/24 at 10:34 A.M., resident had another fall in resident's bathroom. Resident was attempting to self-transfer to toilet; -8/12/24, Day shift (7:00 A.M. - 7:00 P.M.), no IFU documentation for fall; -8/12/24, Night shift, no IFU documentation for fall; -8/13/24, Day shift, no IFU documentation for fall; -8/13/24, Night shift, no IFU documentation for fall; -8/14/24, Day shift, no IFU documentation for fall. Review of the resident's assessments, dated 8/8/24 through 8/17/24, showed, -No post fall initial clinical assessment completed on 8/8/24 or 8/11/24; -No weekly skin assessment completed on 8/8/24 or 8/11/24. Review of the resident's MDS kardex report located in binder at the nurses' station, dated 9/15/24 at 1:45 P.M., showed: -Accidents/Fall Risk: no injury marked under falls since admission or prior assessment marked, no assistive devices listed; -No interventions were listed. Observation on 9/17/24 at 8:37 A.M., showed one fall mat next to the left side of the resident's bed and no fall mat located on the right side of the resident's bed between the bed and the wall.	F 689		

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During an interview on 9/17/24 at 8:54 A.M., CNA B said the resident only has one fall mat that is located on the left side of his/her bed because the resident can move more on his/her left side and can't move the right side due to a stroke. CNA B said he/she would not know which side of the bed a resident will fall from. CNA B said he/she would know a resident is a fall risk and what interventions are in place for a resident by looking in the kardex binder at the nurse's station. CNA B retrieved the kardex binder from behind the nurse's station. In the kardex binder, the resident had an MDS kardex report that was dated 9/15/24 at 1:45 P.M. The sections for "Accidents/Fall Risk" had no injury marked under falls since admission or prior assessment marked, no assistive devices listed. No interventions were listed on the MDS kardex report.

During an interview on 9/17/24 at 11:05 A.M., the DON said fall mats are placed to mitigate a serious injury. The DON said you do not know what side of the bed the resident will fall from so there should be a fall mat on both sides of the bed if the bed is not against a wall.

3. Review of Resident #3's annual MDS, dated 6/11/24, showed:
-Cognitively intact;
-Always incontinent of bladder and bowel;
-Falls since admission or the prior assessment, yes;
-Number of falls since admission or the prior assessment, one with no injury;
-Diagnoses included high blood pressure, chronic kidney disease (CKD, impaired kidney function) with heart failure, chronic obstructive pulmonary

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disease (COPD, lung disease that block airflow and make it difficult to breathe), muscle weakness, and unsteadiness on feet.

Review of the resident's care plan during the survey, showed:
-Focus: Resident had actual fall from bed. Resident rolled out of bed isolated incident;
-Goal: I will resume usual activities;
-Interventions: 9/3/24 bed moved against wall to decrease falls;
-Focus: History of falls;
-Goal: Resident will be free of falls;
-Interventions:
-Assist resident with ambulation and transfers, utilizing therapy recommendations;
-Determine resident's ability to transfer;
-Evaluate fall risk on admission and as needed (PRN);
-If fall occurs, alert provider;
-If fall occurs, initiate frequent neuro and bleeding evaluation per facility protocol;
-If resident is a fall risk, initiate fall risk precautions;
-Focus: Resident has ADL self care performance deficit related to weakness, fatigue, osteoarthritis (OA, degenerative joint disease occurs when flexible tissue at the end of bones wear down);
-Goal: Anticipate and meet ADL needs daily through next review;
-Interventions:
-Bed mobility: Assist x one - two staff;
-Transfer: Resident requires total assistance with transfers. Hoyer (a balanced sling hoist used to move completely or partially immobile patients) x two staff;
-Toilet use: Resident is not toileted, peri-care (cleaning the private areas of a patient) dependent on staff.

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Review of Post fall 72-hour monitoring report, dated 9/3/24, showed:
-No date or time listed in B x one, once per shift for 72 hours x three;
-B, no documentation (blank) x 1 for: BP, P, R, Orientation to place, person, date/time
-72 hours no documentation (blank) listed x 3 for: BP, P, R, orientation to place, person, date/time, skin bruising, skin tear, clear, other, pain, ROM (4 = normal power, 3 = mild weakness, 2 = severe weakness, 1 = no response, F = full ROM, L limited ROM) right hand, left hand, right arm, left arm right leg, left leg, eye responses, eye score (pupils: assess size, equality, reaction to light, and unilaterally dilated pupils, Some residents will have unequal pupils as their normal, reactive (+), nonreactive (-), closed (c), pupil size from 1 millimeter (mm) through 8 mm).

Review of the resident's progress notes, dated 9/3/24 through 9/6/24, showed:
-9/3/24 at 8:15 A.M., resident rolled out of bed, noted bed was in a high position, no injuries. Resident transferred to bed with assist x 3 staff with draw sheet;
-No documentation that physician was notified;
-9/3/24, Night shift, no IFU documentation for fall;
-9/4/24, Night shift, no IFU documentation for fall;
-9/5/24, Night shift, no IFU documentation for fall.

Review of the resident's assessments, dated 9/3/24 through 9/6/24, showed no post fall initial clinical assessment completed.

Review of the resident's MDS kardex report located in the binder at the nurses' station, dated

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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9/15/24 at 1:45 P.M., showed:
-Accidents/Fall Risk: no injury marked under falls since admission or prior assessment marked, no assistive devices listed;
-No interventions were listed.

4. Review of Resident #4's significant change MDS, dated 6/20/24, showed:
-Severe cognitive impairment;
-Frequently incontinent of bladder;
-No falls since admission or the prior assessment;
-Diagnoses included Alzheimer's, high blood pressure, heart failure, diabetes, arthritis and unsteadiness on feet.

Review of the resident's care plan during the survey, showed:
-Focus: Resident has history of falls and is at risk for future falls;
-Goal: Resident will be free of falls;
-Interventions:
-9/5/24 declutter room and verify night light;
-Assist resident with ambulation and transfers utilizing therapy recommendations;
-Determine residents ability to transfer;
-Evaluate fall risk on admission and PRN;
-If fall occurs alert provider;
-If fall occurs initiate frequent neuro and bleeding evaluation per facility protocol;
-If resident is a fall risk initiate fall risk precautions;
-Focus: Resident has ADL self care performance deficient related to Alzheimer's;
-Goal: Assist with ADL's through next review;
-Interventions: Transfers assist x one staff.

Review of the resident's progress notes, dated 9/6/24 through 9/10/24, showed:

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	265365	A. BUILDING _____ B. WING _____	C 09/19/2024

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-9/6/24 at 10:30 P.M., resident was observed on floor;
-No documentation that physician was notified;
-No documentation that RR was notified;
-No vital signs documented;
-9/7/24, Night shift, no IFU documentation for fall;
-9/8/24, Day shift, no IFU documentation for fall;
-9/8/24, Night shift, no IFU documentation for fall;
-9/9/24, Day shift, no IFU documentation for fall;
-9/9/24, Night shift, no IFU documentation for fall.

Review of resident assessments, dated 9/6/24 through 9/10/24, showed no post fall initial clinical assessment completed, and no weekly skin evaluation completed.

Review of the resident's Post Fall 72-Hour monitoring report, dated 9/6/24, showed:
-9/6/24 at 10:00 P.M., BP: Blank, P: Blank, Right reaction: Blank, Left reaction: Blank;
-9/6/24 at 10:15 P.M., BP: Blank, P: Blank, Right reaction: Blank, Left reaction: Blank;
-9/6/24 at 10:30 P.M., BP: Blank, P: Blank, Right reaction: Blank, Left reaction: Blank;
-9/6/24 at 10:45 P.M., BP: Blank, P: Blank, Right reaction: Blank, Left reaction: Blank;
-9/6/24 at 11:00 P.M., BP: Blank, P: Blank, Right reaction: Blank, Left reaction: Blank;
-9/6/24 at 11:30 P.M., BP: Blank, P: Blank, Right reaction: Blank, Left reaction: Blank;
-9/7/24 at 12:00 A.M., BP: Blank, P: Blank, Right reaction: Blank, Left reaction: Blank;
-9/7/24 at 1:00 A.M., BP: Blank, P: Blank, Right reaction: Blank, Left reaction: Blank;
-9/7/24 at 2:00 A.M., BP: Blank, P: Blank, Right reaction: Blank, Left reaction: Blank;
-9/7/24, Day shift, BP: Blank, P: Blank, Right reaction: Blank, Left reaction: Blank;

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-9/7/24, Night shift, BP: Blank, P: Blank, Eyelid response: Blank;
-9/8/24, Day shift, BP: Blank, P: Blank;
-9/8/24, Night shift, BP: Blank, P: Blank, Eyelid response: Blank;
9/9/24, Day shift, BP: Blank, P: Blank, R: Blank, Orientation: Blank, ROM right and left hand: Blank, Eyelid response: Blank; Pupils: Right size: Blank, Right reaction: Blank, Left size: Blank, Left reaction: Blank.

Review of the resident's MDS kardex report located in a binder at the nurses' station, dated 9/15/24 at 1:45 P.M., showed:
-Accidents/Fall Risk: falls since admission or prior assessment not marked, no assistive devices listed;
-No interventions were listed.

5. During an interview on 9/17/24 at 11:05 A.M., the DON said the kardex and care plan should be up to date with the current interventions. The DON expected the kardexes in the kardex binder to be up to date with current interventions. The DON said the CNAs look at the kardex for interventions for the residents and if the interventions were not listed, the CNAs would not know what interventions are in place for the resident. Medical Records (MR) is responsible for printing off the residents' kardex and keeping the kardex binders up to date at the nurse's stations. If a resident has a fall, the DON expected the nurses to do a head-to-toe physical assessment, complete vital signs including neuros if the resident hit their head or had an unwitnessed fall. The nurse would notify the physician and RR and enter any new orders from the physician. The fall would be entered into risk management and would include the head-to-toe assessment,

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injuries, and notifications. When a fall is entered into risk management, the post fall risk assessment populates under assessments and would be completed at the time of the fall. A skin assessment should also be completed to document if the resident had any injuries. A progress note would then be completed that included how the resident fell, all vital signs including results of neuro assessment if completed, results of the head-to-toe physical assessment, any injuries, ROM, notifications that were made to the physician and RR and any if new orders were received from the physician. IFU documentation should be completed for 72 hours after the fall. The DON expected progress notes to be entered each shift for 72 hours after a fall or an incident that requires neuro checks. The IFU progress note would include results of neuro checks, all vital signs, any changes of condition such as bruising or new pain. If any changes were noticed the physician and RR would be notified and it would be documented in a progress note including if any new orders were given.

6. During an interview on 9/19/24 at 10:40 A.M., the MDS Coordinator (MDSC) said MR is responsible for printing the kardex for residents and placing them in the binder at the nurse's stations. The MDSC said she is responsible for updating the residents' care plans, including interventions. After new interventions are placed into a resident's care plan, the MR would print of a new kardex for the resident. The MDSC said when she started at the facility approximately six months ago, MR was responsible for printing off the updated kardexes and placing them in the binders at the nurses station. The MDSC showed MR how to properly print of the clinical kardex yesterday after it was brought to their attention

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that the kardex that MR was printing off did not show interventions that were in place for the residents. CNAs use the kardex to see what interventions are in place for residents and the kardex MR was printing off did not show interventions.

7. During an interview on 9/19/24 at 11:07 A.M., MR said she started in medical records in October, 2023. She said she has been printing a kardex for each resident and placing them in binders at the nurse's station since then. She would print out a new kardex for each resident every Friday and place them in the binders. Yesterday, on 9/18/24, the MDSC showed her how to print off the clinical kardex that showed the interventions that are in place for residents.

8. Review of Resident #5's admission MDS, dated 8/26/24, showed:
-Cognitively intact;
-Upper and lower extremity impairment on both sides;
-Always incontinent of bladder and bowel;
-Dependent on staff for all care;
-Diagnoses included traumatic spinal cord injury, quadriplegia, high blood pressure, weakness and diabetes.

Review of the resident's care plan in use at time of survey, showed:
-Focus: 9/5/24 resident made an allegation, he/she reported that direct staff care was "too rough" causing him/her to hit his/her head when repositioning;
-Goal: Maintain resident safety;
-Interventions:
-Educated staff on proper repositioning and providing "care in pairs"(two staff members when

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providing care);
-Head to toe assessment;
-Neuro checks and monitoring 72 hours post event;
-Focus: Resident has ADL self performance deficit related to being a quadriplegic. Resident prefers for staff to wear gloves with all ADLs including feeding;
-Goal: Staff will meet ADL needs daily;
-Interventions: Resident is totally dependent on staff for: Toileting, bathing, bed mobility, personal hygiene/oral care, dressing, eating, and transfers.

Review of the resident's progress notes, showed:
-9/5/24 at 2:19 P.M., resident stated when two CNAs were pulling him/her up in bed the top of the resident's head hit the headboard;
-No documentation RR notified of incident;
-9/6/24, Night shift, no IFU documentation for fall;
-9/7/24, Day shift, no IFU documentation for fall;
-9/7/24, Night shift, no IFU documentation for fall;
-9/8/24, Day shift, no IFU documentation for fall.

During an interview on 9/19/24 at 10:51 A.M., the DON said if a resident hits their head and does not have an actual fall, she expected staff to follow the same procedure for a fall. The staff would assess the resident, fill out a skin assessment documenting if there were any injuries including if there were none, complete neuro checks, contact the physician and RR. All would be documented in risk management and in a progress note. The progress note would include a description of what happened, the assessment and if there were any injuries, notifications, any new orders, and the resident's vital signs, including results of neuro check. She expected staff to complete the IFU documentation for 72 hours each shift in a progress note that shows the

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F 689	Continued From page 30 staff were monitoring for any change of condition. The documentation would include any changes of condition, vital signs and results of neuro checks for that shift. 9. During an interview on 9/19/24 at 1:35 P.M., the Administrator and DON said they expected staff to be knowledgeable of the facility policies and for staff to follow the facility policies. They expected all documentation to be completed on all residents for all incidents. MO00242023	F 689		

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	14200	A. BUILDING: _____ B. WING _____	C 09/19/2024

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A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice. I/II This regulation is not met as evidenced by: Class II See the deficiency cited at F689.	A4075		

PLAN OF CORRECTION

Provider/Supplier Name:	StoneBridge Florissant
Street Address, City, Zip:	6768 N. Highway 67 Florissant, Mo 63034
Date of Survey:	9/19/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265365

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F-689 SS=E A4075	This Plan of Corrections is submitted as required under State and Federal Law. The submission of the Plan of Corrections does not constitute an admission on the part of Stonebridge Florissant as to the accuracy of the surveyor's findings nor the conclusion drawn from those findings. Submission of the Plan of Correction does not constitute an admission on the part of Stonebridge Florissant that the findings constitute a deficiency, or that the scope and severity determinations are correct. This Plan of Correction is intended to constitute the facility credible letter alleging compliance. Compliance has been and will be achieved no later than the Plan of Correction, date of 10.24.2024. Compliance will be maintained as provided in the Plan of Correction. 1. The facility will continue to ensure resident #1 and all residents with falls will have timely and appropriate interventions implemented. 2. The facility will continue to ensure residents #1, #2, #3, #4, #5 and all residents with falls are adequately assessed in accordance with acceptable standards of practice, to include an initial assessment and 72-hour follow-up. Skin checks will be completed, with abnormal finding documented in the clinical record. Neuro assessments will be completed and documented in the clinical record with unwitnessed falls and/or falls with head injury. 3. The facility will continue to ensure that resident #4, and all residents will have their physician/designee notified of all falls. 4, The facility will continue to ensure that resident # 4, #5 and all residents will have their Resident Representatives notified of all incidents. Resident Representative and Physician for #4 was updated on 10/10/24 on resident fall occurring on 9/6/24.	10/24/2024

	Resident Representative for resident #5 was notified on 9.5.2024 at 1842 concerning incident on 9.5.2024 at 1419. Resident #5 was discharged on 9.16.2024. The facility will continue to ensure that resident #1, #2 #3 #4, and all other residents will have their Kardex and Care Plans updated to reflect current interventions. All updated Kardex in the Kardex binders are available for review by frontline nursing staff. The Director of Nursing/Designee will re-educate Licensed staff on completion of a post fall initial clinical assessment, 72-hour post fall monitoring, skin check as well as neuro assessment on resident with unwitnessed falls or falls with head injuries. The Director of Nursing/Designee will re-educate Licensed staff on notifying the Physician/Designee and Resident Representative timely after all resident incidents. Admin/Designee will re-educate MDS nurse on reviewing and updating the resident Kardex and Care Plans to reflect any updated fall interventions. The Director of Nursing/Designee will ensure continued compliance through rounds, observations and completion Post Fall audit Quality Improvement Tool for each fall/incident for 4 weeks, then monthly thereafter until sustained compliance is met. The Interdisciplinary Team will review falls and interventions weekly to ensure effectiveness and appropriateness of the interventions. The Director of Nursing will have oversight of this requirement The Quality Improvement tools will be reviewed in the Weekly Risk Meetings and results discussed monthly in Quality Assurance Meeting along with any needed action plan(s).	

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.