STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035174	A. Building B. Wing	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Avenue Health and Rehabilitation Center	2001 North Park Avenue Tucson, AZ 85719

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41020 Based on clinical record review, staff interviews, and review of policy, the facility failed to ensure that one resident ' s (#3) comprehensive care plan accurately reflected his needs. The sample size was 3. The deficient practice could result in a lack of care provided to meet the resident ' s needs. Findings include: Resident #3 admitted to the facility 09/28/22 with diagnoses including type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene, morbid (severe) obesity due to excess calories and quadriplegia. A self-care performance deficit care plan dated 09/28/22 included conditions such as quadriparesis related to cervical cord compression with myelopathy status post cervical C2 laminectomy had a goal to show improvement in level of function. Interventions included staff participation to reposition and turn in bed. However, the number of staff or the extent of physical assistance was not identified in the plan of care. A Nurse Practitioner / Physician ' s Assistant (NP/PA) progress note dated 09/29/22 at 11:17 a.m. included that the resident had multiple hospital/skilled nursing stays within the past few months, that he was having progressively worsening weakness of the upper and lower extremities, and that he was found to have quadriparesis due to cervical cord compression with myelopathy. The note indicated the resident had undergone a posterior cervical C2 laminectomy, discectomy and fusion and had received inpatient rehabilitation for ongoing physical and occupational therapy (PT/OT). According to the note, the resident made very minimal progress with PT/OT and still required maximal assistance x2 and the Hoyer lift for transfers. An NP/PA progress note dated 10/03/22 at 12:55 p.m. included that the resident had incomplete quadriplegia 2/2 cervical cord compression, was non-ambulatory with limited use of upper extremities. The note indicated there had been no significant change over the past few months and the expectation was that this condition would be the resident ' s new baseline. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident scored 14 on the brief interview for mental status, indicating intact cognition. The resident required extensive 2+ person physical assistance for most activities of daily living and he did not have a pressure ulcer/pressure injury. A Physical Therapy Treatment Encounter Note dated 10/11/22 revealed the resident required substantial/maximal assistance to roll left and right for bed mobility. On 10/11/22 at 11:57 a.m. an NP/PA progress note included that the resident ' s strength in his lower extremities was assessed to be 0 out of 5. The Occupational Therapy Evaluation conducted on 10/12/22 included that the resident completed bed mobility including rolls left to right with maximal assistance, and initiated with bilateral upper extremities to cross reach across midline. The note further indicated that the resident required assistance at the hips to hold position for wound dressing and brief change. A nursing progress note dated 10/22/22 at 9:40 a.m. included that a Certified Nursing Assistant (CNA) notified nursing that the resident was on the floor. Per the CNA, the resident had rolled off the bed while the CNA was providing care. Upon arrival of the nurse, the resident was observed laying on the floor with a noticeable hematoma on the left side of his head. The note indicated that the resident complained of pain to his head and left knee. The Director of Nursing (DON), charge nurse, and therapist came into the room to assist the resident back into his bed with the Hoyer lift. On 10/26/22 at 9:48 a.m. an interdisciplinary progress note included that the resident was sent to the ER for a computed tomography (CT) scan of the hematoma. The resident returned to the facility with no new orders. The note revealed that the resident would be placed onto a larger bed. An interview was conducted on 02/07/23 at 2:24 p.m. with a Certified Nursing Assistant (CNA/staff #20). She stated that she remembered the resident as being a large and a tall man. She stated that on the night of the incident (10/21/22), she was providing incontinence care to the resident in his bed. She stated that she thinks she was standing on the left side of the resident ' s bed and that the resident was turned onto his right side, facing away from her. She stated that while the resident was on his side, he reached up with his hand to grab the headboard to help her. She stated that when he grabbed up for the headboard, he turned over too far and flipped off the side of the bed. She stated that this was the first time she had worked with this resident and that she had only been on duty for a couple of hours. She stated that she had been told that the resident was a one-person assist for bed mobility during report at the start of her shift. She stated that a nurse manager and a physical therapist came into the room to help get the resident back into bed. She stated that they ended up using a Hoyer lift to get him back into bed because he was so big. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 10:06 a.m. on 02/08/23 an interview was conducted with the MDS nurse (staff #15). She stated that she gets information for the MDS assessment from information such as the CNA Point of Care notes, as well as the user defined notes, and compares it to the therapy charting. She stated that she would anticipate that the care plan would identify the resident as dependent on the ADL care plan. She stated that she would anticipate that the resident's care plan would indicate that 2 staff were required for ADL care, such as incontinence care. Because the resident was a quadriplegic/extensive 2-person assist, she stated that risks would include falls or injury to the resident and/or staff if there was only one person providing care. She stated that nursing staff identify residents with 2 staff requirements through the care plan and through report. An interview was conducted on 02/08/23 at 11:45 a.m. with an RN (staff #18). She stated that she is responsible for writing the care plans. She stated that she gets information for the comprehensive care plan from the baseline care plan and from doctor and nursing notes. She stated that MDS information is also a source. She stated that in the case of a resident who is a quadriplegic and/or requires extensive staff assistance, she will just indicate that the resident requires staff participation or staff assistance. She stated that since she's been creating care plans, she has never specified how many staff. She stated that she's just used to not specifying. She stated that risks to the resident might include falling out of bed and maybe getting injured. On 02/08/23 at 12:09 p.m. an interview was conducted with the DON (staff #17). She stated that she did not remember the resident being a quadriplegic. She stated that how much assistance the resident required would depend on how well he was able to roll over. She stated that she was not sure how well the resident rolled. She stated that she would think that the resident's care plan would match the MDS assessment. She stated that she wouldn't understand why it wouldn't match. However, she stated that she would not think that it would matter to patient care if the MDS did not match the care plan. She stated that in nursing school it matters, but in the real world it doesn't. She stated that the care plan would not state that the resident required 2-person physical assistance. She said they don't put that into the care plan. She stated that the MDS gets their information from the Plan of Care CNA documentation, and nursing and provider notes based on the level of care the resident has required according to the rule of 3 [three or more instances of the most extensive care the resident required.] She said she would not say that if the resident's clinical record (POC/nursing/provider notes) revealed that the resident required 2-person extensive assistance, and it was stated as such in the resident's MDS assessment, that the resident had been assessed to require 2-person extensive assistance. The Care Planning policy, reviewed 09/2022, included that it is the policy of the facility that the IDT shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident ' s medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will be developed within 7 days of completion of the resident MDS and will include the resident's needs as identified in the comprehensive assessment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41020 Based on clinical record review, staff interviews, and review of policy, the facility failed to ensure one resident (#3) was provided care and services, consistent with professional standards of practice, to prevent, treat and/or heal a pressure ulcer. The sample size was 3. The deficient practice could result in pain, worsening and/or infection of pressure ulcers. Findings include: Resident #3 admitted to the facility 09/28/22 with diagnoses including type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene, morbid (severe) obesity due to excess calories and quadriplegia. A Skin/Wound Note dated 09/29/2022 12:02 included an initial visit with the resident. The note revealed that the resident has a Braden scale score of 15 [at risk for the development of pressure ulcers]. A healed stage 2 pressure injury with scarring was noted to the sacral area. A physician ' s order dated 09/29/22 included to cleanse the denuded area on sacrum with soap and water. Apply Triad (triamcinolone/corticosteroid) hydrophilic cream twice daily, every day and evening shift. A potential impairment to skin integrity care plan dated 09/29/22 related to scarring to sacrum and total bowel and bladder incontinence had a goal to be free from injury. Interventions included to monitor/document location, size and treatment of skin injury, report abnormalities, failure to heal, signs or symptoms of infection, maceration, etc. to the medical doctor. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident scored 14 on the brief interview for mental status, indicating intact cognition. The resident required extensive 2+ person physical assistance for most activities of daily living and he did not have a pressure ulcer/pressure injury noted on the assessment. A physician's order dated 10/11/22 included a low air loss mattress to bed frame to promote skin integrity, every shift. Another order from the same date revealed wedges to assist with repositioning every shift as tolerated. An IDT (Interdisciplinary Team) Skin Review dated 10/12/22 included MASD (Moisture Associated Skin Damage) to the resident's sacrum with treatment in place. Physician's Order dated 10/14/22 included to cleanse the denuded area on sacrum with soap and water, apply Medi-honey (enzyme), adhesive foam, Change 3 times per week, every day shift on Monday, Wednesday and Friday. On 10/16/22 the resident's care plan was updated to include actual impairment to skin integrity related to MASD to the resident's sacrum. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An IDT Skin Review dated 10/19/22 included MASD to sacrum with skin loss; pink tissue with epithelial tissue to wound edges noted. On 10/19/2022 at 7:48 a.m. a Skin/Wound Note included that the resident was seen for wound rounds that morning. The note indicated the resident had MASD to his sacrum with skin loss. The note further identified the wound bed with some slough present along with pink granulation tissue, and stated the area was resolving. The physician ' s orders included continuing with Medihoney and Hydrogel, and to cover with an adhesive foam dressing change 3 x week. However, a complete evaluation of the wound, including measurements and description of exudate and peri wound was not completed. An IDT Skin Review dated 10/26/22 included the resident had MASD to the sacrum with shearing present. Treatment included Medihoney gel and adhesive foam dressing. Review of the October 2022 Wound Administration Record revealed dressing changes were completed in accordance with the physician ' s orders. On 11/01/22 at 8:39 a.m. a Skin/Wound Note included that the resident's family was notified that the denuded area to the resident ' s sacrum had not responded well to treatment. The note indicated that the resident was compliant with dressing changes, but at times non-compliant with repositioning. The note included that the current dressing was not assisting with drainage and that the order was changed to assist with drainage. The wound had developed an odor and eschar. Provider notified. A Wound assessment dated [DATE] at 5:20 p.m. revealed a sacral wound measuring 15 cm (centimeters) x 10 cm x UTD (unable to determine), moderate serous exudate, and odor. The note indicated that a drastic change to the wound bed, drainage and odor was identified. The note included that the provider had been notified and that the resident had been sent to the hospital. Review of the Nurse Home to Hospital Transfer Form revealed the resident was sent to the ER related to an infected wound of the sacrum. On 02/07/23 at 4:22 p.m. an interview was conducted with the wound care nurse (staff #43). She stated that the resident had been admitted to the facility with MASD to the sacrum. However, after review of her own admission progress note, she did not respond when asked if her documentation had correctly identified a healed stage 2 pressure ulcer with scarring to the resident's sacrum. She stated that all of her wound assessments were listed under the IDT (Interdisciplinary Team)/Skin Meeting Notes. She stated that they do not use the weekly skin/wound templates in the facility. She stated that she will just describe the assessments in a progress note. On 02/08/23 at 8:50 a.m. an interview was conducted with a Registered Nurse (RN/staff #40). She stated that the CNAs (Certified Nursing Assistants) are the eyes and ears of the nurses. If the CNAs see a wound, they will come and let the nurse know. She stated that once she is aware, she will assess/observe the wound herself. Then, she stated she would inform the doctor, the wound nurse, the DON (Director of Nursing) and the resident's family. She stated that the wound nurse would complete a full assessment and notify the IDT for further review. She stated that if there is a change in the wound, she would notify the wound nurse and doctor and document it in a progress note. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on 02/08/23 at 12:09 p.m. with the DON (staff #17). She stated that a wound assessment should include wound measurements, a description of the wound bed, wound edges, peri wound, exudate and whether or not there was an odor. She stated that if a healed pressure ulcer reopened, someone would have to assess what stage it was, but that it would make sense that a re-opened stage 2 pressure ulcer would be considered to be a stage 2 pressure ulcer. She stated that the wound IDT meets weekly to discuss all the wound rounds and whether or not the interventions are working. She stated that if the resident was discussed, it would be in the IDT notes. She reviewed the resident's clinical record and noted that the resident had been discussed on 10/19/22 and 10/26/22. She stated that per the Wound Administration Records, treatments were provided 3 times per week as ordered. She reviewed the photograph of the wound dated 11/01/22 and stated that the wound did not appear to be MASD. On 02/08/23 at 1:26 p.m. a follow-up interview was conducted with the wound care nurse (staff #43). She stated that once an open area was identified on the resident ' s skin, she would assess it. She stated that if she was the one who identified it, she would notify the resident's family, the provider and DON. She stated that the open area and notifications should be documented in a progress note, and that she would like to think that she had documented it. She stated that she would ensure that a treatment was in place, if needed, and that it would be updated depending on the wound. She stated that she would complete an assessment on a weekly basis, or if an issue was identified. She stated that based on her assessment, she would ask for additional orders and that she would document that in the progress notes. She stated that she would notify dietary for a worsening of a pressure ulcer so that they could implement additional supplements. She stated that wound assessments include measurements, description of wound bed, peri wound, exudate and whether or not there was any odor. She stated that she identified MASD to the resident's sacrum as opposed to a stage 2 pressure ulcer because there was a lot of moisture in that area related to incontinence and/or sweating. She stated that there was one open area to the resident ' s sacrum. She stated that she did not measure it and that she did not assess the wound bed or the exudate. She stated that she completed the treatments as ordered and that if she had assessed it, the assessment would be in the IDT notes. She stated that once a wound has been identified as MASD, the wound program would not allow for reclassification. She stated that if she could have, she would have reclassified it as an unstageable pressure ulcer. However, she stated that the wound program had locked her into the MASD classification. The Wound Management policy, revised 08/2022, included that a resident who enters the facility without pressure ulcers does not develop pressure ulcers unless the resident ' s clinical condition or other factors demonstrate that a developed pressure ulcer was unavoidable; and a resident having pressure ulcers receives necessary treatment and services to promote healing, prevent infection, and prevent new, avoidable sores from developing. The Complex Wound Management policy, revised 06/2022, included that it is the policy of the facility to have a flow sheet to enable medical staff to evaluate the status of wounds. A complex wound includes a pressure ulcer. Each wound will be measured in centimeters weekly. Measurements, size and depth, drainage, odor, color and a short statement on progress (or lack of) will be documented on the Skin Pressure Ulcer Weekly or Skin Ulcer Non-Pressure Weekly UDA. Treatments ordered by the physician will be used. If no improvement, the physician will be called for an evaluation.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41020 Based on clinical record review, staff interviews, and review of policy, the facility failed to ensure one resident (#3) was provided services to prevent an accident. The census was 134. The deficient practice increases the risk for residents to sustain injury through preventable accidents. Findings include: Resident #3 admitted to the facility 09/28/22 with diagnoses including type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene, morbid (severe) obesity due to excess calories and quadriplegia. The Initial Admission Record dated 09/28/22 included the resident had weakness in both his right and left legs. A self-care performance deficit care plan dated 09/28/22 included conditions such as quadriparesis related to cervical cord compression with myelopathy status post cervical C2 laminectomy had a goal to show improvement in level of function. Interventions included staff participation to reposition and turn in bed. A Nurse Practitioner / Physician ' s Assistant (NP/PA) progress note dated 09/29/22 at 11:17 a.m. included that the resident had multiple hospital/skilled nursing stays within the past few months, that he was having progressively worsening weakness of the upper and lower extremities, and that he was found to have quadriparesis due to cervical cord compression with myelopathy. The note indicated the resident had undergone a posterior cervical C2 laminectomy, discectomy and fusion and had received inpatient rehabilitation for ongoing physical and occupational therapy (PT/OT). According to the note, the resident made very minimal progress with PT/OT and still required maximal assistance x2 and the Hoyer lift for transfers. The daily skilled note dated 09/30/22 at 3:59 p.m. included that the resident was totally dependent for bed mobility and that he required 2+ persons physical assistance. On 10/02/22 at 1:10 p.m. a daily skilled note indicated the resident required extensive 2+ person physical assistance with bed mobility. An NP/PA progress note dated 10/03/22 at 12:55 p.m. included that the resident had incomplete quadriplegia 2/2 cervical cord compression, was non-ambulatory with limited use of upper extremities. The note indicated there had been no significant change over the past few months and the expectation was that this condition would be the resident ' s new baseline. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident scored 14 on the brief interview for mental status, indicating intact cognition. The resident required extensive 2+ person physical assistance for most activities of daily living (ADLs) including bed mobility. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A daily skilled note dated 10/07/22 at 1:10 p.m. revealed the resident was totally dependent for bed mobility and required 2+ person physical assistance. A physician ' s order dated 10/11/22 included a low air loss mattress to the bedframe to promote skin integrity. A Physical Therapy Treatment Encounter Note dated 10/11/22 revealed the resident required substantial/maximal assistance to roll left and right for bed mobility. On 10/11/22 at 11:57 a.m. an NP/PA progress note included that the resident ' s strength in his lower extremities was assessed to be 0 out of 5. The Occupational Therapy Evaluation conducted on 10/12/22 included that the resident completed bed mobility including rolls left to right with maximal assistance, and initiated with bilateral upper extremities to cross reach across midline. The note further indicated that the resident required assistance at the hips to hold position for wound dressing and brief change. A daily skilled note dated 10/13/22 at 9:14 a.m. indicated the resident required extensive to total assistance for range of motion, ADL care, locomotion, and assistive device use. The note included that range of motion for upper and lower body was limited and no musculoskeletal changes had been observed. Review of the Weights and Vitals report dated 10/20/22 revealed the resident ' s weight had been documented at 227.0 pounds. A nursing progress note dated 10/22/22 at 9:40 a.m. included that a Certified Nursing Assistant (CNA) notified nursing that the resident was on the floor. Per the CNA, the resident had rolled off the bed while the CNA was providing care. Upon arrival of the nurse, the resident was observed laying on the floor with a noticeable hematoma on the left side of his head. The note indicated that the resident complained of pain to his head and left knee. The Director of Nursing (DON), charge nurse, and therapist came into the room to assist the resident back into his bed with the Hoyer lift. On 10/26/22 at 9:48 a.m. an interdisciplinary progress note included that the resident was sent to the ER for a computed tomography (CT) scan of the hematoma. The resident returned to the facility with no new orders. The note revealed that the resident would be placed onto a larger bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on 02/07/23 at 2:24 p.m. with a CNA (staff #20). She stated that she remembered the resident as being a large and a tall man. She stated that on the night of the incident (10/21/22), she was providing incontinence care to the resident in his bed. She stated that she thinks she was standing on the left side of the resident's bed and that the resident was turned onto his right side, facing away from her. She stated that while the resident was on his side, he reached up with his hand to grab the headboard to help her. She stated that when he grabbed up for the headboard, he turned over too far and flipped off the side of the bed. She stated that this was the first time she had worked with this resident and that she had only been on duty for a couple of hours. She stated that she had been told that the resident was a one-person assist for bed mobility during report at the start of her shift. She stated that after the resident fell off the bed she went to get the nurse. She said the nurse assessed the resident and she took the resident ' s vitals. She stated that a nurse manager and a physical therapist came into the room to help get the resident back into bed. She stated that they ended up using a Hoyer lift to get him back into bed because he was so big. She stated that the resident had hit his head and had some blood on his forehead. She said he had a little bump there and a small amount of bleeding from the area. She stated that after the resident had been assisted back into bed he was sent to the ER for evaluation. On 02/08/23 at 8:50 a.m. an interview was conducted with a Registered Nurse (RN/staff #40). She stated that she would anticipate seeing 2 people in the room to give care to a larger resident, especially a quadriplegic or someone who required extensive assistance. Stated that would include almost all ADLs, and definitely peri and/or incontinence care. She stated that if she sees that the resident requires extensive 2-person assistance in the care plan, she will let the CNA know so that they can provide care safely for both the resident and themselves. She stated that it could potentially be a danger to the resident and themselves if the CNA changed a larger, disabled resident by themselves. On 02/08/23 at 9:04 a.m. an interview was conducted with a CNA (staff #22). She stated that sometimes she will check in with therapy to determine the number of staff necessary during care, or if the resident looks larger, she will be able to just see that the resident needs 2-3 people for care. She stated that it would be a safety issue to change a large resident by herself. She stated that if the resident was new to her, she would receive instructions during report. She stated that a very large person with extensive muscle weakness and/or quadriplegia would not be able to assist with turning and/or to stop themselves from rolling off the bed, especially if they have an air mattress. She stated that it would not be safe to try to provide incontinence care by herself. At 10:06 a.m. on 02/08/23 an interview was conducted with the MDS nurse (staff #15). She stated that she gets information for the MDS assessment from information such as the CNA Point of Care notes, as well as the user defined notes, and compares it to the therapy charting. She stated that she would anticipate that the care plan would identify the resident as dependent on the ADL care plan. She stated that she would anticipate that the resident's care plan would indicate that 2 staff were required for ADL care, such as incontinence care. Because the resident was a quadriplegic/extensive 2-person assist, she stated that risks would include falls or injury to the resident and/or staff if there was only one person providing care. She stated that nursing staff identify residents with 2 staff requirements through the care plan and through report. (continued on next page)

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	035174	A. Building B. Wing	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Avenue Health and Rehabilitation Center	2001 North Park Avenue Tucson, AZ 85719

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 0689 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on 02/08/23 at 11:45 a.m. with an RN (staff #18). She stated that she is responsible for writing the care plans. She stated that she gets information for the comprehensive care plan from the baseline care plan and from doctor and nursing notes. She stated that MDS information is also a source. She stated that in the case of a resident who is a quadriplegic and/or requires extensive staff assistance, she will just indicate that the resident requires staff participation or staff assistance. She stated that since she's been creating care plans, she has never specified how many staff. She stated that she's just used to not specifying. She stated that risks to the resident might include falling out of bed and maybe getting injured. On 02/08/23 at 12:09 p.m. an interview was conducted with the DON (staff #17). She stated that she did not remember the resident being a quadriplegic. She stated that how much assistance the resident required would depend on how well he was able to roll over. She stated that she was not sure how well the resident rolled. She stated that she would think that the resident's care plan would match the MDS assessment. She stated that she wouldn't understand why it wouldn't match. However, she stated that she would not think that it would matter to patient care if the MDS did not match the care plan. She stated that in nursing school it matters, but in the real world it doesn't. She stated that the care plan would not state that the resident required 2-person physical assistance. She said they don't put that into the care plan. She stated that the MDS gets their information from the Plan of Care CNA documentation, and nursing and provider notes based on the level of care the resident has required according to the rule of 3 [three or more instances of the most extensive care the resident required.] She said she would not say that if the resident's clinical record (POC/nursing/provider notes) revealed that the resident required 2-person extensive assistance, and it was stated as such in the resident's MDS assessment, that the resident had been assessed to require 2-person extensive assistance. The Incidents and Accidents policy, revised 05/2021, included that it is the policy of the facility to implement and maintain measures to avoid hazards and accidents. Should an accident/incident occur, the resident will be provided immediate attention by a licensed nurse, who will notify the medical provider, family member, EMS, etc. as appropriate.