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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. Building B. Wing	02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regal Heights Healthcare & Rehab Center	6525 Lancaster Pike Hockessin, DE 19707

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 32545 Based on interview and review of the clinical record, it was determined that for one (R1) out of three residents reviewed for accidents, the facility failed to immediately inform both R1's Physician and the POA when there was an accident, specifically a fall on 1/13/22, involving the resident which resulted in serious injury that required treatment in the emergency room (ER) with subsequent hospitalization . Findings include: Cross refer to F684, F689 Review of R1's clinical record revealed: 1/13/22 at 2 AM - A Nurse's Note documented that R1 fell , sustained a visual head injury and was placed back in bed. E15 (RN) documented that a message was left for the on-call Physician, she was waiting for a return call and the family would be notified in the morning. The Physician never returned the call and no further calls were made by E15 (RN). 1/13/22 at 8:40 AM - Over seven hours later, a Nurse's Note by E13 (RN, 7AM to 3 PM Supervisor) documented that R1's Physician and POA were notified. R1 was sent to the ER to be evaluated as she was on anticoagulant medication and had a visual head injury. 2/8/22 at 10 AM - During an interview about the 1/13/22 fall, E14 (LPN, Supervisor) stated that she asked E15 (RN) between 6 AM and 6:30 AM if the Physician called back and E15 replied no. 2/9/22 at 2:15 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E3 (Director of Clinical Services), E4 (RN Risk Manager) and E13 (RN Supervisor). The facility failed to immediately inform both R1's Physician and POA of an unwitnessed fall on 1/13/22 at 1 AM where she sustained a visual head injury.

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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 40264 Based on interviews and review of the clinical record, facility documentation and the State Survey Agency's Incident Report for one (R4) out of three residents reviewed for accidents, the facility failed to identify and immediately report an allegation of neglect. Findings include: Cross refer to F610 and F689 Review of R4's clinical record revealed the following: 12/3/121 - The quarterly MDS assessment stated that R4 had a memory problem and required extensive assist of two (2) staff for bed mobility and total dependence of two (2) staff assist for toilet use. Review of the State Agency Incident Reporting Center revealed that on 12/22/21 at 9:30 PM, a fall was reported by the facility. R4 rolled out of bed sustaining a hematoma to head and was sent to the ER (emergency room) for evaluation. 12/22/21 (8/23/18 revised) - R4 was care planned for potential for falls related to poor safety awareness (4/27/20). 12/22/21 at 9:10 PM - A nurse progress note by E11 (RN) documented that while CNA (E12) was providing care, resident (R4) rolled out of bed onto the floor mat. R4 was noted with a hematoma to upper forehead and was sent to the ER for evaluation. 2/1/22 at 10:40 AM - During interview, E12 revealed that on 12/22/21 at 9:00 PM she entered R4's room to do provide toileting. R4 began moving so E12 moved R4 towards the center of the bed. E12 walked to the other side of the bed to get supplies but R4 had started rolling off the bed and by the time E12 got to him he was already on the floor. 2/1/22 at 11:30 AM - In an interview, E11 stated that on 12/22/21 at 9:10 PM, she responded to E12's report of resident (R4) falling onto the floor. E11 further stated that R4 needed two (2) person staff assist with bed mobility including toileting activity or incontinence care being done in bed. E11 also added that E12 was provided on the spot education to ensure bed is kept in low position when direct care is not provided and to make sure all her supplies are set to avoid interruptions, leaving the resident unattended when providing toileting activity of a dependent resident in bed. 2/1/22 at 3:30 PM - An interview with E2 (DON) confirmed that the facility failed to identify that E12 provided incontinent care by herself to R4 who was a dependent resident and required two (2) person staff assist for bed mobility. E2 revealed that the facility lacked evidence that they identified this fall as an allegation of neglect. This resulted in failure to report the allegation of neglect and initiate an investigation related to the allegation of neglect. Findings were reviewed with E1 (NHA) and E2 during the Exit Conference on 2/9/22 beginning at 1:51 PM

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate treatment and care according to orders, resident’s preferences and goals.

32545

Based on interviews and review of the clinical record, facility documentation and other sources as indicated, it was determined that the facility failed to follow professional standards of practice after R1's unwitnessed fall on 1/13/22. The facility failed to consider the potential of cervical trauma based on the blunt mechanism of R1's fall; failed to ensure R1 was thoroughly assessed on the fall mat before moving the resident with a head injury; and failed to complete neurological (neuro) evaluations (checks) of R1 according to standards of practice and the facility's specified times. The facility failed to immediately transfer a resident on blood thinning medication with head trauma to the emergency room for evaluation. Findings include:

Cross refer to F689

Mosby's nursing textbook entitled Medical-Surgical Nursing: Assessment and Management of Clinical Problems 6th Edition, dated 2004, stated, . Spinal Cord Trauma . Causes of spinal cord injury include . falls . After stabilization at the accident scene, the person is transferred to a medical facility . Fractures can occur as a result of . blunt trauma . All patients with facial injuries should be treated as though they have a cervical injury until proven otherwise by examination and imaging studies .

Mosby's nursing textbook entitled Priorities in Critical Care Nursing 5th Edition, dated 2008, stated, . Trauma . Blunt trauma is seen most often with . falls. Injuries occur because of the forces sustained during a rapid change in velocity (deceleration) . The goal of prehospital care is immediate stabilization and transportation. This is achieved through . immobilization of the patient, and immediate transport . to the closest appropriate medical facility .Nursing management of the patient with traumatic injuries begins the moment a call for help is received .Assessment .The neurological assessment is the most important tool for evaluating the patient . because it can indicate severity of injury, provide prognostic information, and dictate the speed with which further evaluation and treatment must proceed .

The facility's policy and procedure entitled Assessing Falls and Their Causes, last revised March 2018, documented, .Identify the resident's current medications . After a Fall: 1. If a resident .is found on the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine, and extremities . 3. If there is evidence of injury, .obtain medical treatment immediately .

Review of R1's clinical record and the facility's fall incident documentation revealed:

On 1/13/22 at 1:00 AM - R1, a resident with dementia, had an unwitnessed fall out of bed. E15 (RN) assessed R1 on the fall mat for ABCs (airway, breathing and circulation) by squatting down. Two CNAs (E16 and E17) were told to put R1 back in bed by E15. R1 was picked up by the two CNAs and placed back in bed. E15 continued her assessment and started neuro checks when E14 (LPN, 11 PM to 7 AM Supervisor) joined her at the bedside. It was at this time that E15 saw R1's left forehead hematoma.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/13/22 - While E15 (RN) documented neuro checks of R1 on the facility's form, the evaluations were not complete nor were some of them done timely according to the facility's specified times to be performed. R1's neuro checks were missing responses on R1's speech, pupil sizes, if pupils were equal and reactive to light, pain, and movement of extremities. Despite the facility's specified times for neuro checks to be performed, E15 documented the last neuro check at 5 AM. The facility failed to ensure that R1's neuro checks were performed at 6:00 AM and 7:00 AM. 1/13/22 at 9:08 AM - A nurses note documented that the Physician ordered R1 to be transferred to the emergency room (ER) at 8:55 AM. R1 was on anticoagulant medication (blood thinner), Xarelto. 1/13/22 - After arrival to the ER at approximately 9:00 AM, the hospital diagnosed R1 with the following injuries: left forehead hematoma that extended to the left eye; C1-C2 subluxation; compression fracture of L4 vertebrae; right femur (thigh bone) fracture; and right hip fracture. According to the facility's investigation conducted ten days after the incident, it was confirmed that R1 was lifted from the floor by two CNAs and placed back into bed for the remainder of the night shift. 2/8/22 at 10 AM - During an interview, E14 (LPN, 11 PM to 7 AM Supervisor) confirmed that she did not document any notes on R1's fall, except the root cause analysis; she did not review the neurological evaluations by E15 (RN); and did not know that R1 was on an anticoagulant. 2/8/22 at 10:38 AM - During an interview, E15 (RN) stated that she did not see R1's knot during her initial assessment when the resident's face was turned to the left, where her left ear was on the fall mat. E15 stated that she quickly assessed R1 by squatting down and checking ABCs (airway, breathing, circulation). E15 left the room as she knew she would have to do neuro checks and vital signs. When she returned, R1 was in bed and she saw the left forehead knot. E15 stated that R1's assessment was done together with E14 (LPN, 11 PM to 7 AM Supervisor). The facility failed to consider the potential of cervical trauma based on the blunt mechanism of R1's fall; failed to ensure R1 was thoroughly assessed on the fall mat before moving the resident after an unwitnessed fall with a head injury; failed to complete neuro checks on R1 according to standards of practice and the facility's specified times; and failed to immediately transfer resident on blood thinning medication and with head trauma to the ER for evaluation. 2/9/22 at 2:15 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E3 (Director of Clinical Services), E4 (RN Risk Manager) and E13 (RN Supervisor).

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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.

32545

Based on interviews and reviews of clinical records, facility documentation, and hospital records, it was determined that for two (R1 and R4) out of three residents reviewed for accidents, the facility failed to ensure that the residents' environment remained free of accident hazards. For R1, the facility failed to ensure that bilateral body pillows were securely in place on the 11 PM to 7 AM shift on 1/13/22 when she had an unwitnessed fall out of bed and sustained a hematoma to her left forehead. R1 was picked up by two CNAs using their hands and placed back into bed. Over seven (7) hours later, R1 was transferred to the emergency room for evaluation and diagnosed with a new subluxation of C1, compression fracture of L4, right femur fracture, right hip fracture and severe osteopenia (weak bones). The facility failed to ensure that R1's bilateral body pillows were securely in place and failed to prevent two staff from lifting her off the floor, which resulted in harm for R1. For R4, the facility failed to ensure that R4 received adequate supervision with two staff assistance for bed mobility during toileting resulting in a hematoma and transfer to the hospital for evaluation. Findings include:

1. Cross refer to F580, F684, F697

Review of R1's clinical record revealed:

3/4/15 - R1 was admitted to the facility for long term care with diagnoses including, but not limited to, a stroke, dementia and aFib.

3/5/15 - R1 was care planned for falls with interventions that included, but not limited to, bed in the lowest position, bariatric low air loss mattress, bilateral body pillows and bilateral fall mats. In addition, R1 was care planned for transfers using a hoyer lift with the assistance of two staff.

10/26/21 - The quarterly MDS assessment documented R1's BIMS as zero (severe cognitive impairment), her vision was impaired, and R1 had no other falls since the prior assessment.

1/13/21 at 2 AM - According to the nurses note, R1 had an unwitnessed fall out of bed and was found moaning and face down on the fall mat. After an initial assessment was done by E15 (RN), R1 was placed back in bed. R1 was noted to have a bump on her left forehead.

1/13/22 at 3:40 AM - A fall note with the root cause analysis by E14 (LPN, 11 PM to 7 AM Supervisor) documented that all fall interventions per R1's care plan were in place at the time of her fall, including bedside body pillows, fall mats and the bed was in the lowest position.

1/13/22 at 9:08 AM - A nurses note documented that the Physician ordered R1 to be transferred to the ER at 8:55 AM. R1 was on anticoagulant medication, Xarelto, that thins the blood.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	1/13/22 - The hospital ER record documented that R1 was placed in a cervical collar and noted with bruising and swelling to the left forehead and left eye and exhibited pain by grimacing and withdrawing. The results from multiple diagnostic tests showed R1 with a new subluxation of C1, compression fracture of L4, right femur fracture, and right hip fracture. In addition, R1 was also diagnosed with severe osteopenia. 1/24/22 - E2's (DON) telephone interview with E17 (agency CNA) documented, .Me (E17) and (E16, CNA) put her back in the bed. I know she uses the hoyer lift, but she's so light we just picked her up . She (R1) even had her body pillows in place. Usually they put the pillows under her fitted sheet, but I put them under her transfer sheet . her body pillow was still halfway on the bed. 1/24/22 - E2's (DON) telephone interview with E14 (LPN, 11 PM to 7 AM Supervisor) documented, . I saw her (R1) body pillow that is on the side of her window was in place, but not the one on her other side was not . 2/8/22 at 9:13 AM - During an interview, E16 (CNA) stated that R1's body pillows were under the sheets and the pillow rolled with R1. 2/8/22 at 1:20 PM - During an interview, E13 (RN, 7 AM to 3 PM Supervisor) stated that the facility has oversized fitted sheets for the bariatric low air loss mattresses and the body pillows would be placed under the fitted sheets. The facility failed to ensure that R1's body pillows were securely in place and failed to prevent two staff from lifting her with their hands and placing her back in bed. 2/9/22 at 2:15 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E3 (Director of Clinical Services), E4 (RN Risk Manager) and E13 (RN Supervisor). 40264 Cross refer to F600 and F610 2. Review of R4's clinical records revealed the following: 8/22/18 - R4 was admitted to the facility with diagnoses including dementia with muscle weakness and unsteadiness on the feet. 8/23/18 (revised 12/22/21) - R4 was care planned for potential for falls related to poor safety awareness with interventions including bed in lowest position when care is not being provided (initiated 8/23/18) and two person staff assist for bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture) (initiated 9/17/18 and revised 4/27/20). 8/23/18 (revised 5/1/20) - R4 was care planned to require ADL assistance that included toilet use due to cognitive loss with interventions including two person staff assist for bed mobility (initiated 8/23/18). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	7/13/20 - A Physical Therapy discharge summary revealed that R4's mobility with rolling from left and right required substantial or maximal staff assistance and dependent for toilet transfer. 12/3/21 - R4's quarterly MDS Assessment for ADL revealed that R4 needed extensive assistance requiring 2 person staff to provide weight bearing support for bed mobility and that R4 was always incontinent of bowel and bladder requiring extensive assistance of 2 staff person for toilet use. 2/1/22 at 10:00 AM - Review of E11's (RN) nurse progress note dated 12/22/21 at 9:10 PM revealed that while CNA (E12) was providing care, resident (R4) rolled out of bed onto the floor mat. R4 was noted with a hematoma to upper forehead and was sent to the ER for evaluation. 2/1/22 at 10:40 AM - During interview, E12 revealed that on 12/22/21 at 9:00 PM she entered R4's room to do a toileting activity or incontinence care. E12 stated that, Resident (R4) had a bowel movement and I was getting ready to clean him up as he was already lying on his left side - facing the door with the pillow on his back. He started moving so I moved him a little bit towards the center of the bed. I went to the other side of the bed to get some wipes but he started rolling off the bed and by the time I got to him he was already on the floor. E12 further stated that, They said in the POC (Point of Care documentation instruction) kiosk that he is always a 1 or 2 person assist for bed mobility depending on R4's tolerance because he does fight back and resists care while lying in bed. If I started moving him and he doesn't fight back, I will do the incontinence care and just change him in bed by myself. I don't have to call for other people to help me. When asked if R4's bed was in low position prior to the fall, E12 stated, No, I don't think so. I can not remember'. 2/1/22 at 11:30 AM - In an interview, E11 stated that on 12/22/21 at 9:10 PM, she responded to E12's report of resident (R4) falling onto the floor. E11 further stated that E12 needed 2 person staff assist with bed mobility including toileting activity or incontinence care being done in bed. E11 also added that E12 had a spot on education to ensure bed is kept in low position when direct care is not provided and to make sure all her supplies are set to avoid interruptions, leaving the resident unattended when providing toileting activity of a dependent resident in bed. 2/2/22 at 2:10 PM - A review of the facility's CNA/Nurse Fall Reporting Form revealed that prior to the fall, R4's bed was not in the low position. 2/1/22 at 3:30 PM - Findings were discussed with E2 (DON). The facility failed to ensure that R4 was free from accident hazards and that R4 received adequate supervision with a 2 person staff assist for bed mobility during a toileting activity. R4's bed was not in a low position prior to him rolling onto the floor on 12/22/21 causing a hematoma on his forehead that lead to his transfer to the ER for evaluation. Findings were reviwed with E1 (NHA) and E2 (DON) during the Exit Conference on 2/9/22 beginning at 1:51 PM.

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 44885 Based on observation, clinical record review, interviews, review of the facility's policies and procedures, and review of other facility documentation as indicated, it was determined that the facility failed to ensure that emergency equipment was available for accidental dislodgement for two (R6 and R8) out of two active residents in the facility reviewed for tracheostomy (trach) related care. The lack of available emergency equipment, in addition to the lack of competent trained staff in tracheostomy care posed an immediate jeopardy (IJ) situation to the residents with tracheostomies. The IJ was identified on 2/2/22 at 6:00 PM and was abated on 2/3/22 at 3:45 PM. Additionally, it was determined that the facility failed to ensure that one (R6) out of two residents in the sample received tracheostomy care consistent with professional standards of practice and facility policies and procedures. Findings include: 1. EMERGENCY EQUIPMENT: The facility's policy, titled Tracheostomy Care, revised August 2013, stated, General Guidelines .a replacement tracheostomy tube must be available at the bedside at all times .a suction machine, supply of suction catheters, exam and sterile gloves, and flush solution, must be available at the bedside at all times . 1a. Review of R6's clinical record revealed the following: 8/2/18 - R6 was admitted to the facility with chronic respiratory failure and a trach. 12/30/20 - A Physicians order for R6 stated, Trach care .a disposable inner cannula (fits inside of the trach tube) size 6.0 and 1 size down, ambu bag (used for emergency resuscitation), functioning suction .to be kept at bedside at all times. 6/17/21 - A Physicians order for R6 stated that R6 had a Tracheostomy size 6.0 XLT (non-cuffed) Type: Shiley 6.0 mm (size and type of trach) . (will be referred to as Shiley #6 XLT non-cuffed). 2/1/22 at approximately 9:34 AM - During an observation at R6's bedside with E7 (LPN), it was revealed that a replacement trach Shiley #6 XLT (cuffed), Shiley #6.5 inner cannulas, and Shiley #6 XLT inner cannulas were at R6's bedside. An Ambu bag was not visible at R6's bedside. E7 was unable to confirm what size trach R6 had and stated she .was a new nurse . and needed to get another nurse to assist her . in identifying R6's trach supplies. A Shiley #6 XLT non-cuffed trach was not observed at R6's bedside. 2/1/22 9:49 AM - Another nurse, E8 (LPN) entered R6's room to assist E7 (LPN) and was observed removing R6's Ambu bag from the closed bottom drawer of the dresser and hung it on R6's wall. E8 revealed that the Ambu bag should have been hanging on the wall and also confirmed that the Shiley #6.5 inner cannulas at R6's bedside were the incorrect size for R6 and then removed them from R6's room. 1b. Review of R8's clinical record revealed the following: 8/27/20 - R8 was admitted to the facility with chronic respiratory failure and a trach. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1/15/22 - A Physician's order stated, Trach care . a disposable inner cannula size 6.0 and 1 size down, ambu bag, functioning suction .to be kept at bedside at all times. 1/15/22 - A second Physician's order stated, Keep replacement trach at bedside size 7.5; type Shiley; cuffed; in addition keep one size smaller than current size at bedside. 2/1/22 10:22 AM - Observation at R8's bedside with E8 (LPN) revealed that an Ambu bag and one size smaller trach was not in R8's room. At R8's beside was a trach #7.5 labeled back up trach in marker and size #5 inner cannulas. E8 confirmed that an Ambu bag and any additional size trach supplies were not in R8's room. 2/1/22 10:34 AM - The Surveyor notified E1 (NHA) regarding the findings for R6 and R8. 2/1/22 10:39 AM - E1 advised that an Ambu bag was placed in R8's room. 2/1/22 12:30 PM - During an interview with E2 (DON) and E13 (RN Supervisor) it was confirmed that the facility did not have the Physician ordered sizes of back up trachs for R6. Per E2 and E13, the facility just ordered the back up trach set for R6, and it will arrive in the facility on 2/2/22 at 11:00 AM. E13 revealed that the facility had a size 4DCFS (#5 cuffless) and that they planned to consult E21, the respiratory therapist (RT) upon her arrival to the facility to determine if that would be acceptable as a temporary emergency size one down back up trach for R6. 2/1/22 2:26 PM - During an interview with E21 (RT), E21 confirmed that the #6 (cuffed) trach observed in R6's room could be used in the event of dislodgement, but that it was the improper type of trach (cuffed). E21 stated this would be considered a safe practice if staff did not inflate the cuff when the trach was inserted into R6's tracheostomy. E21 also stated that in the event the cuff was inflated, it could cause damage to R6's airway over time. E21 confirmed that R6 did not have the next size down trach available at the bedside at the time of observation and the facility had ordered the correct back up trach (#6 non-cuffed), in addition to the next size down trach. 2/2/22 at approximately 11:40 AM - During an observation at the beside of R6, E10 (LPN) confirmed that the temporary back up smaller size trach set now at the bedside was a size 4DCFS (#5 cuffless), which was one size down for R6. 2/2/22 3:53 PM - During an interview with E13 (RN Supervisor), it was revealed that the correct replacement trach set the facility ordered for R6 and one size smaller just arrived at the facility. 2. COMPETENT TRAINED STAFF: The facility's policy, titled Tracheostomy Care, revised August 2013, stated, General Guidelines .Aseptic technique must be used .during tracheostomy changes, either reusable or disposable .a replacement tracheostomy tube must be available at the bedside at all times .a suction machine, supply of suction catheters, exam and sterile gloves, and flush solution, must be available at the bedside at all times . The facility's policy did not include steps to be taken during the event of a trach dislodgement. The facility's competencies, titled Competency Assessment Tracheostomy Care, did not include steps to take during a trach dislodgement. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regal Heights Healthcare & Rehab Center	6525 Lancaster Pike Hockessin, DE 19707

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2/2/22 12:39 PM - During an interview with E8 (LPN), it was revealed that during the event of a dislodgement, a 14-16 (size) Foley catheter could be placed in the tracheotomy (hole the tracheostomy tube goes in) to keep it open . 2/2/22 12:58 - During an interview with E10 (LPN), it was revealed that in the event of a trach dislodgement E10 had No idea what to do, but would call the supervisor for help. 2/2/22 1:48 PM - During an interview, E4 (SE/ICP) confirmed that the facility had no evidence of tracheostomy emergency training or competencies for all current staff. 2/2/22 6:00 PM - During an interview with E1 (NHA), E2 (DON), E4 (RN Risk Manager) E6 (SD/IC), and E13 (RN Supervisor), the parties were advised that the lack of emergency equipment and lack of competent trained staff for dislodgement of a trach was an Immediate Jeopardy. Findings were confirmed with E1, E2, E4, E6, and E13. 2/2/22 9:52 PM - The facility had evidence of training for the three staff caring for residents with trachs initiated by E4 (SD/IC). 2/2/22 10:44 PM - A written plan to train the remaining nursing staff was received. 2/3/22 9:30 AM - Training for all but two licensed staff on the 2/2/22 7-3/3-11/11-7 shifts was received. 2/3/22 1:20 PM - Interviews were conducted with current nursing staff to determine they received training as outlined in the written plan. 2/3/22 3:45 PM - It was determined that the facility abated the IJ. 2/3/22 5:18 PM - During an interview with E1 (NHA), it was reported that the facility had trained 76% of full-time nurses and 53% of agency nurses were trained. 2/9/22 1:00 PM - Findings were reviewed at the exit conference with E1 (NHA), E2 (DON), E3 (Director of Clinical Services), E4 (Risk Manager) E6 (SD/IC), and E13 (RN Supervisor).

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 32545 Based on interview and review of the clinical record and the facility's fall incident documentation, it was determined that for one (R1) out of three residents reviewed for accidents, the facility failed to ensure that pain management was provided to R1 after she fell out of bed, sustained a head injury and it was documented on a pain evaluation tool that R1 was moaning post fall. Findings include: Cross refer to F684, F689 Review of R1's clinical record and the 1/13/22 fall incident documentation revealed: 1/13/22 at 1 AM - R1, a resident with dementia with a BIMS of zero (severe cognitive impairment), fell out of bed and sustained a visual head injury. 1/13/22 at 2 AM - A post-fall Pain Evaluation Tool, completed by E14 (LPN, 11PM to 7AM Supervisor) documented that R1's Site and intensity of pain unknown, resident moaning slightly . Review of R1's January 2022 eMAR revealed that R1 was not administered PRN Tylenol at any time after her fall out of bed nor after E14's pain evaluation of R1 moaning at 2 AM. 2/8/22 at 10:38 AM - During an interview, E15 (RN) stated that she applied a cold compress to R1's forehead to reduce the swelling. While E15 stated that R1 had no pain during her assessments, this contradicted E14's (LPN, 11PM to 7AM Supervisor) pain assessment at 2 AM when R1 was moaning. 2/9/22 at 2:15 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E3 (Director of Clinical Services), E4 (RN Risk Manager) and E13 (RN Supervisor).

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32545 Based on interviews and review of the clinical record, it was determined that for one (R1) out of three residents reviewed for accidents, the facility failed to have nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure R1's safety after a fall on 1/13/22. In addition, the facility failed to provide facility orientation to agency staff before providing direct care to residents. Findings include: Cross refer to F580, F684, F689 1a. As a result of R1's 1/13/22 fall incident, the facility's investigation revealed: -E14 (LPN, 11PM to 7AM Supervisor) lacked the skill set to recognize an emergent situation with a resident on an anticoagulant with a visual head injury, document her observations and ensure that E15 (RN) followed through with contacting the Physician and followed the facility's fall policy and procedure. E14 confirmed that she did not receive Supervisor training despite being the supervisor on the 11 PM to 7 AM shift when R1 fell on [DATE] and sustained significant injuries. -E15 (RN) failed to recognize an emergent situation and thoroughly assess R1, a resident with dementia, on the floor after an unwitnessed fall with a visual head injury while on anticoagulant medication. In addition, E15 failed to perform thorough, timely neurological checks and failed to notify the Physician/family immediately for a change in R1's condition. -E16 (CNA) and E17 (agency CNA) improperly transferred R1 by picking her up with their hands when they both were aware that she was a hoyer lift. 1b. As an incidental finding from R1's 1/13/22 fall incident, the facility's assessment was reviewed and lacked details of both facility and agency staff training and competencies. In addition, the facility failed to have a process ensuring that agency staff were oriented to the facility's policies and procedures before providing direct care to residents. 2/8/22 at 3:50 PM - During an interview, E6 (SDE/ICP) confirmed that the facility's last full competencies occurred before she became Staff Development Educator, which was in November 2019. E6 also confirmed that the facility does not have any agency orientation in place before agency staff are placed on the floor to work with the residents. E6 showed the Surveyor that the facility was currently working on a binder for agency orientation. When asked about Supervisor training, E6 stated that she was not involved and deferred to the DON. E6 confirmed that she was currently conducting fall training with all staff (including agency staff) as a result of the 1/13/22 incident with R1. 2/9/22 at 2:15 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E3 (Director of Clinical Services), E4 (RN Risk Manager) and E13 (RN Supervisor).

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 32545 Based on interview and review of the Facility Assessment, it was determined that the facility failed to include the following: the use of contract personnel, as well as their education and/or training and any competencies related to resident care; contracts with third parties to provide services; and staff competencies that are necessary to provide the level and types of care needed for the resident population. Findings include: 2/1/22 - Upon request by the Surveyor, the facility provided a two page roster of agency personnel, Nurses and CNAs with hire dates that provided care to residents in the facility from 1/1/21 through the present day. The roster listed seven (7) staffing agencies supporting the facility at the present time. The facility's assessment lacked evidence of the use of and contracts with seven staffing agencies, the agency's personnel training/education and any competencies related to resident care; and the facility's staff competencies that were necessary to provide the level and types of care needed for the resident population. According to the facility assessment, the QAA Committee reviewed it on 7/30/2021. 2/9/22 at 12:40 PM - During an interview, the facility's assessment missing the above listed components was discussed with E1 (NHA). No further information was provided to the Surveyor. 2/9/22 at 2:15 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E3 (Director of Clinical Services), E4 (RN Risk Manager) and E13 (RN Supervisor).

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 40264 Based on interview and review of facility documentation as indicated, it was determined that the facility failed to ensure that required training on dementia care was completed for one (E16) out of 11 randomly sampled staff members. Findings include: Review of E16's personnel records revealed: 8//5/13 - The first day of assignment at the facility for E16 (CNA). 2/9//22 at 9:30 AM - In an interview, E1 (NHA) confirmed that E16 did not receive her dementia care training. Findings where reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 2/9/22 beginning at 1:51 PM.