STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676281	A. BUILDING _____ B. WING _____	08/03/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SCC AT WESTOVER HILLS REHABILITATION AND HEALTHCAR	9922 STATE HWY. 151 SAN ANTONIO, TX 78251

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0224 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement written policies and procedures that prohibited neglect for two (#3 and #4) of eight residents reviewed for neglect. 1. Resident #4 was not appropriately assessed or care planned for use of an electric scooter, fell from the scooter and was hospitalized and passed away. Physical Therapy staff identified the safety issues and this communication was never passed on to direct care staff. These failures resulted in an Immediate Jeopardy (IJ) which was identified on [DATE]. The IJ was removed on [DATE], but the facility remained out of compliance at a severity level of actual harm at pattern because the facility had not had time to monitor and evaluate the effectiveness of the Plan of Removal. 2. Resident #3 had a fractured left femur. The facility did not treat the pain prior to being transferred to the hospital after extreme pain was first observed. The resident returned to the facility, placed on hospice, and died within the month. This was determined to be past non-compliance at an Immediate Jeopardy level due to the facility's implementation of actions that corrected the non-compliance prior to the investigation on [DATE]. The facility was out of compliance from [DATE] to [DATE]. The facility's corrected action was completed on [DATE]. These deficient practices placed 6 residents identified as having poor safety awareness and 5 residents identified as having increased confusion at risk for risk of accidents and injury to include death and 10 residents identified with having pain at risk for experiencing long periods of pain Findings include: 1. Review of Resident #4's face sheet dated [DATE] revealed he was admitted on [DATE]. Further review revealed Resident #4 had [DIAGNOSES REDACTED]. Review of Resident #4's hospital death summary dated [DATE] revealed under preliminary cause of death: Immediate cause: (Final diseases or condition resulting in death)[MEDICAL CONDITION], Hepatic [MEDICAL CONDITIONS] and right side sub arachnoid hemorrhage .ED course: (discharged from the facility on [DATE] after he fell from his motor scooter in the parking lot) intubated on arrival neurosurgery and neurology consulted for sub arachnoid hematoma on CT and [MEDICAL CONDITION]. Review of Resident #4's initial mobility fall risk assessment dated [DATE] revealed he scored low risk for falls on admission. Review of Resident #4's fall risk assessment on [DATE] revealed he was at risk for falls . with a Yes to does the resident display any of the following behaviors: easily distracted; periods of altered perception of awareness of surroundings; episodes of disorganized speech; periods of restlessness; periods of lethargy; mental function varies over the course of the day; wanders. Under section 11 Gait .Impaired, has difficulty rising from chair, grasps furniture, person or aid when ambulating. Cannot walk unassisted. Review of Resident #4's fall risk assessment on [DATE] revealed he was at risk for falls .with overestimates or forgets limits. Review of Resident #4's comprehensive plan of care initiated on [DATE] revealed under problem .ADL self care performance deficit r/t CONFUSION, LACK OF COORDINATION, MUSCLE WEAKNESS. Further review of this document revealed under interventions .staff will assist with transfers and visually check the resident every two hours and as needed. Interview on [DATE] at 11:29 a.m. with ADON B revealed that Resident #4's motorized chair arrived sometime around [DATE]st, 2016, and it was not with him when he arrived on the week of the 20th. He said that Resident #4 originally received the motor scooter from the Veteran's Administration, and had used it previously. Review of Resident #4's comprehensive plan of care initiated on [DATE] revealed it did not address his motorized chair. Interview on [DATE] at 12:40 p.m. with the MDS nurses A and B revealed that Resident #4's motorized chair needed to be care planned and they did not know why it was not. Review of the facility's Power Mobility Device policy and procedure (undated) revealed that .since a power mobility device can pose a potential risk to the safety, property, and well-being of its user and to others and their property, each facility will assess and document each resident's individualized need regarding appropriate interventions proposed to meet the residents needs. Review of Resident #4's 14 day scheduled MDS assessment dated [DATE] revealed on section [MEDICAL CONDITION] revealed that he had disorganized thinking or was incoherent . behavior present continuously and does not fluctuate. Further review indicated under section G0300 Balance during Transitions and Walking that he was not steady, only able to stabilize with staff assistance. Further review of this document revealed Resident #4 required extensive assist and two person physical assist with transfers .locomotion on unit required supervision and one person physical assist, and supervision off unit required limited assistance and one person physical assist. Review of Resident #4's Care Plan Conference Summary dated [DATE] revealed under Risks/Consequences .potential for falls. Review of Resident #4's Physical Therapy note dated [DATE] at 2:39 p.m. revealed under NOTE: Pt trained in safe power wheel chair mobility to increase safety and decrease risk of injury to self and others. Pt instructed in steering, obstacle negotiation and maneuvering in small spaces. Pt continues to require stand by assistance and visual cueing of the above mentioned skills. Review of Resident #4's comprehensive plan of care initiated [DATE] revealed under problem that due to an unsteady gait he had a fall. Further review of this document revealed that under the section approach .anticipate needs, provide prompt assistance. No revisions were noted. Review of the facility Fall Investigation Worksheet dated [DATE] at 5:45 a.m. revealed that Resident #4 fell while trying to go to the restroom. Under did resident require supervision .response was yes. Further review of this same document revealed resident was found on floor seated and leaning against his bed .stated he was trying to go to bathroom when he got caught by his covers and slipped while grabbing on to his bed mattress. He was reminded to use his call light. Review of the facility Fall Investigation Worksheet dated [DATE] revealed that Resident #4 had a fall at 12:00 a.m. in his room witnessed by the room mate who said that resident was reaching for something that fell on floor and he fell out of bed. Further review of this document revealed that Resident #4 received skin tears to both forearms Review of Resident #4's Progress Notes dated [DATE] at 12:36 a.m. revealed resident experienced fall. residents room mate witnessed the fall. said he was rolling around in bed and fell out. residents bed was locked in lowest position. skin tears to both forearms noted. Review of the facility incidents for [DATE] and [DATE] revealed Resident #4 had falls in his bedroom and was unsteady. Interview on [DATE] at 11:04 a.m. with the DON revealed that Resident #4 had fluctuations with confusion and lucidity, and

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

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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F 0224 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 1) that he had falls on [DATE] and [DATE]. She reported that Resident #4 should have had a formal assessment for safety to drive his motorized wheel chair and it needed to be care planned which did not happen. Interview on [DATE] at 09:50 a.m. with RN A revealed Resident #4 was acting very anxious the week before his fall on [DATE]. She was informed on [DATE] that the resident was acting confused over the weekend when she got report. She stated that Resident #4 was not very balanced, when referring to his level of physical stability. RN A stated that she sent Resident #4 out to the hospital on [DATE] because soon after she came on for her shift from 6:00 a.m. to 2:00 p.m., the morning after the fall she discovered Resident #4 in his room without his clothes on, and he had a blank stare and would not respond. Review of facility Progress Notes (page 3) written by LVN C and dated [DATE] at 12:08 p.m. revealed, Pt appears to have fallen face first onto surface, has multiple new skin issues including most notable lesion to right brow that was bleeding moderately, pt also has multiple new skin tears to face and extremities. During an interview on [DATE] at 11:35 a.m. with PTA A and the PT who worked for the corporation revealed Resident #4 had a history of [REDACTED]. PTA A stated that some days the resident was very confused, and at times impossible to work with the resident on the days he was confused. PTA A confirmed that there would have been no line-of-sight supervision for the resident on the day he fell off the scooter as to where he fell outside, and that he should not have been outside without supervision. The PT confirmed that Resident #4 was a stand by assist, so he needed to have someone standing by and assisting him. She said that Resident #4 needed verbal cues, in order to avoid things like trash cans and other obstacles the resident had to navigate while operating his scooter. She said that Resident #4 needed this assistance not only on the motorized chair, but also in a regular wheel chair. She said that therapy was usually very good at communicating resident needs to the nursing staff, but that this time it did not happen. PTA A stated that he was very surprised to hear that Resident #4 was outside in his power scooter. He stated that nursing had access to all of the therapy notes. The PT said the resident had poor safety awareness, in that he had a hard time being convinced that he could not do some of the same activities he could do when he was younger. She said that he did not have his power scooter on the day of his initial mobility assessment on [DATE]. Interview on [DATE] at 2:07 p.m. with CNA G, revealed that most of the time the Physical Therapy Department informally communicated with the staff regarding the needs of the resident, but said that she was not told anything specific, and that it was not on her assignment sheet. When asked if Resident #4 was getting stand by assistance or visual cueing while in his electric wheel chair, she said no. She stated that Resident #4 should not have been outside by himself without supervision because of his confusion. Interview on [DATE] at 1:55 p.m. with the facilities Medical Director revealed that she typically goes with the opinion of therapy regarding the screening of residents, and that she was not aware of the resident having safety awareness issues with the scooter, but was aware of his falls. Interview on [DATE] at 4:00 p.m. with the Physical Therapy Director, Administrator and DON revealed that there was not a formal method of communicating therapy information to nursing staff in place .and that was why his need for supervision addressed by therapy was never noted by the direct care staff who took care of him. Interview on [DATE] at 09:30 a.m. with the OTA A and PTA A revealed that Resident #4's behaviors would fluctuate from being lucid to being confused. PTA A said Resident #4's judgement would be confused. He stated that the resident advised her he had an electric scooter and then one day, he showed up with it. PTA A and OTA A both agreed that Resident #4 had safety awareness issues and he was not safe being outside without supervision because of his fluctuations and confusion. Telephone interview on [DATE] at 1:33 p.m. with the witness revealed she saw Resident #4 on the ground behind the facility in the parking lot on [DATE] between 6:30 p.m. and 7:00 p.m. She stated that Resident #4 was bleeding near the right eye, and she went for help. Telephone interview on [DATE] at 1:45 p.m. with Resident #4's emergency contact revealed he was deceased , and that she spoke to him the evening of his fall and said that he sounded different, , but she just assumed he did not have his dentures in .and sounded confused, and did not tell her about the fall. Interview on [DATE] at 2:32 p.m. with LVN B revealed he assessed Resident #4 after he had his fall and he assisted LVN C with getting Resident #4 back into his chair and to his room. He said that resident #4 had a large wound above his right eye. Interview on [DATE] at 2:40 p.m. with LVN C revealed he was alerted on [DATE] that Resident #4 was lying on his right side on the ground in the back of the facility and he said that he did some first aide on the skin tears and the resident did not appear to have fractured anything. He said the resident informed staff that his electric chair fell off the curb. The Administrator was notified of noncompliance at an IJ level on [DATE] at 3:30 p.m. and a plan of removal was requested. The facility plan of removal on [DATE]: -Residents using electric wheel chairs were reassessed by the ADON and administrative nursing staff for safety by [DATE]. -Care plans were checked to ensure residents had a plan of care that recognized and addressed resident's safety needs related to electric wheelchair use by [DATE]. -Nursing staff were trained on recognizing residents with potential of having intermittent confusion by [DATE]. -Existing residents using electric wheel chairs would be assessed quarterly and with any significant change by nursing, therapy and maintenance by [DATE]. -New admissions with electric wheel chairs would be assessed by nursing, therapy, and maintenance prior to use as of [DATE]. -Electric wheel chair assessments would be brought to the weekly IDT meeting for review, and any changes to the plan of care would be communicated through the CNA assignment sheets by [DATE]. -These actions were taken to QA for approval on [DATE]. Confirmation of plan of removal was staff who were interviewed on [DATE] included LVN's, CNAs, and a Med Aide regarding recent in-services, assessments, documenting on the 24 hour book, monitoring of residents, and understanding of the dot system (explains residents ' needs) The topics discussed with each staff person depended on their discipline. Physical Therapy developed a new system of integrating information into the morning facility meetings to disseminate safety concerns of residents to direct care staff. The IJ was removed on [DATE], but the facility remained out of compliance at a severity level of actual harm at pattern because the facility had not had time to monitor and evaluate the effectiveness of the Plan of Removal. The number of residents at high risk for safety issues (6) and with increased confusion (5) was provided by the DON. 2. Review of Resident #3's face sheet revealed she was admitted on [DATE] and readmitted on [DATE] on Hospice, after she was transferred to the hospital on [DATE] with a [MEDICAL CONDITION] femur. Further review of this same document revealed Resident #3's [DIAGNOSES REDACTED]. Review of Resident #3's Quarterly MDS with an ARD of [DATE] revealed Resident #3 could understand and be understood. Further review revealed she scored a ,[DATE] on her BIMS indicating severe cognitive impairment. She was assessed to have no pain and had not taken any PRN pain medication during the review period. Review of Resident #3's physician orders dated [DATE] to [DATE] revealed she had orders to be monitored for pain every shift and to use pain scale (A) ,[DATE] for alert residents and (B) for confused residents. This order originated on [DATE]. Further review revealed orders for [MEDICATION NAME] 7XXX[DATE] ML-Give 10 ML PO Q 4 Hours PRN for pain and [MEDICATION NAME] HCL Tablet 50 MG, Give 1 tablet by mouth every 4 hours as needed for pain, and Tylenol Extra Strength Tablet 500 MG, Give 1 tablet by mouth every 6 hours as needed for pain. Review of Resident #3's MAR for ,[DATE] revealed she was assessed for pain every shift and had no pain indicated for days ,[DATE], however, she was assessed to have a level 6 pain documented on [DATE] for the 6 a.m.- 2 p.m., 2 p.m.-10 p.m., and the 10 p.m.-6 a.m. ([DATE]-[DATE]) shifts. Review of Resident #3's MAR for [DATE] revealed she was provided a [MEDICATION NAME] 7XXX[DATE] ML, 10 ML by mouth as needed for pain at 4:25 p.m. Review of Resident#3's nursing note by LVN B written on [DATE] at 4:45 p.m. revealed [MEDICATION NAME] 7XXX[DATE] ML-Give 10 ML PO Q 4 hours PRN for pain given .Resident c/o pain in LEFT knee. When questioned regarding cause/onset resident was easily distracted and could not elaborate on the pain and could not specify location. Would mention that her back hurt but would point to her LEFT thigh. Review of Resident #3 's hospital flow-sheet, dated [DATE], revealed a displaced [MEDICAL CONDITION] diaphysis (long thigh bone) and metaphysis (wide part of the long thigh bone) of the femur. There is an oblique fracture through the distal diaphysis and distal metaphysis of the femur. The distal fragment is displaced laterally 8 mm .the main distal fragment is displaced posteriorly nearly 1 cm.

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F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) Review of Resident #3's Comprehensive plan of care created on [DATE] and revised on [DATE] revealed she had impaired cognitive function related to dementia. Further review revealed she had pain related to disease process of [MEDICAL CONDITION]. Interventions include: Nursing to monitor/record/report any signs or symptoms of non-verbal pain and verbal complaints of pain, or request for pain medications .notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. Interview on [DATE] at 12:55 p.m. with ADON A revealed Resident #3 arrived to the facility on hospice and was then removed from hospice because she was doing well. Furthermore, ADON A stated the resident started declining and was having numerous UTIs and ended up getting ESBL and was on isolation. ADON A said the resident could not understand why she was on isolation and, . started to change, mentally. She said the resident got out of isolation and started yelling, screaming and kicking at the door, and then on the late afternoon of [DATE] complained of back and knee pain. The ADON said the resident was assessed and then given a pain pill. ADON A said the resident was sent to a hospital the next day for excessive pain and LOC. ADON A said the hospital did an x-ray because the resident had a swollen leg and determined there had been a fracture. The ADON said the hospital did not do any reparations and the resident was sent back to the facility on hospice and passed away weeks later. Interview on [DATE] at 10:29 a.m. with LVN G revealed the resident was very social so being in isolation was very difficult for her. She said the resident was more confused than usual the day she left. She said the resident was seen kicking the door the day before she left the facility. LVN G said the morning she sent the resident out on [DATE] she called the ambulance because the resident was acting confused but said when she pulled the resident ' s sheets up and began turning the resident at about 10:30 a.m. and she screamed in pain and complained of leg pain. LVN G said she noticed swelling above the knee. She said she was unsure if the resident was going into shock but did not scream when still without movement, which is why she did not give the resident any pain medication. The nurse acknowledged she would have done it differently looking back by issuing the resident pain medication. The nurse said if the resident had been more vocal she could have been able to communicate her pain and would have been more likely to have been issued pain medication. She said she advised the ambulance driver the resident was complaining of severe pain before she left the facility. She said she spoke to CNA A from the evening shift prior, who asked if the resident was sent out for her legs. She said CNA A informed her that the resident had been complaining of leg pain during his shift on [DATE]. Review of the LVN G ' s Progress Note dated [DATE] revealed, Resident transferred at 1220pm, to the hospital. Interview on [DATE] at 10:59 a.m. with the DON confirmed on [DATE] at 4:45 p.m., the resident got her first and only dose of pain medication ([MEDICATION NAME] 7XXX[DATE] ML PRN every 4 hours) from the time she complained of pain until the time she was discharged the next day. Review of the facility ' s SBAR dated [DATE] time of 11:25 a.m., on page one for Resident #3 revealed, change in condition calling about minimally responsive, moaning and grimacing in pain, lethargic .this started on [DATE], since then had gotten worse. Review of page 5 of 6 of the SBAR note revealed Resident resting in bed with eyes closed, but very restless, moaning and jumpy. While repositioning, resident cries out in pain, focusing on left leg, just above the knee. Review of Resident #3 ' s Medication Review Report, dated [DATE], page 3 of 5, for date range [DATE]-[DATE] revealed a PRN prescription for [MEDICATION NAME] 7XXX[DATE]ML PO Q 4 HOURS PRN FOR PAIN. Interview on [DATE] at 11:50 a.m. with CNA A revealed Resident #3 was complaining of pain the day before she left for the hospital. CNA A said the resident first started complaining of pain in her left knee around 4 p.m. on [DATE]. He said he saw the resident try to move but said that she could not because of the pain in her leg. He said he noticed, . something was going on with her. He said he talked to LVN G the next day to see if the resident got an x-ray because she was complaining about her leg. The CNA said the resident would display confusion at times. He said the resident informed him on [DATE] that she had, a lot of pain. He said when he was doing his morning rounds at 6:00 a.m. on [DATE] when he saw Resident #3 shaking and grimacing so he went to talk to LVN G who told him the resident would be going to the hospital. The CNA stated he had been trained to notify a nurse when a resident had a change in condition. Interview with CNA D on [DATE] at 12:30 p.m. revealed CNA D first noticed Resident # 3 crying in pain around 6:45 a.m. on [DATE], telling her and CNA A, No no, don ' t move my leg. CNA D said she told LVN G that CNA A informed her the resident was in pain and was told by LVN G to leave the resident in her bed. She said normally the resident would get up for breakfast but said this time the resident refused to get up. CNA D said the nursing staff were checking on the resident about 30 or 40 minutes after she had seen the resident. CNA D stated she had been trained to notify a nurse when a resident has a change in condition. Telephone interview on [DATE] at 1:10 p.m. with LVN H who worked the overnight shift with the resident from [DATE]-[DATE] revealed he was not made aware of the resident complaining of pain during his shift. He could not explain why a pain assessment had been done on his shift with a score of 6. He said he had been in to put ointment on Resident #3's bottom and that she did not appear to be in pain. Interview on [DATE] at 1:15 p.m. with the DON revealed Resident #3 should have been sent out quicker or given something for pain for the six hours and 20 minutes (on [DATE] from 6:00 a.m. until discharge to hospital at 12:20 p.m.) she waited for the ambulance. Interview on [DATE] at 11:59 a.m. with LVN B revealed he saw slight swelling on Resident #3's knee. When asked why the nurse did not note the resident ' s pain in his 24 hour report he stated that he was unsure. He said the resident was initially complaining about her back and said it took a while to find out the resident ' s pain was in her legs. He acknowledged the resident ' s level of pain indicated a, . change of condition. When asked if the nurse notified the doctor he said he did not but said, I probably should have. The nurse stated he gave the resident 1 dose of her PRN [MEDICATION NAME] at 4:45 p.m. during his shift to on [DATE] to manage the resident's leg pain. Interview on [DATE] at 12:44 p.m. with ADON A revealed she was informed after the morning meeting on [DATE], at 10:30 a.m. by LVN G that, something was going on with Resident #3 and she was going to send her to the hospital. She said the resident was, . making a very odd noise. She stated the resident did not appear comfortable. She said she observed this when CNAs A and D were changing the resident. She said she assessed the resident and noticed her left knee area was swollen. She said she asked LVN G what had happened to the resident and was informed by the nurse that the resident was kicking the door the day prior. When asked why the resident was not medicated for pain when she had medication ordered, ADON A said she was told by LVN G that the resident appeared like she could not have swallowed a pill. When asked why the resident wasn ' t ' ordered and given a liquid pain medication she speculated that LVN G may have thought the resident could not swallow anything. ADON A agreed that she could have crushed pain medication and put it into apple sauce or other type of method. When asked what other medication the nurse could have given the resident she said [MEDICATION NAME] which the resident already had a prescription for. When asked why ADON A did not say anything about the resident ' s pain, she said she did not anticipate the discharge to the hospital would take so long. Interview on [DATE] at 1:46 p.m. with the Facility ' s Medical Director revealed she thought the Resident's first complaint of the pain did not involve any swelling so she felt the resident would not have needed an x-ray. When asked if the Medical Director felt she should have been called for x-ray she said she would have if the resident presented with [MEDICAL CONDITION] she would have. Review of the facility policy and procedure on Pain Management Program Revised ,[DATE] revealed Effective pain recognition and management requires ongoing facility-wide commitment to resident comfort .the onset of acute pain may indicate a new injury or a potentially life-threatening condition or illness. Review of facility policy on Abuse and Neglect (not dated) revealed, NEGLECT (as defined in 40 TAC 19.101(1)) The failure to provide goods or services, including medical services that are necessary to avoid physical or emotional harm, pain, or mental illness. The facility must determine if an injury, harm, to or death of a resident was due to a facility failure to provide services, treatment or care to a resident The Administrator was notified on [DATE] at 3:30 p.m. that a past non compliant Immediate Jeopardy was identified due to the above failures. The facility demonstrated the following measures to correct the past noncompliance and had initiated correction with in-services on [DATE] with neglect and on [DATE] with pain management, assessments and change in condition: Pain Assessment · Pain evaluations will be completed for current residents. New admissions will be assessed for pain upon admission.

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F 0224 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 3) · Physician will be notified for changes of condition regarding new onset or changed pain; pain management will be implemented per physician ' s orders. · Nursing staff will be reeducated regarding completion of pain evaluations upon admission, quarterly, and with changes in condition. Nursing managers will review the 24-Hour binders for changes in condition & review new telephone orders in the morning clinical meeting. Nursing managers will review changes to ensure follow-up documentation is in place along with MD & RP/resident notifications. The weekend nursing supervisor will review the 24-Hour binders for changes in condition in regards to pain issues & ensure appropriate follow-up is documented including appropriate notification of the MD & RP/resident for changes. · Residents will continue to have pain levels monitored every shift & documented on the MAR; interventions will be implemented according to needs. · Performance Improvement Plan for pain control will be reviewed monthly in the QAPI meeting with the Medical Director for recommendations for improving identification of resident pain. · Education will continue each shift until 100% of the staff is educated on the above. Those employees on leave will have their education completed upon arrival for the start of the next scheduled shift to work. Review of information provided by the facility on [DATE] revealed there were 2 residents with changes of condition, and 10 residents being treated for [REDACTED].
F 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement written policies and procedures that prohibited neglect for two (#3 and #4) of eight residents reviewed for neglect. 1. Resident #4 was not appropriately assessed or care planned for use of an electric scooter, fell from the scooter and was hospitalized and passed away. Physical Therapy staff identified the safety issues and this communication was never passed on to direct care staff. These failures resulted in an Immediate Jeopardy (IJ) which was identified on [DATE]. The IJ was removed on [DATE], but the facility remained out of compliance at a severity level of actual harm at pattern because the facility had not had time to monitor and evaluate the effectiveness of the Plan of Removal. 2. Resident #3 had a fractured left femur. The facility did not treat the pain prior to being transferred to the hospital after extreme pain was first observed. The resident returned to the facility, placed on hospice, and died within the month. This was determined to be past non-compliance at an Immediate Jeopardy level due to the facility's implementation of actions that corrected the non-compliance prior to the investigation on [DATE]. The facility was out of compliance from [DATE] to [DATE]. The facility's corrected action was completed on [DATE]. These deficient practices placed 6 residents identified as having poor safety awareness and 5 residents identified as having increased confusion at risk for risk of accidents and injury to include death and 10 residents identified with having pain at risk for experiencing long periods of pain Findings include: Review of the facilities Power Mobility Device policy and procedure (undated) revealed that .since a power mobility device can pose a potential risk to the safety, property, and well-being of its user and to others and their property, each facility will assess and document each resident's individualized need regarding appropriate interventions proposed to meet the residents needs. Review of the facility policy and procedure on Pain Management Program Revised ,[DATE] revealed Effective pain recognition and management requires ongoing facility-wide commitment to resident comfort .the onset of acute pain may indicate a new injury or a potentially life-threatening condition or illness. Review of facility policy on Abuse and Neglect (not dated) revealed, NEGLECT (as defined in 40 TAC 19.101(1)) The failure to provide goods or services, including medical services that are necessary to avoid physical or emotional harm, pain, or mental illness. The facility must determine if an injury, harm, to or death of a resident was due to a facility failure to provide services, treatment or care to a resident Review of Resident #4's face sheet dated [DATE] revealed he was admitted on [DATE]. Further review revealed Resident #4 had [DIAGNOSES REDACTED]. Review of Resident #4's hospital death summary dated [DATE] revealed under preliminary cause of death: Immediate cause: (Final diseases or condition resulting in death)[MEDICAL CONDITION], Hepatic [MEDICAL CONDITIONS] and right side sub arachnoid hemorrhage .ED course: (discharged from the facility on [DATE] after he fell from his motor scooter in the parking lot) intubated on arrival neurosurgery and neurology consulted for sub arachnoid hematoma on CT and [MEDICAL CONDITION]. Review of Resident #4's initial mobility fall risk assessment dated [DATE] revealed he scored low risk for falls on admission. Review of Resident #4's fall risk assessment on [DATE] revealed he was at risk for falls . with a Yes to does the resident display any of the following behaviors: easily distracted; periods of altered perception of awareness of surroundings; episodes of disorganized speech; periods of restlessness; periods of lethargy; mental function varies over the course of the day; wanders. Under section 11 Gait .Impaired, has difficulty rising from chair, grasps furniture, person or aid when ambulating. Cannot walk unassisted. Review of Resident #4's fall risk assessment on [DATE] revealed he was at risk for falls .with overestimates or forgets limits. Review of Resident #4's comprehensive plan of care initiated on [DATE] revealed under problem .ADL self care performance deficit r/t CONFUSION, LACK OF COORDINATION, MUSCLE WEAKNESS. Further review of this document revealed under interventions .staff will assist with transfers and visually check the resident every two hours and as needed. Interview on [DATE] at 11:29 a.m. with ADON B revealed that Resident #4's motorized chair arrived sometime around [DATE]st, 2016, and it was not with him when he arrived on the week of the 20th. He said that Resident #4 originally received the motor scooter from the Veteran's Administration, and had used it previously. Review of Resident #4's comprehensive plan of care initiated on [DATE] revealed it did not address his motorized chair. Interview on [DATE] at 12:40 p.m. with the MDS nurses A and B revealed that Resident #4's motorized chair needed to be care planned and they did not know why it was not. Review of Resident #4's 14 day scheduled MDS assessment dated [DATE] revealed on section [MEDICAL CONDITION] revealed that he had disorganized thinking or was incoherent . behavior present continuously and does not fluctuate. Further review indicated under section G0300 Balance during Transitions and Walking that he was not steady, only able to stabilize with staff assistance. Further review of this document revealed Resident #4 required extensive assist and two person physical assist with transfers .locomotion on unit required supervision and one person physical assist, and supervision off unit required limited assistance and one person physical assist. Review of Resident #4's Care Plan Conference Summary dated [DATE] revealed under Risks/Consequences .potential for falls. Review of Resident #4's Physical Therapy note dated [DATE] at 2:39 p.m. revealed under NOTE: Pt trained in safe power wheel chair mobility to increase safety and decrease risk of injury to self and others. Pt instructed in steering, obstacle negotiation and maneuvering in small spaces. Pt continues to require stand by assistance and visual cueing of the above mentioned skills. Review of Resident #4's comprehensive plan of care initiated [DATE] revealed under problem that due to an unsteady gait he had a fall. Further review of this document revealed that under the section approach .anticipate needs, provide prompt assistance. No revisions were noted. Review of the facility Fall Investigation Worksheet dated [DATE] at 5:45 a.m. revealed that Resident #4 fell while trying to go to the restroom. Under did resident require supervision .response was yes. Further review of this same document revealed resident was found on floor seated and leaning against his bed .stated he was trying to go to bathroom when he got caught by his covers and slipped while grabbing on to his bed mattress. He was reminded to use his call light. Review of the facility Fall Investigation Worksheet dated [DATE] revealed that Resident #4 had a fall at 12:00 a.m. in his

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) room witnessed by the room mate who said that resident was reaching for something that fell on floor and he fell out of bed. Further review of this document revealed that Resident #4 received skin tears to both forearms Review of Resident #4's Progress Notes dated [DATE] at 12:36 a.m. revealed resident experienced fall. residents room mate witnessed the fall. said he was rolling around in bed and fell out. residents bed was locked in lowest position. skin tears to both forearms noted. Review of the facility incidents for [DATE] and [DATE] revealed Resident #4 had falls in his bedroom and was unsteady. Interview on [DATE] at 11:04 a.m. with the DON revealed that Resident #4 had fluctuations with confusion and lucidity, and that he had falls on [DATE] and [DATE]. She reported that Resident #4 should have had a formal assessment for safety to drive his motorized wheel chair and it needed to be care planned which did not happen. Interview on [DATE] at 09:50 a.m. with RN A revealed Resident #4 was acting very anxious the week before his fall on [DATE]. She was informed on [DATE] that the resident was acting confused over the weekend when she got report. She stated that Resident #4 was not very balanced, when referring to his level of physical stability. RN A stated that she sent Resident #4 out to the hospital on [DATE] because soon after she came on for her shift from 6:00 a.m. to 2:00 p.m., the morning after the fall she discovered Resident #4 in his room without his clothes on, and he had a blank stare and would not respond. Review of facility Progress Notes (page 3) written by LVN C and dated [DATE] at 12:08 p.m. revealed, Pt appears to have fallen face first onto surface, has multiple new skin issues including most notable lesion to right brow that was bleeding moderately, pt also has multiple new skin tears to face and extremities. During an interview on [DATE] at 11:35 a.m. with PTA A and the PT who worked for the corporation revealed Resident #4 had a history of [REDACTED]. PTA A stated that some days the resident was very confused, and at times impossible to work with the resident on the days he was confused. PTA A confirmed that there would have been no line-of-sight supervision for the resident on the day he fell off the scooter as to where he fell outside, and that he should not have been outside without supervision. The PT confirmed that Resident #4 was a stand by assist, so he needed to have someone standing by and assisting him. She said that Resident #4 needed verbal cues, in order to avoid things like trash cans and other obstacles the resident had to navigate while operating his scooter. She said that Resident #4 needed this assistance not only on the motorized chair, but also in a regular wheel chair. She said that therapy was usually very good at communicating resident needs to the nursing staff, but that this time it did not happen. PTA A stated that he was very surprised to hear that Resident #4 was outside in his power scooter. He stated that nursing had access to all of the therapy notes. The PT said the resident had poor safety awareness, in that he had a hard time being convinced that he could not do some of the same activities he could do when he was younger. She said that he did not have his power scooter on the day of his initial mobility assessment on [DATE]. Interview on [DATE] at 2:07 p.m. with CNA G, revealed that most of the time the Physical Therapy Department informally communicated with the staff regarding the needs of the resident, but said that she was not told anything specific, and that it was not on her assignment sheet. When asked if Resident #4 was getting stand by assistance or visual cueing while in his electric wheel chair, she said no. She stated that Resident #4 should not have been outside by himself without supervision because of his confusion. Interview on [DATE] at 1:55 p.m. with the facilities Medical Director revealed that she typically goes with the opinion of therapy regarding the screening of residents, and that she was not aware of the resident having safety awareness issues with the scooter, but was aware of his falls. Interview on [DATE] at 4:00 p.m. with the Physical Therapy Director, Administrator and DON revealed that there was not a formal method of communicating therapy information to nursing staff in place .and that was why his need for supervision addressed by therapy was never noted by the direct care staff who took care of him. Interview on [DATE] at 09:30 a.m. with the OTA A and PTA A revealed that Resident #4's behaviors would fluctuate from being lucid to being confused. PTA A said Resident #4's judgement would be confused. He stated that the resident advised her he had an electric scooter and then one day, he showed up with it. PTA A and OTA A both agreed that Resident #4 had safety awareness issues and he was not safe being outside without supervision because of his fluctuations and confusion. Telephone interview on [DATE] at 1:33 p.m. with the witness revealed she saw Resident #4 on the ground behind the facility in the parking lot on [DATE] between 6:30 p.m. and 7:00 p.m. She stated that Resident #4 was bleeding near the right eye, and she went for help. Telephone interview on [DATE] at 1:45 p.m. with Resident #4's emergency contact revealed he was deceased , and that she spoke to him the evening of his fall and said that he sounded different, , but she just assumed he did not have his dentures in .and sounded confused, and did not tell her about the fall. Interview on [DATE] at 2:32 p.m. with LVN B revealed he assessed Resident #4 after he had his fall and he assisted LVN C with getting Resident #4 back into his chair and to his room. He said that resident #4 had a large wound above his right eye. Interview on [DATE] at 2:40 p.m. with LVN C revealed he was alerted on [DATE] that Resident #4 was lying on his right side on the ground in the back of the facility and he said that he did some first aide on the skin tears and the resident did not appear to have fractured anything. He said the resident informed staff that his electric chair fell off the curb. The Administrator was notified of noncompliance at an IJ level on [DATE] at 3:30 p.m. and a plan of removal was requested. The facility plan of removal on [DATE]: -Residents using electric wheel chairs were reassessed by the ADON and administrative nursing staff for safety by [DATE]. -Care plans were checked to ensure residents had a plan of care that recognized and addressed resident's safety needs related to electric wheelchair use by [DATE]. -Nursing staff were trained on recognizing residents with potential of having intermittent confusion by [DATE]. -Existing residents using electric wheel chairs would be assessed quarterly and with any significant change by nursing, therapy and maintenance by [DATE]. -New admissions with electric wheel chairs would be assessed by nursing, therapy, and maintenance prior to use as of [DATE]. -Electric wheel chair assessments would be brought to the weekly IDT meeting for review, and any changes to the plan of care would be communicated through the CNA assignment sheets by [DATE]. -These actions were taken to QA for approval on [DATE]. Confirmation of plan of removal was staff who were interviewed on [DATE] included LVN's, CNAs, and a Med Aide regarding recent in-services, assessments, documenting on the 24 hour book, monitoring of residents, and understanding of the dot system (explains residents ' needs) The topics discussed with each staff person depended on their discipline. Physical Therapy developed a new system of integrating information into the morning facility meetings to disseminate safety concerns of residents to direct care staff. The IJ was removed on [DATE], but the facility remained out of compliance at a severity level of actual harm at pattern because the facility had not had time to monitor and evaluate the effectiveness of the Plan of Removal. The number of residents at high risk for safety issues (6) and with increased confusion (5) was provided by the DON. 2. Review of Resident #3's face sheet revealed she was admitted on [DATE] and readmitted on [DATE] on Hospice, after she was transferred to the hospital on [DATE] with a [MEDICAL CONDITION] femur. Further review of this same document revealed Resident #3's [DIAGNOSES REDACTED]. Review of Resident #3's Quarterly MDS with an ARD of [DATE] revealed Resident #3 could understand and be understood. Further review revealed she scored a ,[DATE] on her BIMS indicating severe cognitive impairment. She was assessed to have no pain and had not taken any PRN pain medication during the review period. Review of Resident #3's physician orders dated [DATE] to [DATE] revealed she had orders to be monitored for pain every shift and to use pain scale (A) ,[DATE] for alert residents and (B) for confused residents. This order originated on [DATE]. Further review revealed orders for [MEDICATION NAME] 7XXX[DATE] ML-Give 10 ML PO Q 4 Hours PRN for pain and [MEDICATION NAME] HCL Tablet 50 MG, Give 1 tablet by mouth every 4 hours as needed for pain, and Tylenol Extra Strength Tablet 500 MG, Give 1 tablet by mouth every 6 hours as needed for pain. Review of Resident #3's MAR for ,[DATE] revealed she was assessed for pain every shift and had no pain indicated for days ,[DATE], however, she was assessed to have a level 6 pain documented on [DATE] for the 6 a.m.- 2 p.m., 2 p.m.-10 p.m., and the 10 p.m.-6 a.m. ([DATE]-[DATE]) shifts. Review of Resident #3's MAR for [DATE] revealed she was provided a [MEDICATION NAME] 7XXX[DATE] ML, 10 ML by mouth as needed for pain at 4:25 p.m. Review of Resident#3's nursing note by LVN B written on [DATE] at 4:45 p.m. revealed [MEDICATION NAME] 7XXX[DATE] ML-Give 10

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 5) ML PO Q 4 hours PRN for pain given .Resident c/o pain in LEFT knee. When questioned regarding cause/onset resident was easily distracted and could not elaborate on the pain and could not specify location. Would mention that her back hurt but would point to her LEFT thigh. Review of Resident #3 's hospital flow-sheet, dated [DATE], revealed a displaced [MEDICAL CONDITION] diaphysis (long thigh bone) and metaphysis (wide part of the long thigh bone) of the femur. There is an oblique fracture through the distal diaphysis and distal metaphysis of the femur. The distal fragment is displaced laterally 8 mm .the main distal fragment is displaced posteriorly nearly 1 cm. Review of Resident #3's Comprehensive plan of care created on [DATE] and revised on [DATE] revealed she had impaired cognitive function related to dementia. Further review revealed she had pain related to disease process of [MEDICAL CONDITION]. Interventions include: Nursing to monitor/record/report any signs or symptoms of non-verbal pain and verbal complaints of pain, or request for pain medications .notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. Interview on [DATE] at 12:55 p.m. with ADON A revealed Resident #3 arrived to the facility on hospice and was then removed from hospice because she was doing well. Furthermore, ADON A stated the resident started declining and was having numerous UTIs and ended up getting ESBL and was on isolation. ADON A said the resident could not understand why she was on isolation and, . started to change, mentally. She said the resident got out of isolation and started yelling, screaming and kicking at the door, and then on the late afternoon of [DATE] complained of back and knee pain. The ADON said the resident was assessed and then given a pain pill. ADON A said the resident was sent to a hospital the next day for excessive pain and LOC. ADON A said the hospital did an x-ray because the resident had a swollen leg and determined there had been a fracture. The ADON said the hospital did not do any reparations and the resident was sent back to the facility on hospice and passed away weeks later. Interview on [DATE] at 10:29 a.m. with LVN G revealed the resident was very social so being in isolation was very difficult for her. She said the resident was more confused than usual the day she left. She said the resident was seen kicking the door the day before she left the facility. LVN G said the morning she sent the resident out on [DATE] she called the ambulance because the resident was acting confused but said when she pulled the resident ' s sheets up and began turning the resident at about 10:30 a.m. and she screamed in pain and complained of leg pain. LVN G said she noticed swelling above the knee. She said she was unsure if the resident was going into shock but did not scream when still without movement, which is why she did not give the resident any pain medication. The nurse acknowledged she would have done it differently looking back by issuing the resident pain medication. The nurse said if the resident had been more vocal she could have been able to communicate her pain and would have been more likely to have been issued pain medication. She said she advised the ambulance driver the resident was complaining of severe pain before she left the facility. She said she spoke to CNA A from the evening shift prior, who asked if the resident was sent out for her legs. She said CNA A informed her that the resident had been complaining of leg pain during his shift on [DATE]. Review of the LVN G ' s Progress Note dated [DATE] revealed, Resident transferred at 1220pm, to the hospital. Interview on [DATE] at 10:59 a.m. with the DON confirmed on [DATE] at 4:45 p.m., the resident got her first and only dose of pain medication ([MEDICATION NAME] 7XXX[DATE] ML PRN every 4 hours) from the time she complained of pain until the time she was discharged the next day. Review of the facility ' s SBAR dated [DATE] time of 11:25 a.m., on page one for Resident #3 revealed, change in condition calling about minimally responsive, moaning and grimacing in pain, lethargic .this started on [DATE], since then had gotten worse. Review of page 5 of 6 of the SBAR note revealed Resident resting in bed with eyes closed, but very restless, moaning and jumpy. While repositioning, resident cries out in pain, focusing on left leg, just above the knee. Review of Resident #3 ' s Medication Review Report, dated [DATE], page 3 of 5, for date range [DATE]-[DATE] revealed a PRN prescription for [MEDICATION NAME] 7XXX[DATE] ML PO Q 4 HOURS PRN FOR PAIN. Interview on [DATE] at 11:50 a.m. with CNA A revealed Resident #3 was complaining of pain the day before she left for the hospital. CNA A said the resident first started complaining of pain in her left knee around 4 p.m. on [DATE]. He said he saw the resident try to move but said that she could not because of the pain in her leg. He said he noticed, . something was going on with her. He said he talked to LVN G the next day to see if the resident got an x-ray because she was complaining about her leg. The CNA said the resident would display confusion at times. He said the resident informed him on [DATE] that she had, a lot of pain. He said when he was doing his morning rounds at 6:00 a.m. on [DATE] when he saw Resident #3 shaking and grimacing so he went to talk to LVN G who told him the resident would be going to the hospital. The CNA stated he had been trained to notify a nurse when a resident had a change in condition. Interview with CNA D on [DATE] at 12:30 p.m. revealed CNA D first noticed Resident # 3 crying in pain around 6:45 a.m. on [DATE], telling her and CNA A, No no, don ' t move my leg. CNA D said she told LVN G that CNA A informed her the resident was in pain and was told by LVN G to leave the resident in her bed. She said normally the resident would get up for breakfast but said this time the resident refused to get up. CNA D said the nursing staff were checking on the resident about 30 or 40 minutes after she had seen the resident. CNA D stated she had been trained to notify a nurse when a resident has a change in condition. Telephone interview on [DATE] at 1:10 p.m. with LVN H who worked the overnight shift with the resident from [DATE]-[DATE] revealed he was not made aware of the resident complaining of pain during his shift. He could not explain why a pain assessment had been done on his shift with a score of 6. He said he had been in to put ointment on Resident #3's bottom and that she did not appear to be in pain. Interview on [DATE] at 1:15 p.m. with the DON revealed Resident #3 should have been sent out quicker or given something for pain for the six hours and 20 minutes (on [DATE] from 6:00 a.m. until discharge to hospital at 12:20 p.m.) she waited for the ambulance. Interview on [DATE] at 11:59 a.m. with LVN B revealed he saw slight swelling on Resident #3's knee. When asked why the nurse did not note the resident ' s pain in his 24 hour report he stated that he was unsure. He said the resident was initially complaining about her back and said it took a while to find out the resident ' s pain was in her legs. He acknowledged the resident ' s level of pain indicated a, . change of condition. When asked if the nurse notified the doctor he said he did not but said, I probably should have. The nurse stated he gave the resident 1 dose of her PRN [MEDICATION NAME] at 4:45 p.m. during his shift to on [DATE] to manage the resident's leg pain. Interview on [DATE] at 12:44 p.m. with ADON A revealed she was informed after the morning meeting on [DATE], at 10:30 a.m. by LVN G that, something was going on with Resident #3 and she was going to send her to the hospital. She said the resident was, . making a very odd noise. She stated the resident did not appear comfortable. She said she observed this when CNAs A and D were changing the resident. She said she assessed the resident and noticed her left knee area was swollen. She said she asked LVN G what had happened to the resident and was informed by the nurse that the resident was kicking the door the day prior. When asked why the resident was not medicated for pain when she had medication ordered, ADON A said she was told by LVN G that the resident appeared like she could not have swallowed a pill. When asked why the resident wasn ' t ' ordered and given a liquid pain medication she speculated that LVN G may have thought the resident could not swallow anything. ADON A agreed that she could have crushed pain medication and put it into apple sauce or other type of method. When asked what other medication the nurse could have given the resident she said [MEDICATION NAME] which the resident already had a prescription for. When asked why ADON A did not say anything about the resident ' s pain, she said she did not anticipate the discharge to the hospital would take so long. Interview on [DATE] at 1:46 p.m. with the Facility ' s Medical Director revealed she thought the Resident's first complaint of the pain did not involve any swelling so she felt the resident would not have needed an x-ray. When asked if the Medical Director felt she should have been called for x-ray she said she would have if the resident presented with [MEDICAL CONDITION] she would have. The Administrator was notified on [DATE] at 3:30 p.m. that a past non compliant Immediate Jeopardy was identified due to the above failures. The facility demonstrated the following measures to correct the past noncompliance and had initiated correction with in-services on [DATE] with neglect and on [DATE] with pain management, assessments and change in condition: Pain Assessment · Pain evaluations will be completed for current residents. New admissions will be assessed for pain upon admission.

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F 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 6) · Physician will be notified for changes of condition regarding new onset or changed pain; pain management will be implemented per physician ' s orders. · Nursing staff will be reeducated regarding completion of pain evaluations upon admission, quarterly, and with changes in condition. Nursing managers will review the 24-Hour binders for changes in condition & review new telephone orders in the morning clinical meeting. Nursing managers will review changes to ensure follow-up documentation is in place along with MD & RP/resident notifications. The weekend nursing supervisor will review the 24-Hour binders for changes in condition in regards to pain issues & ensure appropriate follow-up is documented including appropriate notification of the MD & RP/resident for changes. · Residents will continue to have pain levels monitored every shift & documented on the MAR; interventions will be implemented according to needs. · Performance Improvement Plan for pain control will be reviewed monthly in the QAPI meeting with the Medical Director for recommendations for improving identification of resident pain. · Education will continue each shift until 100% of the staff is educated on the above. Those employees on leave will have their education completed upon arrival for the start of the next scheduled shift to work. Review of information provided by the facility on [DATE] revealed there were 2 residents with changes of condition, and 10 residents being treated for [REDACTED].
F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the care plan described the services to be furnished to meet the resident's highest practicable level of medical and nursing needs for 2 of 6 residents (Resident #1 and #3) reviewed for care plans, in that: 1. Resident #1's care plan addressed that he had a [MEDICAL CONDITION], which he never had. 2. Resident #4's care plan did not address his nutritional needs, such as a renal diet and, or his motorized chair. This deficient practice could affect the one other resident identified with a motorized chair and the 22 residents identified that have specific care needs such as a ostomy care, Hospice, and nutritional needs. The findings were: Review of Resident #1's face sheet dated 7/14/16 revealed he was originally admitted to the facility on [DATE] with a readmission date of [DATE]. Resident #1 had [DIAGNOSES REDACTED]. Review of his MDS with an ARD of 5/5/16 revealed he was incontinent of bowel and had an indwelling urinary catheter. His BIMS was 2/15 making him severely cognitively impaired. Review of Resident #1's MDS with an ARD of 5/5/16 revealed he had an indwelling urinary catheter and was incontinent of bowel. Review of Resident #1's comprehensive plan of care dated 2/18/16 revealed he had a [MEDICAL CONDITION]. Observation on 7/13/16 at 2:50 p.m. of Resident #1 receiving catheter care revealed he had a bowel movement and did not have a [MEDICAL CONDITION]. Interview on 7/15/16 at 12:30 p.m. with MDS nurses A and B revealed that neither knew how [MEDICAL CONDITION] was on Resident #1's plan of care and further confirmed that it should have been caught when reviewed in February 2016. 2. Review of Resident #4's face sheet dated 7/14/16 revealed he was admitted on [DATE] and had [DIAGNOSES REDACTED]. Review of Resident #4's physician orders [REDACTED].>Review of Resident #4's physical therapy notes dated 6/3/16 and 6/4/16 revealed he had a motorized chair. Review of Resident #4's Care Area Assessment Summary dated 5/27/16 revealed that #12 nutritional status was triggered. Review of Resident #4's comprehensive plan of care dated 6/5/16 revealed it did not address his nutritional status or motorized chair. Interview on 7/15/16 at 12:40 p.m. with the MDS nurses A and B revealed that Resident #3's nutrtitional status and motorized chair needed to be care planned and they did not know why they were not. Review of facility policy and procedure on Power Mobility Device (undated) revealed that the facility will initiate a care plan with appropriate interventions proposed to meet the resident's needs. Review of the facility CMS Form 672 provided showed 22 residents with special needs such as ostomy care, Hospice and nutritional needs and the one resident with motorized chair information was provided by the DON.
F 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the necessary care and services to maintain the highest practical physical, mental, and psychosocial well-being for one of one resident with pain (Resident #3) in that: 1. Resident #3 had a fractured left femur. The facility did not treat the pain prior to being transferred to the hospital after extreme pain was first observed. The resident returned to the facility, placed on hospice, and died within the month. This was determined to be past non-compliance at an IJ level due to the facility's implementation of actions that corrected the non-compliance prior to the investigation on [DATE]. The facility was out of compliance from [DATE] to [DATE]. The facility's corrected action was completed on [DATE]. This deficient practice could affect 10 residents identified with having pain, and result in experiencing long periods of pain. Findings include: Review of Resident #3's face sheet revealed she was admitted on [DATE] and readmitted on [DATE] on Hospice, after she was transferred to the hospital on [DATE] with a [MEDICAL CONDITION] femur. Further review of this same document revealed Resident #3's [DIAGNOSES REDACTED]. Review of Resident #3's Quarterly MDS with an ARD of [DATE] revealed Resident #3 could understand and be understood. Further review revealed she scored a ,[DATE] on her BIMS indicating severe cognitive impairment. She was assessed to have no pain and had not taken any PRN pain medication during the review period. Review of Resident #3's physician orders dated [DATE] to [DATE] revealed she had orders to be monitored for pain every shift and to use pain scale (A) ,[DATE] for alert residents and (B) for confused residents. This order originated on [DATE]. Further review revealed orders for [MEDICATION NAME] 7XXX[DATE] ML-Give 10 ML PO Q 4 Hours PRN for pain and [MEDICATION NAME] HCL Tablet 50 MG, Give 1 tablet by mouth every 4 hours as needed for pain, and Tylenol Extra Strength Tablet 500 MG, Give 1 tablet by mouth every 6 hours as needed for pain. Review of Resident #3's MAR for ,[DATE] revealed she was assessed for pain every shift and had no pain indicated for days ,[DATE], however, she was assessed to have a level 6 pain documented on [DATE] for the 6 a.m.- 2 p.m., 2 p.m.-10 p.m., and the 10 p.m.-6 a.m. ([DATE]-[DATE]) shifts. Review of Resident #3's MAR for [DATE] revealed she was provided a [MEDICATION NAME] 7XXX[DATE] ML, 10 ML by mouth as needed for pain at 4:25 p.m. Review of Resident#3's nursing note by LVN B written on [DATE] at 4:45 p.m. revealed [MEDICATION NAME] 7XXX[DATE] ML-Give 10 ML PO Q 4 hours PRN for pain given .Resident c/o pain in LEFT knee. When questioned regarding cause/onset resident was easily distracted and could not elaborate on the pain and could not specify location. Would mention that her back hurt but would point to her LEFT thigh. Review of Resident #3 's hospital flow-sheet, dated [DATE], revealed a displaced [MEDICAL CONDITION] diaphysis (long thigh bone) and metaphysis (wide part of the long thigh bone) of the femur. There is an oblique fracture through the distal diaphysis and distal metaphysis of the femur. The distal fragment is displaced laterally 8 mm .the main distal fragment is displaced posteriorly nearly 1 cm. Review of Resident #3's Comprehensive plan of care created on [DATE] and revised on [DATE] revealed she had impaired cognitive function related to dementia. Further review revealed she had pain related to disease process of [MEDICAL CONDITION]. Interventions include: Nursing to monitor/record/report any signs or symptoms of non-verbal pain and verbal complaints of pain, or request for pain medications .notify physician if interventions are unsuccessful or if current complaint is a significant change from

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 7) residents past experience of pain. Interview on [DATE] at 12:55 p.m. with ADON A revealed Resident #3 arrived to the facility on hospice and was then removed from hospice because she was doing well. Furthermore, ADON A stated the resident started declining and was having numerous UTIs and ended up getting ESBL and was on isolation. ADON A said the resident could not understand why she was on isolation and, . started to change, mentally. She said the resident got out of isolation and started yelling, screaming and kicking at the door, and then on the late afternoon of [DATE] complained of back and knee pain. The ADON said the resident was assessed and then given a pain pill. ADON A said the resident was sent to a hospital the next day ([DATE]) for excessive pain and LOC. ADON A said the hospital did an x-ray because the resident had a swollen leg and determined there had been a fracture. The ADON said the hospital did not do any reparations and the resident was sent back to the facility on hospice and passed away weeks later. Interview on [DATE] at 10:29 a.m. with LVN G revealed the resident was very social so being in isolation was very difficult for her. She said the resident was more confused than usual the day she left. She said the resident was seen kicking the door the day before she left the facility. LVN G said the morning she sent the resident out on [DATE] she called the ambulance because the resident was acting confused but said when she pulled the resident ' s sheets up and began turning the resident at about 10:30 a.m. and she screamed in pain and complained of leg pain. LVN G said she noticed swelling above the knee. She said she was unsure if the resident was going into shock but did not scream when still without movement, which is why she did not give the resident any pain medication. The nurse acknowledged she would have done it differently looking back by issuing the resident pain medication. The nurse said if the resident had been more vocal she could have been able to communicate her pain and would have been more likely to have been issued pain medication. She said she advised the ambulance driver the resident was complaining of severe pain before she left the facility. She said she spoke to CNA A from the evening shift prior, who asked if the resident was sent out for her legs. She said CNA A informed her that the resident had been complaining of leg pain during his shift on [DATE]. Review of the LVN G ' s Progress Note dated [DATE] revealed, Resident transferred at 12:20pm, to the hospital. Interview on [DATE] at 10:59 a.m. with the DON confirmed on [DATE] at 4:45 p.m., the resident got her first and only dose of pain medication ([MEDICATION NAME] 7XXX[DATE] ML PRN every 4 hours) from the time she complained of pain until the time she was discharged the next day. Review of the facility ' s SBAR dated [DATE] time of 11:25 a.m., on page one for Resident #3 revealed, change in condition calling about minimally responsive, moaning and grimacing in pain, lethargic .this started on [DATE], since then had gotten worse. Review of page 5 of 6 of the SBAR note revealed Resident resting in bed with eyes closed, but very restless, moaning and jumpy. While repositioning, resident cries out in pain, focusing on left leg, just above the knee. Review of Resident #3 ' s Medication Review Report, dated [DATE], page 3 of 5, for date range [DATE]-[DATE] revealed a PRN prescription for [MEDICATION NAME] 7XXX[DATE] ML PO Q 4 HOURS PRN FOR PAIN. Interview on [DATE] at 11:50 a.m. with CNA A revealed Resident #3 was complaining of pain the day before she left for the hospital. CNA A said the resident first started complaining of pain in her left knee around 4 p.m. on [DATE]. He said he saw the resident try to move but said that she could not because of the pain in her leg. He said he noticed, . something was going on with her. He said he talked to LVN G the next day to see if the resident got an x-ray because she was complaining about her leg. The CNA said the resident would display confusion at times. He said the resident informed him on [DATE] that she had, a lot of pain. He said when he was doing his morning rounds at 6:00 a.m. on [DATE] when he saw Resident #3 shaking and grimacing so he went to talk to LVN G who told him the resident would be going to the hospital. The CNA stated he had been trained to notify a nurse when a resident had a change in condition. Interview with CNA D on [DATE] at 12:30 p.m. revealed CNA D first noticed Resident # 3 crying in pain around 6:45 a.m. on [DATE], telling her and CNA A, No no, don ' t move my leg. CNA D said she told LVN G that CNA A informed her the resident was in pain and was told by LVN G to leave the resident in her bed. She said normally the resident would get up for breakfast but said this time the resident refused to get up. CNA D said the nursing staff were checking on the resident about 30 or 40 minutes after she had seen the resident. CNA D stated she had been trained to notify a nurse when a resident has a change in condition. Telephone interview on [DATE] at 1:10 p.m. with LVN H who worked the overnight shift with the resident from [DATE]-[DATE] revealed he was not made aware of the resident complaining of pain during his shift. He could not explain why a pain assessment had been done on his shift with a score of 6. He said he had been in to put ointment on Resident #3's bottom and that she did not appear to be in pain. Interview on [DATE] at 1:15 p.m. with the DON revealed Resident #3 should have been sent out quicker or given something for pain for the six hours and 20 minutes (on [DATE] from 6:00 a.m. until discharge to hospital at 12:20 p.m.) she waited for the ambulance. Interview on [DATE] at 11:59 a.m. with LVN B revealed he saw slight swelling on Resident #3's knee. When asked why the nurse did not note the resident ' s pain in his 24 hour report he stated that he was unsure. He said the resident was initially complaining about her back and said it took a while to find out the resident ' s pain was in her legs. He acknowledged the resident ' s level of pain indicated a, . change of condition. When asked if the nurse notified the doctor he said he did not but said, I probably should have. The nurse stated he gave the resident 1 dose of her PRN [MEDICATION NAME] at 4:45 p.m. during his shift to on [DATE] to manage the resident's leg pain. Interview on [DATE] at 12:44 p.m. with ADON A revealed she was informed after the morning meeting on [DATE], at 10:30 a.m. by LVN G that, something was going on with Resident #3 and she was going to send her to the hospital. She said the resident was, . making a very odd noise. She stated the resident did not appear comfortable. She said she observed this when CNAs A and D were changing the resident. She said she assessed the resident and noticed her left knee area was swollen. She said she asked LVN G what had happened to the resident and was informed by the nurse that the resident was kicking the door the day prior. When asked why the resident was not medicated for pain when she had medication ordered, ADON A said she was told by LVN G that the resident appeared like she could not have swallowed a pill. When asked why the resident wasn ' t ' ordered and given a liquid pain medication she speculated that LVN G may have thought the resident could not swallow anything. ADON A agreed that she could have crushed pain medication and put it into apple sauce or other type of method. When asked what other medication the nurse could have given the resident she said [MEDICATION NAME] which the resident already had a prescription for. When asked why ADON A did not say anything about the resident ' s pain, she said she did not anticipate the discharge to the hospital would take so long. Interview on [DATE] at 1:46 p.m. with the Facility ' s Medical Director revealed she thought the Resident's first complaint of the pain did not involve any swelling so she felt the resident would not have needed an x-ray. When asked if the Medical Director felt she should have been called for x-ray she said she would have if the resident presented with [MEDICAL CONDITION] she would have. Review of the facility policy and procedure on Pain Management Program Revised ,[DATE] revealed Effective pain recognition and management requires ongoing facility-wide commitment to resident comfort .the onset of acute pain may indicate a new injury or a potentially life-threatening condition or illness. The Administrator was notified on [DATE] at 3:30 p.m. that a past non compliance IJ was identified due to the above failures. The facility implemented the following measures to correct the noncompliance: Pain Assessment · Pain evaluations will be completed for current residents. New admissions will be assessed for pain upon admission. · Physician will be notified for changes of condition regarding new onset or changed pain; pain management will be implemented per physician ' s orders. · Nursing staff will be reeducated regarding completion of pain evaluations upon admission, quarterly, and with changes in condition. Nursing managers will review the 24-Hour binders for changes in condition & review new telephone orders in the morning clinical meeting. Nursing managers will review changes to ensure follow-up documentation is in place along with MD & RP/resident notifications. The weekend nursing supervisor will review the 24-Hour binders for changes in condition in regards to pain issues & ensure appropriate follow-up is documented including appropriate notification of the MD & RP/resident for changes. · Residents will continue to have pain levels monitored every shift & documented on the MAR; interventions will be implemented according to needs. · Performance Improvement Plan for pain control will be reviewed monthly in the QAPI meeting with the Medical Director for

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 8) recommendations for improving identification of resident pain. · Education will continue each shift until 100% of the staff is educated on the above. Those employees on leave will have their education completed upon arrival for the start of the next scheduled shift to work. Review of information provided by the facility on [DATE] revealed there were 2 residents with changes of condition, and 10 residents being treated for [REDACTED].
F 0315 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that each resident who enters the nursing home without a catheter is not given a catheter, and receive proper services to prevent urinary tract infections and restore normal bladder function.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that a resident who was incontinent of bladder receive appropriate treatment and services for 1 of 4 residents (#1) reviewed for indwelling catheters in that: Resident #1's suprapubic catheter was not anchored to his leg to prevent trauma. This deficient practice could affect 4 residents with indwelling urinary catheters and could result in trauma or infection. The findings were: Review of Resident #1's face sheet dated 7/14/16 revealed he was originally admitted to the facility on [DATE] with a readmission date of [DATE]. Resident #1 had [DIAGNOSES REDACTED]. Review of his MDS with an ARD of 5/5/16 revealed he was incontinent of bowel and had an indwelling urinary catheter. His BIMS was 2/15 making him severely cognitively impaired. Observation on 7/13/16 at 2:50 p.m. of Resident #1 receiving catheter care revealed he did not have a leg strap to anchor his catheter tubing. In an interview at the same time with CNA A, who worked evening shift, he said that the resident did not have one on, but was supposed to, and that he would go and get one. Observation on 7/14/16 at 09:40 a.m. with ADON A revealed Resident #1 did not have a leg strap in place to anchor his catheter tubing. In an interview at the same time, she said that out of the four residents with indwelling urinary catheters, that Resident #1 was the only one supposed to have a leg strap. Interview on 7/14/16 at 10:30 a.m. with CNA A revealed that he forgot about getting the leg strap the evening prior and that Resident #1 still did not have a leg strap in place. Review of Resident #1's comprehensive plan of care dated 1/25/16 revealed the Focus as I have a FOLEY Catheter: [MEDICAL CONDITION] per urologist .under interventions/tasks .monitor for catheter secure device or strap. Review of facility CNA Catheter Care Proficiency dated on 3/2/16 and checked off for CNA A revealed #12, .secure catheter to thigh according to facility policy. The number four of residents with indwelling urinary catheters was provided by the DON.
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that each resident had the required supervision to prevent accidents for one (Resident #4) of 6 residents reviewed for supervision. Resident #4 was not appropriately assessed or care planned for use of an electric scooter, fell from the scooter and was hospitalized and passed away. Physical Therapy staff identified the safety issues and this communication was never passed on to direct care staff. This failure resulted in an IJ which was identified on [DATE]. The IJ was removed on [DATE], but the facility remained out of compliance at a severity level of actual harm at pattern because the facility had not had time to monitor and evaluate the effectiveness of the Plan of Removal. This deficient practice placed 6 residents identified as having poor safety awareness and 5 residents identified as having increased confusion at risk for risk of accidents and injury to include death. Findings include: Review of Resident #4's face sheet dated [DATE] revealed he was admitted on [DATE]. Further review revealed Resident #4 had [DIAGNOSES REDACTED]. Review of Resident #4's hospital death summary dated [DATE] revealed under preliminary cause of death: Immediate cause: (Final diseases or condition resulting in death) Sepsis, Hepatic [DIAGNOSES REDACTED], seizures and right side sub arachnoid hemorrhage .ED course: (discharged from the facility on [DATE] after he fell from his motor scooter in the parking lot) intubated on arrival neurosurgery and neurology consulted for sub arachnoid hematoma on CT and seizures. Review of Resident #4's initial mobility fall risk assessment dated [DATE] revealed he scored low risk for falls on admission. Review of Resident #4's fall risk assessment on [DATE] revealed he was at risk for falls . with a Yes to does the resident display any of the following behaviors: easily distracted; periods of altered perception of awareness of surroundings; episodes of disorganized speech; periods of restlessness; periods of lethargy; mental function varies over the course of the day; wanders. Under section 11 Gait .Impaired, has difficulty rising from chair, grasps furniture, person or aid when ambulating. Cannot walk unassisted. Review of Resident #4's fall risk assessment on [DATE] revealed he was at risk for falls .with overestimates or forgets limits. Review of Resident #4's comprehensive plan of care initiated on [DATE] revealed under problem .ADL self care performance deficit r/t CONFUSION, LACK OF COORDINATION, MUSCLE WEAKNESS. Further review of this document revealed under interventions .staff will assist with transfers and visually check the resident every two hours and as needed. Interview on [DATE] at 11:29 a.m. with ADON B revealed that Resident #4's motorized chair arrived sometime around [DATE]st, 2016, and it was not with him when he arrived on the week of the 20th. He said that Resident #4 originally received the motor scooter from the Veteran's Administration, and had used it previously. Review of Resident #4's comprehensive plan of care initiated on [DATE] revealed it did not address his motorized chair. Interview on [DATE] at 12:40 p.m. with the MDS nurses A and B revealed that Resident #4's motorized chair needed to be care planned and they did not know why it was not. Review of the facility's Power Mobility Device policy and procedure (undated) revealed that .since a power mobility device can pose a potential risk to the safety, property, and well-being of its user and to others and their property, each facility will assess and document each resident's individualized need regarding appropriate interventions proposed to meet the residents needs. Review of Resident #4's 14 day scheduled MDS assessment dated [DATE] revealed on section Delirium revealed that he had disorganized thinking or was incoherent . behavior present continuously and does not fluctuate. Further review indicated under section G0300 Balance during Transitions and Walking that he was not steady, only able to stabilize with staff assistance. Further review of this document revealed Resident #4 required extensive assist and two person physical assist with transfers .locomotion on unit required supervision and one person physical assist, and supervision off unit required limited assistance and one person physical assist. Review of Resident #4's Care Plan Conference Summary dated [DATE] revealed under Risks/Consequences .potential for falls. Review of Resident #4's Physical Therapy note dated [DATE] at 2:39 p.m. revealed under NOTE: Pt trained in safe power wheel chair mobility to increase safety and decrease risk of injury to self and others. Pt instructed in steering, obstacle negotiation and maneuvering in small spaces. Pt continues to require stand by assistance and visual cueing of the above mentioned skills. Review of Resident #4's comprehensive plan of care initiated [DATE] revealed under problem that due to an unsteady gait he had a fall. Further review of this document revealed that under the section approach .anticipate needs, provide prompt assistance. No revisions were noted. Review of the facility Fall Investigation Worksheet dated [DATE] at 5:45 a.m. revealed that Resident #4 fell while trying to

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 9) go to the restroom. Under did resident require supervision .response was yes. Further review of this same document revealed resident was found on floor seated and leaning against his bed .stated he was trying to go to bathroom when he got caught by his covers and slipped while grabbing on to his bed mattress. He was reminded to use his call light. Review of the facility Fall Investigation Worksheet dated [DATE] revealed that Resident #4 had a fall at 12:00 a.m. in his room witnessed by the room mate who said that resident was reaching for something that fell on floor and he fell out of bed. Further review of this document revealed that Resident #4 received skin tears to both forearms. Review of Resident #4's Progress Notes dated [DATE] at 12:36 a.m. revealed resident experienced fall. residents room mate witnessed the fall. said he was rolling around in bed and fell out. residents bed was locked in lowest position. skin tears to both forearms noted. Review of the facility incidents for [DATE] and [DATE] revealed Resident #4 had falls in his bedroom and was unsteady. Interview on [DATE] at 11:04 a.m. with the DON revealed that Resident #4 had fluctuations with confusion and lucidity, and that he had falls on [DATE] and [DATE]. She reported that Resident #4 should have had a formal assessment for safety to drive his motorized wheel chair and it needed to be care planned which did not happen. Interview on [DATE] at 09:50 a.m. with RN A revealed Resident #4 was acting very anxious the week before his fall on [DATE]. She was informed on [DATE] that the resident was acting confused over the weekend when she got report. She stated that Resident #4 was not very balanced, when referring to his level of physical stability. RN A stated that she sent Resident #4 out to the hospital on [DATE] because soon after she came on for her shift from 6:00 a.m. to 2:00 p.m., the morning after the fall she discovered Resident #4 in his room without his clothes on, and he had a blank stare and would not respond. Review of facility Progress Notes (page 3) written by LVN C and dated [DATE] at 12:08 p.m. revealed, Pt appears to have fallen face first onto surface, has multiple new skin issues including most notable lesion to right brow that was bleeding moderately, pt also has multiple new skin tears to face and extremities. During an interview on [DATE] at 11:35 a.m. with PTA A and the PT who worked for the corporation revealed Resident #4 had a history of [REDACTED]. PTA A stated that some days the resident was very confused, and at times impossible to work with the resident on the days he was confused. PTA A confirmed that there would have been no line-of-sight supervision for the resident on the day he fell off the scooter as to where he fell outside, and that he should not have been outside without supervision. The PT confirmed that Resident #4 was a stand by assist, so he needed to have someone standing by and assisting him. She said that Resident #4 needed verbal cues, in order to avoid things like trash cans and other obstacles the resident had to navigate while operating his scooter. She said that Resident #4 needed this assistance not only on the motorized chair, but also in a regular wheel chair. She said that therapy was usually very good at communicating resident needs to the nursing staff, but that this time it did not happen. PTA A stated that he was very surprised to hear that Resident #4 was outside in his power scooter. He stated that nursing had access to all of the therapy notes. The PT said the resident had poor safety awareness, in that he had a hard time being convinced that he could not do some of the same activities he could do when he was younger. She said that he did not have his power scooter on the day of his initial mobility assessment on [DATE]. Interview on [DATE] at 2:07 p.m. with CNA G, revealed that most of the time the Physical Therapy Department informally communicated with the staff regarding the needs of the resident, but said that she was not told anything specific, and that it was not on her assignment sheet. When asked if Resident #4 was getting stand by assistance or visual cueing while in his electric wheel chair, she said no. She stated that Resident #4 should not have been outside by himself without supervision because of his confusion. Interview on [DATE] at 1:55 p.m. with the facilities Medical Director revealed that she typically goes with the opinion of therapy regarding the screening of residents, and that she was not aware of the resident having safety awareness issues with the scooter, but was aware of his falls. Interview on [DATE] at 4:00 p.m. with the Physical Therapy Director, Administrator and DON revealed that there was not a formal method of communicating therapy information to nursing staff in place .and that was why his need for supervision addressed by therapy was never noted by the direct care staff who took care of him. Interview on [DATE] at 09:30 a.m. with the OTA A and PTA A revealed that Resident #4's behaviors would fluctuate from being lucid to being confused. PTA A said Resident #4's judgement would be confused. He stated that the resident advised her he had an electric scooter and then one day, he showed up with it. PTA A and OTA A both agreed that Resident #4 had safety awareness issues and he was not safe being outside without supervision because of his fluctuations and confusion. Telephone interview on [DATE] at 1:33 p.m. with the witness revealed she saw Resident #4 on the ground behind the facility in the parking lot on [DATE] between 6:30 p.m. and 7:00 p.m. She stated that Resident #4 was bleeding near the right eye, and she went for help. Telephone interview on [DATE] at 1:45 p.m. with Resident #4's emergency contact revealed he was deceased , and that she spoke to him the evening of his fall and said that he sounded different, , but she just assumed he did not have his dentures in .and sounded confused, and did not tell her about the fall. Interview on [DATE] at 2:32 p.m. with LVN B revealed he assessed Resident #4 after he had his fall and he assisted LVN C with getting Resident #4 back into his chair and to his room. He said that resident #4 had a large wound above his right eye. Interview on [DATE] at 2:40 p.m. with LVN C revealed he was alerted on [DATE] that Resident #4 was lying on his right side on the ground in the back of the facility and he said that he did some first aide on the skin tears and the resident did not appear to have fractured anything. He said the resident informed staff that his electric chair fell off the curb. The Administrator was notified of noncompliance at an IJ level on [DATE] at 3:30 p.m. and a plan of removal was requested. The facility plan of removal on [DATE]: -Residents using electric wheel chairs were reassessed by the ADON and administrative nursing staff for safety by [DATE]. -Care plans were checked to ensure residents had a plan of care that recognized and addressed resident's safety needs related to electric wheelchair use by [DATE]. -Nursing staff were trained on recognizing residents with potential of having intermittent confusion by [DATE]. -Existing residents using electric wheel chairs would be assessed quarterly and with any significant change by nursing, therapy and maintenance by [DATE]. -New admissions with electric wheel chairs would be assessed by nursing, therapy, and maintenance prior to use as of [DATE]. -Electric wheel chair assessments would be brought to the weekly IDT meeting for review, and any changes to the plan of care would be communicated through the CNA assignment sheets by [DATE]. -These actions were taken to QA for approval on [DATE]. Confirmation of plan of removal was staff who were interviewed on [DATE] included LVN's, CNAs, and a Med Aide regarding recent in-services, assessments, documenting on the 24 hour book, monitoring of residents, and understanding of the dot system (explains residents ' needs) The topics discussed with each staff person depended on their discipline. Physical Therapy developed a new system of integrating information into the morning facility meetings to disseminate safety concerns of residents to direct care staff. The IJ was removed on [DATE], but the facility remained out of compliance at a severity level of actual harm at pattern because the facility had not had time to monitor and evaluate the effectiveness of the Plan of Removal. The number of residents at high risk for safety issues (6) and with increased confusion (5) was provided by the DON.
F 0441 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Have a program that investigates, controls and keeps infection from spreading.** Based on observation, interview and record review the facility failed to maintain an infection control program, including handwashing, to provide a sanitary environment to prevent the transmission of disease and infection for 2 of 6 residents (#1) and (#2) reviewed for infection control practices, in that: 1. CNA A did not wash his hands or use hand sanitizer after changing gloves during perineal care for Resident #1. 2. CNA B and CNA C did not wipe the mattress surface clean when soaked with urine prior to placing clean linen and a clean brief onto Resident #2. CNA B did not change Resident #2's shirt which was also soaked in urine during perineal care. This deficient practice could affect the 38 incontinent residents on the 100 and 400 Halls and could result in the spread of infection. The findings were:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676281	A. BUILDING _____ B. WING _____	**08/03/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SCC AT WESTOVER HILLS REHABILITATION AND HEALTHCAR	**9922 STATE HWY. 151 SAN ANTONIO, TX 78251**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0441 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 10) 1. Observation on 7/13/16 at 2:50 p.m. to 3:00 p.m. revealed when perineal care was provided to Resident #1, CNA A changed his gloves several times and did not wash his hands or use hand sanitizer after each glove change. Interview on 7/13/16 at 3:00 p.m. with CNA A confirmed CNA A did not use hand sanitizer or wash his hands after soiled gloves were removed and before clean gloves were donned. Interview with the DON on 7/13/16 at 3:20 p.m. revealed employees should wash their hands or use hand sanitizer after changing gloves and before donning clean ones. 2. Observation on 7/14/16 at 2:00 p.m. to 2:07 p.m. revealed when perineal care was provided to Resident #2, the mattress was wet with urine and that CNA B and CNA C did not clean the mattress surface on the right side of Resident #2 because they ran out of wipes, and CNA B placed clean linen under Resident #2 and put a clean incontinent brief onto her when the back side of Resident #2's shirt was not changed, but was also soaked with urine. Interview with CNA B on 7/14/16 at 2:10 p.m. confirmed that clean linen was placed onto the soiled mattress surface and that Resident #2's shirt was not changed, soaked in urine and had clean linen placed under it. Review of the facility policy and procedure on Perineal Care dated revised October 2010 revealed #18. Replace gown or clothing if wet or soiled .#19. Soiled linens not on floor or clean bed, #20. Remove gloves and wash hands. Information provided by the facility revealed 38 incontinent residents on 100 and 400 halls.
F 0465 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** Based on observation, interview and record review, the facility failed to provide a safe environment for residents on 1 of 4 halls (300 hall) reviewed for safe environment. This deficient practice could result in an accident of the oxygen tank falling over causing rapid decompression and increased fire risk with an oxygen leak placing the 18 residents and others present at risk for injury. Findings: Observation on 7/14/16 at 3:00 p.m. revealed a size E oxygen tank sitting next to the door in room # 306 on 300 Hall. Interview on 7/14/16 at 3:05 p.m. with MDS Nurse B, who checked the oxygen tank and said it was almost full revealed that the oxygen tank needed to be secured. Interview on 7/15/16 at 11:00 a.m. with RN A revealed that she was trying to get two residents out the door at the same time and she left the tank there unsecured on 7/14/16. She said that she knew better, but was in a hurry. Review of the NFPA99 revealed that compressed gas such as oxygen Cylinders in service and storage shall be individually secured and located to prevent falling or being kicked over. Review of the resident roster revealed there were 18 residents who resided on 300 Hall.