STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105965	A. Building B. Wing	08/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capri Health and Rehabilitation Center	1450 East Venice Avenue Venice, FL 34292

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25618 Based on observation, record review, review of policy and procedure, resident and staff interview, the facility failed to have documentation of an interdisciplinary evaluation to determine the ability to safely self-administer medications for 1 (Residents #144) of 3 residents observed with unsecured medications at the bedside. The findings included: The facility's Medication Administration: Self-Administration of Medications policy dated 11/2017 stated the purpose of the policy is to provide guidance for the patients, wishing to self-administer medications. The policy stated the resident has the right to self-administer medication if the interdisciplinary team (IDT) has determined the medication(s) is clinically appropriate, the resident's cognitive status, the resident's capacity to follow directions of when the medication needs to be taken, the safety and appropriateness of the medication(s), and the resident's ability to ensure the medication(s) are stored safely and securely after use. The decision to allow a patient to self-administer medication(s) is subject to periodic assessment by the IDT based on changes in the resident's medical and decision-making status. On 7/24/22 at 12:09 p.m., observed one Fluticasone Propionate (Flonase) 50 micrograms nasal spray, two Albuterol Sulfate HFA inhalers, and one tube Nystatin Triamcinolone Acetonide (antifungal) cream unsecured on Resident #144's bedside table. The medications did not have a pharmacy label on them with the resident's name, the name of the medication with directions for use, and/or any other pertinent information. On 7/24/22 at 12:11 p.m., Resident #144 said, she was admitted to the facility several weeks ago and the nurse told her she could use the nasal spray and inhalers when she needed them. She said she was not given directions for the use of the medications and was not told she needed to keep the medications secured at all times. She said she keeps the medications on the bedside table, even when she is not in the room. On 7/25/22 at 1:34 p.m., observed one Fluticasone Propionate 50 mcg nasal spray, two Albuterol Sulfate HFA inhalers, and one tube Nystatin Triamcinolone Acetonide cream unsecured on Resident #144's bedside table. Resident #144 was not in her room during the observation. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #144's clinical record revealed she was admitted to the facility on [DATE]. The physician orders dated 7/8/22 included Albuterol Sulfate HFA, two puffs inhale every six hours as needed for shortness of breath and wheezing and Fluticasone Propionate 50 mcg, two sprays in both nostrils every 24 hours as needed for allergies. The clinical record lacked documentation the interdisciplinary team (IDT) evaluated and determined it was clinically appropriate for Resident #144 to self-administer the Fluticasone Propionate, the Albuterol Sulfate inhaler or applying the Nystatin Triamcinolone Acetonide cream. On 7/25/22 at 2:45 p.m., Registered Nurse (RN) Staff K said she has been working at the facility for five months and is Resident #144's nurse. She said some of the residents are allowed to self-administer their medications and keep them at their bedside. She said she was aware Resident #144 had medications in her room, which she can take at any time when she thinks she needs too. She said she didn't know the facility's policy related to residents' self-administering their medications and how the medications should be stored in the resident's room. On 7/25/22 at 2:50 p.m., a joint observation of Resident #144's room with RN Staff K revealed the bottle of Fluticasone Propionate, the two Albuterol inhalers and the tube of Nystatin Triamcinolone cream remained stored, unsecured on the resident's bedside table. RN Staff K verified the medications were unlabeled. RN Staff K said she did not document when the resident used the medications or if they were effective.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905 Based on observation and staff interview the facility failed to ensure a safe, functional, and comfortable environment for residents in 9 (room [ROOM NUMBER], 226, 227,228, 229, 231, 232, 239, 230) of 31 rooms observed by failure to store personal items in a sanitary manner, failure to repair walls and peeling wallpaper, failure to secure exposed cable wires. The findings included: Review of Promedica Senior Care AM Care procedure- #19 Return equipment to designated area and clean/dispose as indicated. #20 Verify that personal items are stored separately in closed, labeled containers. On 7/24/22 at 10:12 a.m., observation revealed an uncovered, unlabeled wash basin was sitting on the toilet of bathroom [ROOM NUMBER]. On 7/24/22 at 10:15 a.m., observation revealed several personal care items including bed pans and wash basins were unlabeled and uncovered in bathroom of room [ROOM NUMBER]. One bedpan was on the floor, one bedpan was tucked between the grab bar and wall behind the toilet and 2 wash basins were sitting on the toilet. On 7/24/22 at 10:29 a.m., observation revealed an uncovered specimen collection item used to collect urine and/or feces was wedged between the grab bar and wall in the bathroom of room [ROOM NUMBER]. An uncovered wash basin was on the floor between the wall and toilet of room [ROOM NUMBER]. On 7/24/22 at 10:54 a.m., observation revealed an uncovered, unlabeled wash basin was in the sink of the bathroom of room [ROOM NUMBER]. An uncovered emesis basin was uncovered and unlabeled sitting on the back of the toilet. On 7/24/22 at 11:36 a.m., observation revealed several personal care items were wedged between the grab bar and the wall in the bathroom of room [ROOM NUMBER]. The items contained 2 wash basins and a bed pan. The items were not covered or labeled. On 7/24/22 at 11:55 a.m., observation revealed a bedpan, and two wash basins were unlabeled and uncovered in the bathroom of room [ROOM NUMBER]. On 7/24/22 at 12:03 p.m., observation revealed an uncovered and unlabeled bedpan and wash basin were wedged between the wall and the toilet of the bathroom of room [ROOM NUMBER]. There was another bedpan uncovered and sitting in the corner on the floor. On 7/24/22 at 4:18 p.m., room [ROOM NUMBER] was observed to have peeling wallpaper above the floor molding and an unsecured cable wire protruding from the wall. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/24/22 at 5:00 p.m., observation revealed the cold water in bathroom [ROOM NUMBER] did not function properly. Faucet turns and opens wide, but cold water comes out in only a small trickle. On 7/24/22 at approximately 5:01 p.m., in an interview, the Resident in 239A said she likes to rinse her hair with cold water and cannot do that. She said she told staff. She said it has been that way for a while. On 7/24/22 at 5:20 p.m., Observation revealed peeling paint and several unpatched holes above the television in room [ROOM NUMBER]. On 7/25/22 at 9:06 a.m., second observation of the uncovered bed pan wedged between the grab bar and wall, basin uncovered on the toilet and bed pan uncovered on the floor in room [ROOM NUMBER]. On 7/25/22 at 9:12 a.m., second observation of the uncovered urine/feces collection container uncovered and wedged between the toilet and the wall in room [ROOM NUMBER]. On 7/27/22 at 4:32 p.m., third observation of room [ROOM NUMBER] with two bedpans, two basins and measuring cylinder. During this observation, the items were stacked and sitting on the floor. On 7/27/22 at 4:33 p.m., third observation of room [ROOM NUMBER] with urine/feces specimen collection container uncovered and wedged between the wall and the grab bar. The wash basin remained uncovered behind the toilet on the floor. On 7/29/22 at 2:39 p.m., the Administrator and Director of Nursing said they were aware of the storage issue for personal care items. On 7/29 at 2:44 p.m., the maintenance director said his routine for maintenance and repair include checking the computer. He said staff and residents also let him know of repair and maintenance issues when they see him in the hall, or they call him. He confirmed the cold water was not working in room [ROOM NUMBER] and he would tend to that immediately. He agreed the cable wire was an easy fix and he would take care of that. He agreed the peeling wallpaper should be corrected also.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905 Based on interviews and record reviews, the facility failed to report alleged violations which could constitute neglect, resulting in serious bodily injury for 4 residents (#20, #85, #292, and #392) of 9 residents reviewed. The findings included: The facility's policy titled Patient Protection, Abuse, Neglect, Mistreatment, and Misappropriation Prevention dated 10/2021 noted neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury to the Administrator of the facility and to other officials including to the State Survey Agency. 1. On 7/24/22 at 10:33 a.m., Resident #20 said a Certified Nursing Assistant (CNA) rolled her out of bed, she fell on the floor, and broke her nose. Resident #20 said the CNA was changing her brief and when the CNA rolled her to her side, she rolled out of bed onto the floor. She said she told the CNA she was too close to the edge, but she rolled her anyway. She said she landed on her stomach and face and suffered a broken nose. Review of the medical record for Resident #20 revealed a general progress note dated 1/22/22 at 6:14 p.m. describing Resident #20's fall. Resident #20 was being assisted with toileting and she rolled out of bed landing on her stomach and face, 911 called as well as Medical Doctor (MD), Director of Nursing (DON), and son. Review of the Hospital Record for Resident #20 Indicated Resident #20 was admitted to the hospital on 1/22/22 at 5:05 p.m. and discharged on [DATE] at 3:17 a.m. Discharge Diagnosis included: Closed fracture of the nasal bone; Contusion of left wrist. Review of the facility fall log listed Resident #20 as having a fall with major injury on 1/22/22. Review of the facility reportable events for 2022 did not list Resident #20's fall as being reported to the State Survey Agency. Review of the facility incident report and investigation for Resident #20's fall did not include an immediate or 5-Day report to the State Agency. On 7/26/22 at 4:09 p.m., the Administrator confirmed she did not report Resident #20's fall on 1/22/22 to the State Agency. The Administrator confirmed a broken nose would be considered a serious injury and should have been reported to the State Survey Agency. On 7/26/22 at 4:09 p.m., the Director of Nursing (DON) said he did not report it. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the medical record for Resident #392 revealed a progress note on 5/19/22 at 4:02 a.m. indicating Resident #392 fell in her room at the facility. She was found on the floor, sustained a bump to the back of the head, and was transported to the hospital. Review of the facility handwritten incident report dated 5/19/22 indicated Resident #392 was found on the floor next to her bed at 3:30 a.m. The writer noted a large bump to the back of the resident's head, called the MD, family, and Emergency Medical Services for transport to the emergency room . On 7/28/22 at 9:09 a.m., the DON said when a resident falls, the incident is discussed in the Eagle Room Morning Meeting. The DON could not provide documentation verifying the incident for Resident #392's fall was reported to the State Survey Agency. 45645 3. On 7/24/22 at 2:54 p.m., Review of clinical records for Resident #85 revealed resident admitted on [DATE] with diagnosis of End Stage Renal Disease, anemia. Upon admission, Resident #85 was assessed at risk for falls and care planed. The progress note dated 2/5/22 at 4:19 p.m., noted, CNA went into residents [sic] room and noted that she was lying on the floor in front of the foot of the bed. When nurse went in, she was sitting on her buttocks with knees slightly bent, on the floor at the foot of her bed . The nurse documented she assisted the resident to a standing position. Resident #85 could barely bear any weight on her left leg and complained of pain. The resident was sent to the hospital for evaluation and treatment. The hospital record dated 2/5/22 noted Resident #85 was diagnosed with a left femoral neck fracture, left wrist fracture, left facial abrasion and contusion. The incident report dated 5/14/22 at 10:20 a.m. noted Resident #85 was observed on the floor laying on her right side in front of the wheelchair and the air conditioner. The resident was awake and alert and stated, I slid off the w/c (wheelchair). The resident was sent to the hospital for evaluation and returned with a diagnosis of acute head injury. On 7/26/22 at 11:42 a.m., the Administrator said Resident # 85's falls were not reported to State Survey Agency as required. 4. On 7/27/22 at 2:58 p.m., a review of the facility's incident log showed Resident #292 was admitted on [DATE] and sustained a fall at the facility on 6/11/22. The Admission Minimum Data Set (MDS) assessment with a target date of 6/16/22 showed Resident #292 had severe cognitive impairment and was not able to call for assistance. Diagnoses included traumatic brain injury, and a history of fall in the last month prior to admission. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident was assessed during admission to be at high risk for falls. A care plan for falls was developed due to history of falls, recent falls with head injury, poor safety awareness, new environment, and weakness. The incident report created on 6/13/22 at 1:10 p.m. indicated Resident #292 was found lying on the floor with a serious injury, a head wound actively bleeding. Resident #292 was sent out to the hospital for evaluation and returned on 6/13/22 with staples to his head and a diagnosis of unspecified fall. On 7/28/22 at 3:00 p.m., the DON said the facility did not report the incident to the State Survey Agency as required.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45645 Based on record reviews and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the areas of discharge status, fall and elopement device use for 2 (Resident #94 and #52) of 13 reviewed for MDS accuracy. The findings included: The Resident Assessment Instrument manual (October 2019) noted identification of residents who are at high risk of falling is a top priority for care planning. A previous fall is the most important predictor of risk for future falls. Falls are a leading cause of morbidity and mortality among nursing home residents. The steps for assessment noted to review nursing home incident reports, fall logs and the medical record. Code one if the resident had one non-injurious fall since admission or reentry or prior assessment. 1. On 7/24/22 at 4:04 p.m., Clinical review indicated Resident #52 admitted on [DATE] with diagnosis of Dementia, Essential tremors, and repeated falls. On 7/24/22 at 4:15 p.m., review of fall assessment revealed Resident #52 had a fall on 5/29/22 at 7:59 a.m. The quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 6/10/22 failed to code the fall. On 7/26/22 at 8:53 a.m., MDS Registered Nurse (RN) staff D said the fall of 5/29/22 should have been coded under Section J of the quarterly with ARD 6/10/22. The quarterly Minimum Data Set (MDS) with assessment reference date (ARD) of ARD 6/10/22 also noted Resident #52 used a daily wander/elopement alarm. Review of physician's order showed Resident #52 elopement alarm was discontinued on 3/28/22. On 7/26/22 at 10:11 a.m., MDS coordinator RN Staff A reviewed Resident #52's clinical record and said the elopement alarm was discontinued on 3/28/22. She verified the quarterly MDS assessment was not accurate as Resident #52 did not use an elopement alarm. On 7/28/22 at 9:36 a.m., RN MDS Staff D said the MDS assessment is expected to give an accurate view of the resident's clinical condition and services required so problems can be addressed in the plan of care. 41155 2. On 7/28/22 review of the Discharge MDS with an assessment reference date of 5/2/22 documented Resident #94 had a planned discharge to an acute care hospital. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #94's clinical record showed a nursing progress note dated 5/2/22 which documented the resident discharged home with husband. Home health to do home visits. The resident escorted to her vehicle with spouse. On 7/28/22 at 11:05 a.m., the MDS coordinator reviewed the discharge MDS and confirmed Resident #94 was coded as a discharge to acute hospital. The MDS coordinator verified Resident #94 was discharged home with her spouse. She said the MDS was not coded correctly.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25618 Based on observation, record review, staff and resident interview, the facility failed to ensure 1 (Residents #80) of 1 resident's activity program reviewed had received and/or engaged in their activities of choice as identified in their activity/recreational assessment. The failure to ensure each resident is engaged in an activity program of their choice has a potential to cause loneliness and mental anguish for the resident. The findings included: On 7/24/22 at 9:56 a.m., Resident #80 was observed in his bedroom in a hospital gown not involved in an activity program. Further observation noted the television (TV) was not on nor was there a radio playing music for Resident #80. On 7/24/22 at 10:00 a.m., in an interview, Resident #80 said there is nothing to do at the facility and he doesn't remember the last time he had been invited and/or attended an activity program. On 7/24/22 at 1:00 p.m. and 3:00 p.m., Resident #80 was observed in his bedroom wearing a hospital gown not involved in an activity program. Further observation noted the TV was not on nor was there a radio playing music for Resident #80. On 7/25/22 at 9:00 a.m. and 2:10 p.m., Resident #80 was observed in his bedroom wearing a T-shirt not involved in an activity program. Further observation noted the TV was not on nor was there a radio playing music for Resident #80. On 7/26/22 at 8:30 a.m., 9:34 a.m., and 3:10 p.m., Resident #80 was observed in his bedroom wearing a hospital gown not involved in an activity program. Further observation noted the TV was not on nor was there a radio playing music for Resident #80. On 7/27/22 at 8:20 a.m., 10:24 a.m., and 2:50 p.m., Resident #80 was observed in his bedroom wearing a hospital gown not involved in an activity program. Further observation noted the TV was not on nor was there a radio playing music for Resident #80. On 7/28/22 review of Resident #80's medical record revealed an initial admitted [DATE] and was discharge from the nursing home on 5/09/22. Resident #80 was readmitted to the nursing home on 6/20/22, was discharged to the hospital on 7/07/21 and returned to the nursing home on 7/21/22. Resident #80's admission assessment dated [DATE] stated Resident #80 had a BIMS (Brief Interview for Mental Status) Score as a 10, a score between 8 to 12 means a person was assessed as moderately cognitively impaired for daily decision making. An activity progress note dated 4/14/22 stated Resident #80 is friendly and is easy to talk too. Resident #80 enjoyed leisure activities such as country music, sitting outdoors, reading the newspaper and magazines, time with friends, watching sports and news on the TV and playing cards. Further review of Resident #80's medical records did not reveal an activity program had been implemented on a continuous basis for Resident #80. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/28/22 review of the Activity and Recreation Service Manual dated 7/2019, stated the purpose of the manual is to serve as a guide in providing an ongoing program of activities designed to accommodate individual patient interest and help enhance physical, mental, and psychosocial well-being. The activity and recreation progress notes are developed to include changes in patient's condition and or progress toward the care plan goal and approaches. The section for readmission activity progress note stated it should include but not limited to the reason the patient left the facility, patient's condition upon return to the facility, and the impact on the patient's participation level in activity programming or recreational therapy treatment. Activity program participation documentation should be completed for each patient in the facility. The activity program participation documentation provided the facility with written information of the patient's interest in both facility-sponsored group, one-to-one, friendly visits, individual and independent activities. On 7/28/22 at 3:22 p.m. in an interview, the Activity Director (AD) said the nursing home is a 129-bed facility and currently she was the only person who ran/conducted the activity program during the week, Monday through Friday and a relief activity aide who worked the weekend. She said part of her job duties were to attend all the resident care plan meetings, run the resident council meetings, go shopping for the facility residents as needed and complete a resident activity assessment for all new admission, re-admission, and quarterly assessments as needed. The AD said after she reviewed Resident #80's medical record and confirmed Resident #80 was initially admitted to the facility on [DATE] with a last re-admitted [DATE]. She confirmed her last activity assessment progress note was dated 4/14/22 which stated Resident #80 enjoys leisure activities, country music, sitting outdoors, reading the newspaper and magazines, time with friends, and watching sports and news on the TV. She said she was unable to find documentation she had completed a re-admission activity assessment after each readmission to the facility. The AD further said she was unable to find documentation Resident #80 had attended and/or engaged in any of the activities noted in the 4/11/22 activity progress note, as required per their Activity and Recreation Service Manual.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 45645 Based on record review, review of facility's policy and procedure, staff, and resident interview the facility failed to implement a systemic approach to identify risk factors and implement appropriate interventions to prevent avoidable fall related serious injuries for 5 (Resident #20, #85, #193, #392, and #292) and 2 (Resident #27, and #192) with multiple falls, of 10 residents sampled with falls or fall related injuries. Resident #20 was admitted to the facility on [DATE] and was dependent on staff for repositioning. On 1/22/22 the resident rolled out of bed during care and sustained a nasal bone fracture. Resident #85 was admitted to the facility on [DATE] and was assessed to be at risk for falls. On 2/5/22 and 5/14/22 the resident sustained a fall resulting respectively in a fractured hip and wrist and acute head injury. Resident #193 was admitted to the facility on [DATE] after a fall, and repair of right hip fracture. On 1/10/22 the resident sustained a fall resulting in a dislocation of the right hip prosthesis. Resident #292 was admitted to the facility on [DATE]. The resident was assessed to be at risk for falls. On 6/11/22 the resident was sent to an acute care hospital after he was found on the floor with a head wound actively bleeding, requiring staples. Resident #27 was admitted to the facility on [DATE]. Resident #27 was assessed to be at risk for falls. Resident #27 sustained 12 unwitnessed falls from 2/9/22 through 5/23/22. Resident #192 was admitted to the facility on [DATE] with a history of falls with injury. Resident #192 sustained eight unwitnessed falls, including four falls on 5/31/22. The facility's failure to implement systemic interventions to prevent avoidable falls and fall related serious injuries resulted in noncompliance at the Immediate Jeopardy level starting on 4/20/22. On 7/30/22 at 6:29 p.m., the Administrator was informed of the determination of ongoing Immediate Jeopardy and provided the Immediate Jeopardy templates. The findings included: Cross reference: F835 and F867. The facility's fall policy revised 2/18/22 noted the facility, perform a post fall assessment to determine the root cause of the fall. Gather assessment data from the patient, staff members, and any witnesses to the fall. Review the events that proceeded the fall and contributing factors. After a fall, complete a detailed incident report to help track the frequency of the patient's fall so that the facility can implement prevention measures with high-risk patients. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. On 7/24/22 at 2:54 p.m., Review of the clinical record for Resident #85 showed an admitted [DATE] with diagnoses of End Stage Renal Disease, and anemia. Upon admission, Resident #85 was assessed to be at risk for falls and a care plan developed. The care plan for falls initiated on 10/31/20 noted the resident was at risk for falls due to history of falls, impaired balance, poor coordination, and unsteady gait. The goal was to minimize risk for falls. The interventions included to encourage to transfer and change positions slowly, have commonly used articles within easy reach, provide assistance to transfer, reinforce, re-educate and remind patient of the need to call for assistance and use call light. The Annual Minimum Data Set (MDS) assessment with a target date of 11/17/21 noted Resident #85 was cognitively intact. The discharge from therapy MDS with an assessment reference date of 11/26/21 noted Resident #85 required supervision or touching assistance (Helper provides verbal cues or touching/steadying assistance) for walking as resident completes activity. The progress note dated 1/28/22 at 11:36 a.m., noted, Staff reports that resident states that while reaching for a stuffed animal resident sat herself on the floor . The note did not describe the location of the fall. Review of the incident report created on 2/1/22 (4 days after the fall) at 11:18 a.m., showed on 1/28/22 at 11:00 a.m., Staff reports that resident states that she was reaching for a stuffed animal and sat herself on the floor. The investigation report did not contain any witness statements, or a review of the events that proceeded the fall and contributing factors. The incident investigation did not document if the fall interventions were in place at the time of the incident or interventions implemented to prevent recurrence. The progress note dated 2/5/22 at 4:19 p.m., noted, CNA went into residents [sic] room and noted that she was lying on the floor in front of the foot of the bed. When nurse went in she was sitting on her buttocks with knees slightly bent, on the floor at the foot of her bed . The nurse documented she assisted the resident to a standing position. Resident #85 could barely bear any weight on her left leg and complained of pain. The resident was sent to the hospital for evaluation and treatment. The incident and investigation report dated 2/5/22 at 3:57 p.m. did not document people interviewed during the investigation, a timeline of critical events, actions taken during the investigation, or a conclusion. The hospital record dated 2/5/22 noted Resident #85 said she came out of her room to walk down the hallway to check on someone who sounds like they were crying, she tripped and fell , she could not bear weight afterwards, and she hit her head. The resident was diagnosed with a left femoral neck fracture (part of the thigh bone), left wrist fracture, left facial abrasion and contusion. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #85 returned to the facility on [DATE]. Resident #85 received Physical, and Occupational Therapy. The care plan was not updated to include preventive measures to prevent recurrence of falls. The progress note dated 3/28/22 at 10:18 a.m., noted, Resident with a fall on 3/26/22. IDT (Interdisciplinary team) reviewed fall care plan and risk factors with interventions added. The incident report created on 3/28/22 at 8:36 a.m., (Two days after the fall) noted Date of incident: 3/26/22 2:00 PM. The housekeeper notified the nurse someone is on the floor. The writer observed the resident sitting on the floor in front of her wheelchair. On 3/28/22 at 10:55 a.m., the nurse documented, She [Resident #85] is able to tell the nurse she fell and how it happened. The note did not document the content of the interview with the resident. On 3/28/22 the care plan was updated to Provide resident with rest periods after meals/throughout the day as needed/desired. The investigative report dated 3/28/22 (two days after the fall of 3/26/22) was incomplete and did not document the content of the interview with the resident to determine the root cause of the incident and ensure the interventions listed on the care plan were appropriate to prevent recurrence of avoidable falls and fall related serious injuries. On 3/31/22 at 9:59 a.m. a progress note documented, Resident with a fall on 3/30/22. IDT reviewed fall care plan and risk factors with intervention added. The incident report created on 3/31/22 at 9:35 a.m. noted, Date of incident 3/30/22 at 12:00 p.m. Resident was observed sitting on floor in front of wheelchair. Resident stated she was attempting to get up on her own. Call light within reach and not activated, gripper socks [anti-skid socks] in place. Wheelchair locks engaged and bed in low position. On 3/31/22 the care plan was updated to assist and encourage resident to have her lunch meal in the Dining Room. The investigation report was not completed. It did not include a root cause analysis to determine if the intervention added to the care plan was appropriate to prevent further avoidable falls. On 5/14/22 at 10:20 a.m., an incident report noted Resident #85 was observed on the floor laying on her right side in front of the wheelchair and the air conditioner. The resident was awake and alert and stated, I slid off the w/c (wheelchair). The investigation report was not completed. The resident was sent to the hospital for evaluation and returned with a diagnosis of acute head injury. The care plan was updated on 5/16/22 (two days after the fall with serious injury) to include a Dycem (anti slip material) to the wheelchair seat. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 7/26/22 at 2:23 p.m., the Assistant Director of Nursing (ADON) said it is the facility process to complete a fall investigation. The ADON said Resident # 85 was independent prior to her fall of 2/5/22 and has not been able to ambulate on her own since sustaining those injuries. On 7/26/22 at 4:06 p.m., the Minimum Data Set (MDS) Registered Nurse Staff D said that prior to fall of 2/5/22, Resident #85 required supervision to independence with all functional status. As of last MDS assessment completed on 7/1/22, the resident has declined and requires extensive assistant with all functional mobility and is no longer ambulatory. RN Staff D said despite therapy, Resident #85 has not regained her prior level of function. On 7/26/22 at 2:54 p.m., the Rehabilitation Director said Resident #85 received therapy after her fall with major injuries on 2/5/22. The resident was discharged from therapy on 7/1/22 at a maximum assist to dependent with some functions. 2. Resident #292 was admitted to the facility on [DATE]. The Admission MDS assessment with a target date of 6/16/22 noted the resident had severe cognitive impairment. Resident #292 required extensive physical assistance of one person for bed mobility and extensive assistance of two persons for transfer (how resident moves to or from bed, chair, wheelchair, standing position). The diagnoses included traumatic brain injury. The resident's vision was highly impaired and did not wear corrective lenses. The care plan created on 6/13/22 noted the resident was at risk for falls due to a history of falls, recent falls with head injury, poor safety awareness, new environment, and weakness. On 6/11/22 the facility noted in an incident report, Resident observed lying on the floor with a head wound actively bleeding. He had been placed in w/c [wheelchair] 5 min (minutes) prior d/t (due to) climbing OOB (Out of bed). Resident #292 was sent out to the hospital and returned on 6/13/22 with staples to his head and a diagnosis of unspecified falls. The care plan updated on 6/13/22 noted to, assist with and encourage use of non-skid footwear, non-skid socks in and out of bed. The investigation report was not completed. It did not include a root cause analysis to determine if the intervention added to the care plan was appropriate to prevent further avoidable falls. On 6/14/22 at 12:40 p.m., the facility noted in an incident report, Pt [patient] fell next to bathroom door ambulating without assistive device. The nurse completing the incident report noted the resident sustained a skin tear to the right hand. The care plan was updated on 6/14/22 to assist the resident with toileting and/or provide incontinence care upon rising, before/after meals, at bedtime and as needed. One on one care/observation with staff as needed/indicated. The investigation report for the fall of 6/14/22 was not completed. It did not include an investigation, conclusion to determine the root cause of the incident to ensure the interventions were appropriate to prevent further avoidable falls. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 7/29/22 at 3:00 p.m., the Administrator and the Director of Nursing (DON) said the interdisciplinary team IDT reviewed the falls every morning and afternoon, Mondays through Fridays through the Eagle Room process. The Eagle Room process consists of a check list to ensure the following areas were completed after a fall: Neurological checks, Medication review, Notification of MD and family, electronic incident report, Investigation complete, reportable, fall evaluation completed, Pain evaluation completed, Referral or new intervention, Calcium and Vitamin D protocol, root cause (IDT) management document, care plan and task list (updated). The DON could not provide additional information indicating an investigation to determine root cause of the falls. 25618 3. On 7/28/22 review of Resident #27's medical record revealed he was admitted to the facility on [DATE]. The admission assessment dated [DATE] assessed Resident #27 to have a BIMS score of 11, a score between 8 to 12 means a person was assessed with moderately impaired cognition for daily decision making. Resident #27 admitting diagnoses included anxiety disorder, unspecified cerebral infarction, cognitive communication deficit, and a history of repeated falls. Further review of Resident #27's medical record revealed a fall care plan created on 2/4/2022 stating Resident #27 was at risk for falls due to weakness, confusion, poor safety awareness, resident placed himself on the floor and would slide out of bed and chair. The facility's goal for falls is the facility would minimize the risk of injury related to falls and decrease the number of falls, with a target date of 9/03/2022. The fall care plan interventions stated they would assist and encourage the resident to be up and out of bed and room daily for supervised activities and dining (4/25/2022), assist Resident #27 with toileting, and/or provide incontinence care upon rising, before/after meals and bedtime (3/11/2022), assist with and encourage the use of non-skid footwear (4/20/2022), bed in low position (2/14/2022), Dycem/anti-slip material to wheelchair seat (2/14/2022), encourage resident to be up in chair daily for breakfast (2/28/2022), encourage resident to attend supervised activity (4/08/2022), encourage to transfer and change position slowly (2/17/2022), follow-up with psychiatric Nurse Practitioner (NP) post 4/16/22 fall (4/18/2022), have commonly used articles within easy reach (2/04/2022), implement use of preventative devices for falls (5/24/2022), medication review with physician, NP and pharmacy consultant (4/18/22), monitor positioning while in bed to ensure safety and reposition as needed in bed (5/06/2022), provide assist to transfer and ambulate as needed (2/04/2022), provide stuffed animal while up in wheelchair and in bed for comfort and happiness (4/01/2022), psychiatric service consult related to sliding out of bed and chair behaviors (2/17/2022), reinforce need to call for assistance (2/04/2022), reinforce wheelchair safety as needed (2/27/2022), and the use of a STOP sign to help prompt/cue Resident #27 to call for assistance related to frequent falls (3/07/2022). A review of Resident #27's Incident Report and Investigation Report forms revealed Resident #27 from his admission on 2/04/2022 to 5/23/22 had 12 unwitnessed falls with no major injury. The incident Report created on 2/9/2022 stated Resident #27 was sitting on the floor in front of his wheelchair during lunchtime on 2/09/2022 at 1:00 p.m. with no injuries. The incident and investigation report dated 2/09/2022 said they took his vital signs, did a full assessment, and started neurological (neuro) checks. The incident and investigation report dated 2/09/2022 did not document the facility staff they interviewed during the investigation, timeline of critical events, actions taken during the investigation, or conclusion of their investigation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The incident Report created on 2/11/2022 stated Resident #27 was observed on the floor next to his bed on 2/10/2022 at 11:30 p.m. with no injuries. The incident and investigation report dated 2/11/2022 said they put Resident #17 back to bed, took his vital signs, and started neuro checks. The incident and investigation form did not document the name of the staff interviewed during the investigation, timeline of critical events, actions taken during the investigation, or conclusion of their investigation. The incident Report created on 2/16/2022 stated Resident #27 was observed next to his bed on 2/16/2022 at 6:15 p.m. with no injuries. The incident report stated Resident #27 told the nurse he rolled out of bed. The incident report investigation stated resident was wearing his non-skid socks, the bed was in a low position, the bedside table with fluid was in reach of Resident #27, and Resident #27 was last seen by nursing staff at 5:45 p.m. The incident and investigation report dated 2/16/2022 did not document the name of the staff interviewed during the investigation, the timeline of critical events, and the conclusion of their investigation. The incident report created on 2/23/2022 stated Resident #27 was observed on the floor next to his bed on 2/23/2022 at 6:32 a.m. with his pillow and blanket, with no injuries. The investigation revealed Resident #27's nurse said Resident #27 had yelled out multiple times during the shift, and when the nurse went into his room the resident was on the floor with his pillow and blanket covering him. Resident #27 told the nurse he placed himself on the floor. The investigation said the nurse did neuro checks, a full assessment, vital signs, and assisted the resident back into bed. The incident and investigation report dated 2/23/2022 did not document the name of the staff interviewed during the investigation, and the conclusion of their investigation. The incident report created on 2/27/2022 stated Resident #27 was observed on the floor next to his bed on 2/27/2022 at 5:45 a.m., with no injuries. The investigation stated Resident #27's nurse said they observed Resident #27 was on the floor next to his bed without injuries. She assisted Resident #27 back to bed, did a full assessment, and started five minutes neuro checks. She further said she had seen Resident #27 five minutes earlier in his bed resting quietly at 5:40 a.m. The incident and investigation report dated 2/27/2022 did not document the name of the staff interviewed during the investigation, and the conclusion of their investigation. The incident report created on 3/05/2022 stated Resident #27 was observed on the floor next to his bed on 3/05/2022 at 10:00 a.m., with no injuries. The investigation revealed Resident #27's nurse said she was notified by Resident #27's certified nursing assistant he was on the floor next to his bed without injuries. The resident was unable to state what happened but said he was not in pain. The nurse did a set of vital signs, initiated neuro checks, and put Resident #27 back to bed. The incident and investigation form did not document the staff interviewed during the investigation, the timeline of critical events, or the conclusion of their investigation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The incident report created on 3/10/2022 stated Resident #27 was observed on the floor during hourly rounds next to his bed on 3/10/2022 at 8:30 p.m., with no injuries. The investigation revealed Resident #27's certified nursing assistant said during her hourly rounds she found Resident #27 on the ground. Resident #27's nurse said they assisted Resident #27 back to bed, initiated neuro checks, started vital signs, and gave Resident #27 Tylenol for generalized pain. The investigation revealed Resident #27 had non-skid socks on, his call light was in reach, and the bedside table with fluids was in reach. The incident report said Resident #27 was unable to state what happened but said he was not in pain. The nurse did a set of vital signs and initiated neuro checks. The incident and investigation form did not document the name of the staff interviewed, the timeline of critical events, or the conclusion of their investigation. The incident report created on 4/01/2022 stated Resident #27 was observed next to his bed on the floor on 4/01/2022 at 5:00 a.m. with no injuries. The incident report stated Resident #27 said he did not know what happened when asked by the nurse. The investigation report said Resident #27's nurse started neuro checks, completed a full assessment of the resident, vital signs were completed, and Resident #27 was assisted back into bed. The incident and investigation report dated 4/01/2022 did not document the name of the staff interviewed during the investigation, and the conclusion of their investigation. The incident Report created on 4/08/2022 stated Resident #27 was observed on the floor next to his bed on 4/08/2022 at 10:56 a.m. with no injuries. The incident and investigation report dated 4/08/2022 said Resident #27 slid out of his bed onto the floor, and staff put him into his Geri chair (reclining chair). The nurse started vital signs and conducted a full assessment on Resident #27. The incident and investigation form did not document the name of the staff interviewed during the investigation, timeline of critical events, or conclusion of their investigation. The Incident report created on 4/16/2022 stated Resident #27 was observed sitting on the floor on 4/16/2022 at 7:31 a.m., with no injuries. The investigation revealed Resident #27's certified nursing assistant said they found Resident #27 on the ground next to his bed. Resident #27's nurse said she went to the room and asked the resident what happened, and he said he did not know. The incident report said Resident #27's nurse said his bed was in a low position, and he was sleeping when she did her rounds. The nurse did a set of vital signs and initiated neuro checks. The incident and investigation form did not document the name of the staff interviewed, the timeline of critical events, or the conclusion of their investigation. The incident report created on 5/05/2022 stated Resident #27 was observed on the floor next to his bed on 5/05/2022 at 8:00 p.m. with no injuries. The incident report investigation said Resident #27 was last seen by staff within fifteen minutes of the incident. The investigation said Resident #27's call light was within reach, beside table and fluids were within reach, he was wearing his gripper socks as required. The nurse started neuro checks, did a full assessment and staff assisted Resident #27 back to bed. The incident and investigation report dated 5/05/2022 did not document the name of the staff interviewed during the investigation, timeline of critical events, or conclusion of their investigation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 1/11/22 the Care Plan was updated for the resident to be encouraged to wear nonskid footwear and non-skid socks in and out of bed, and for the bed to be in a low position. There was no documentation as to why these interventions were put in place. On 7/27/22 at 4:29 p.m., the DON verified Resident #193 was interviewable. The DON said since there was no documentation of attempts to interview Resident #193 regarding the cause of the fall, he would not be able to determine the cause of the fall. 5. Resident #192 was admitted to the facility on [DATE] with history of falls with injury. The Admission MDS with a target date of 4/16/22 showed Resident #192's cognition was impaired. The resident required extensive physical assistance of two persons for bed mobility and transfers. A care plan initiated on 4/10/22 showed Resident #192 was a fall risk due to recent falls with fractures and surgery, weakness, cognitive impairment, and poor safety awareness. Review of incident report dated 4/29/22 at 11:10 a.m. for Resident #192 showed on 4/27/22 at 2:15 a.m., the nurse documented she was called to the resident's room by the Certified Nursing Assistant. The resident was observed lying on the floor besides the bed on the left side. The nurse documented she reminded the resident to use the call light and not get up unassisted. The fall evaluation dated 4/27/22 at 2:15 a.m., noted Resident #192 had impaired balance during transition, had impulsivity or poor safety awareness. The care plan for falls was updated to include to assist and encourage use of non-skid footwear, non-skid socks in and out of bed, bed in low position. There was no investigation to determine the root cause of the incident to ensure the interventions were appropriate to prevent further avoidable falls. Review of the incident report dated 5/3/22 showed on 5/3/22 at 11:10 a.m., Resident #192 was observed lying on the floor beside the bed. Bed was low to the floor upon discovery. The resident complained of severe back pain. The resident was sent out to the hospital via emergency medical services. The change in condition progress note dated 5/3/22 noted the resident returned from the hospital. A progress note created on 5/3/22 at 8:28 a.m. shows the MDS Coordinator documented Resident #192 returned from the hospital and that she would be monitored for a significant change for 14 days. The care plan was updated on 5/4/22 to include assist and encourage to be up in chair and ready for breakfast. There was no investigation to determine the root cause of the incident to ensure the interventions were appropriate to prevent further avoidable falls. (continued on next page)

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	105965	A. Building B. Wing	08/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capri Health and Rehabilitation Center	1450 East Venice Avenue Venice, FL 34292

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 5/16/22 after a fall the care plan was updated to implement use of preventative device: Bed pillows to help resident recognize edge of bed. Review of the incident report created on 5/31/22 showed on 5/30/22 at 11:30 p.m., the resident was found, sitting on floor. Unwitnessed fall. There was no documented investigation to determine the root cause of the incident. There was no documentation if the previous fall interventions were in place at the time of the fall. Review of the incident report dated 5/31/22 showed on 5/31/22 at 8:30 a.m., Resident #192 was observed on the floor besides her wheelchair in the cafe. She stated she was looking for her ID and slid out of her chair. There was no immediate intervention to prevent the resident from sliding out of her wheelchair. On 5/31/22 an incident report documented on 5/31/22 at 11:30 a.m., the resident was observed sitting on the floor beside her bed. She continues to report that she slid out of bed looking for her ID. There was no documentation if the previous interventions to prevent the resident from rolling out of bed were in place. There was no immediate intervention to prevent recurrence. On 5/31/22 at 3:30 p.m., an incident report documented Resident #192 was observed sitting on the floor between her wheelchair and over bed table. She slid out of the chair trying to pick up a puzzle piece. There was no investigation or immediate intervention to prevent recurrence. On 5/31/22 at 4:17 p.m., an incident report documented, Resident observed sitting on the floor beside her bed. She continues to report that she sled [sic] out of bed looking for her ID. There was no investigation or immediate interventions documented to prevent further avoidable falls and potential fall related injuries. All incident reports showed no investigation, and no actions taken for the resident's falls, no documented root cause of each incident. The resident was assessed for falls on 4/27/22, 5/14/22, and twice on 5/30/22. The four fall assessments completed by the facility show Resident #192 had an impaired balance. Resident #192 was taking cardiac medications, and narcotic analgesics. 41905 6. On 7/24/22 at 10:33 a.m., Resident # 20 said she was rolled out of bed by a Certified Nursing Assistant (CNA) who was changing her. She said she told the CNA she was too close to the edge of the bed, but the CNA did it anyway. Resident #20 said she fell off the edge of the bed and landed face down on the floor. Resident #20 said she sustained a broken nose from the fall. Review of the MDS with the ARD of 1/21/22 indicated Resident #20 required the assistance of 2 staff when she fell out of bed on 1/22/22 while being assisted by one CNA. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the care plans for Resident #20 revealed the intervention requiring 2 staff at all times for Activities of Daily Living (ADLs) which includes toileting needs, was not updated until 2/17/22. Review of the progress notes for Resident #20 revealed a progress note on 1/22/2022 indicating resident #20 had a fall at the facility and transported by Emergency Medical Services (EMS) to the hospital. The hospital discharge records dated 1/23/22 indicated Resident #20's nose was fractured at the facility where she fell out of bed. The incident report dated 1/22/22 for Resident #20's fall included witness statements from five CNAs who were not in the room at the time of the incident and one CNA in the room assisting the resident. On 7/27/22 at 3:56 p.m., the MDS coordinator responsible for assessing Resident #20 verified the 7-day look back for the MDS with assessment reference date of 1/21/22 indicated Resident #20 required two staff for bed mobility and toileting. On 7/26/22 at 4:09 p.m., the Director of Nursing (DON) confirmed there was only one CNA in the room helping Resident #20 at the time she fell . He said he provided training two days later on 1/24/22. The DON said if the staff were in the facility on that day he provided the training, he would have trained them however, it was not mandatory. Review of the staff training r [TRUNCATED]

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on record review, review of facility's policy and procedure, and staff interview, the facility failed to have documentation of consistent and accurate monitoring of fluid intake for 1(Resident #56) of 1 resident with a physician's ordered fluid restriction. The findings included: The facility policy Fluid Restrictions, Description and Rationale (8/2019) documented, Fluid restrictions are sometimes used for patients with renal failure, congestive heart failure and hyponatremia, or other condition requiring that intake of fluids be minimized. Specific total fluid restrictions are ordered by the physician and communicated to the dietary department. Developing a fluid restriction plan based on a patient's preference and physician order may assist in meeting the patient's hydration needs and compliance with physician's orders. Review of Resident #56's clinical record showed the resident was admitted on [DATE] with diagnoses of legal blindness, anxiety, edema, urinary tract infection and hypertension. Review of the Admission minimum data set (MDS) assessment dated [DATE] documented a weight of 118 pounds and a height of 64 inches. The MDS documented a brief interview for mental status score of 15, indicated the resident's cognition was intact. The MDS documented Resident #56 required supervision and set up at meals. Review of Resident #56's physician orders for July 2022, showed a physician order dated 6/25/22 for a 1500 ml fluid restriction per day. Review of the Dietary progress note dated 7/12/22, documented, a Fluid Restriction Worksheet has been completed for Resident #56. The total daily fluid Physician order is 1500 in milliliters (ml). The Dietary Daily Fluid total is 240 ounces. Please refer to the worksheet for the daily fluid allocation. Review of the Fluid Restriction Worksheet completed by the Registered Dietitian, dated 7/12/22, documented the total fluid allocation for nursing staff to administer was 780 ml per 24 hours, 240 ml for day and evening shift and 280 ml on the night shift. Dietary was to provide a 24-hour total fluid amount of 720 ml. On 7/24/22 at 2:08 p.m., Resident #56 was observed with her meal tray in her room. The dietary ticket read Resident on fluid restriction 8 oz (ounces) with each meal. The resident was observed during dining with a pint (16 ounces) of milk and a cup of coffee. On 7/28/22 at 3:59 p.m., the Registered Dietitian (RD) said Resident #56's meal ticket states 8 ounces (oz) at meals, and they give her milk which is what she wants. The RD said he does not keep a record of the actual amount of fluid Resident #56 consumed throughout the day and said the staff on the unit does that. The RD said the dietary staff only provide 8 ounces of milk on each meal tray and nothing else other than food. The RD said, if the resident asks for additional fluids like coffee, then it is her right, and she can have it. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/28/22 at 4:11 p.m., Licensed Practical Nurse (LPN) Staff P said she was the nurse assigned to Resident #56 and said the reason for the fluid restriction was due to hyponatremia (low blood sodium level). She said the CNAs know who is on restrictions and know not to give anything extra without asking the nurse. The CNAs do not give Resident #56 any fluid other then what is served on the meal tray. The LPN said the staff do not keep a record of the fluids the resident consumes each day. On 7/28/22 at 4:24 p.m., Resident #56 was observed in bed. A 16 ounces Styrofoam cup of ice water was observed on the bedside table within easy reach of the resident. Resident #56 said she knew she was on a fluid restriction, did not ask for the water and, they just brought it to me. The resident said, my mouth gets so dry, I need something. On 7/28/22 at 4:29 p.m., LPN Staff P confirmed Resident #56 had a 16 oz (480 ml's) cup of ice water and said that was ok, now she knew not to give her anything tonight. Review of the laboratory results for Resident #56 showed Normal sodium levels range from 136-145 milliequivalents per liter (mEq/L). Sodium is a mineral that conducts nerve impulses, contracts, and relaxes muscles maintains balance of water and minerals. Low sodium levels can produce symptoms of lethargy, confusion, and fatigue. Review of the laboratory results for Resident #56 showed On 6/14/22 the sodium level was 134 mEq/L On 6/24/22 the sodium level was 129 mEq/L On 6/27/22 the sodium level was 128 mEq/L On 7/01/22 the sodium level was 131 mEq/L On 7/14/22 the sodium level was 131 mEq/L On 7/28/22 at 4:40 p.m., the Director of Nursing (DON) said the nurse documents the fluid restriction on the Treatment Administration Record for fluid restriction of 1500 ml daily. The DON provided a copy of the July 2022 TAR and confirmed it did not show documentation of an accurate amount of fluids the resident received from the staff and said, we don't document that. The DON said if Resident #56 requests fluids, she would receive it, and confirmed there was no documentation of the amount of fluids the CNA's or nurses were actually providing to the resident each shift. A review of the CNA documentation for July 2022, the Hydration/Fluids offered documentation was incomplete and inaccurate. There was no documentation Resident #56 was offered fluids during the day shift on 7/4/22, 7/8/22, 7/10/22, and 7/25/22. The evening shift showed no documentation on 7/15/22, 7/22/22 and 7/26/22. The night shift showed no documentation on 7/3/22, 7/16/22, 7/20/22 and 7/27/22. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/28/22 at 4:57 p.m., the RD said, dietary provides milk on each meal tray for a total 720 ml in 24 hours. The RD said day and evening shift provided 240 ml each shift and night shift 280 ml. The RD said each milk carton was 8 oz which equaled 420 ml. The RD confirmed there was no documentation of the amount of fluid Resident #56 was receiving or accepting daily on each shift. The RD confirmed without documentation of the amount of fluids actually provided to Resident #56 and how much she accepted, it was impossible to know the 1500 ml fluid restriction was being maintained. On 7/28/22 at 5:29 p.m., CNA Staff O said he was assigned to care for Resident #56. CNA Staff O said if a resident was on a fluid restriction, dietary would send the fluids on the meal trays. CNA Staff O said to be honest, I don't know how many ml's of fluid each size cup contained, we don't document it anywhere. The CNA said the nurse just finished instructing me not to give Resident #56 any additional fluids, just let her know and she will give it. The CNA said if a resident wanted fluids, he would get it for them. On 7/29/22 at 12:12 p.m., the facility Medical Director said the fluid restriction was ordered for Resident #56 due to a sodium level of 131 and a previous sodium level of 134. The next step is usually a fluid restriction. The physician said she was aware there was a concern in the facility with documenting fluids and said, I think going forward we will need to do some education on fluid restrictions and better monitoring of the fluids each shift is providing. On 7/29/22 at 12:21 p.m., the Advanced Practice Registered Nurse (APRN) said Resident #56 had hyponatremia (low blood sodium) with associated weakness and was a fall risk. Fluid restriction was a way to get the sodium level back to normal in the elderly population and was the least aggressive treatment. The APRN said hyponatremia could cause confusion, falls and seizures, and that was the main concern with Resident #56.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25618 Based on resident and staff interviews and record review the facility failed to ensure they maintained ongoing communication between the nursing facility and the dialysis center related to the ongoing assessment of a dialysis resident before, during, and after each dialysis treatment for 2 Residents (#25 and #34) of 2 residents receiving dialysis. The findings included: 1. Review of Resident #34's clinical record revealed she was admitted to the facility on [DATE]. Resident #34's diagnoses included end stage renal disease. The physician's orders included hemodialysis Mondays, Wednesdays, and Fridays at a local outpatient dialysis center. The care plan for renal insufficiencies revised on 3/3/22 noted to coordinate dialysis care with the dialysis treatment center. On 7/25/22 at 11:14 a.m., Resident #34 said she goes to the dialysis center on Monday, Wednesday, and Fridays. She said the nursing facility and dialysis center do not always communicate with each other. She said she carries a three-ring dialysis binder with a hemodialysis communication form to the dialysis center and back to the nursing facility when she had completed the dialysis treatment for that day. She said the nursing facility and the dialysis center do not always complete the dialysis communication form. Review of Resident #34's dialysis binder revealed Hemodialysis Communication Forms (HCF) (CLA187) dated 6/22/22, 6/27/22, 7/01/22, 7/04/22, 7/08/22, 7/11/22, and 7/22/22 revealed the facility documentation was incomplete on the HCF, and the dialysis center did not document on the HCF Resident #34's pre and post dialysis vital signs, any patient complication during dialysis, nutritional concerns, medication given during dialysis treatment, laboratory values, post-dialysis instructions and any new physician orders for those treatment days. On the front cover of Resident #34's dialysis binder observed a letter from the nursing facility to the dialysis center asking them to complete the HCF after each dialysis treatment and send the completed HCF back with Resident #34 so then can put the completed HCF into Resident #34's medical record. On 7/26/22 at 10:13 a.m., in an interview, Staff K, a Registered Nurse (RN) said Resident #34 is a dialysis resident and she goes to the dialysis center every Monday, Wednesday, and Friday. She said the nurse sending the resident to the dialysis is responsible to fill out an HCF with the resident's vital signs, an assessment of the dialysis access site, any lab work, and a current medication list. The dialysis center is required to send back the form with updated vital signs, any complications during dialysis treatment, lab values if any drawn during the dialysis treatment, and any post-dialysis instruction and/or new physician orders. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff K confirmed after she reviewed Resident #34's dialysis binder the HCFs dated 6/22, 6/27, 7/01, 7/04, 7/08, 7/11, and 7/22 of 2022, the facility's documentation was incomplete prior to sending Resident #34 to the dialysis center for her dialysis treatments and the dialysis center did not document pre and post dialysis vital signs, any patient complication during dialysis, nutritional concerns, mediation given during dialysis treatment, laboratory values, post-dialysis instructions, and any new physician orders as required. She said she had heard the facility was having concerns about the dialysis center documenting on the HCF forms after each dialysis treatment as required. On 7/26/22 at 10:45 a.m., the Assistant Director of Nursing (ADON) confirmed Resident #34 receives dialysis treatments every Monday, Wednesday, and Friday. She said neither the dialysis center nor the nursing facility is required to fill out the HCF before and after each dialysis treatment as per the facility's dialysis policy. The ADON reviewed Resident #34's dialysis binder and confirmed the HCF dated 6/22, 6/27, 7/01, 7/04, 7/08, 7/11, and 7/22 of 2022 the facility's documentation was incomplete prior to the resident going to the dialysis center, and the dialysis center did not document pre and post dialysis vital signs, any patient complication during dialysis, nutritional concerns, mediation given during dialysis treatment, laboratory values, post-dialysis instructions and any new physician orders on the HCF. She also confirmed a letter attached to Resident #34's dialysis binder from the nursing home asking the dialysis center to complete the HCF aster each dialysis treatment and send the completed HCF back with Resident #34 so then can put the completed HCF into Resident #34's medical record. She said she was unaware the nursing home had asked the dialysis center to fill out the HCF after each dialysis center and return the completed HCF to the facility. On 7/26/22 at 12:45 p.m., an interview with the facility's Registered Dietitian (RD) said, he communicates with the dialysis center RD every month, and they review Resident #34 lab values and discuss any concerns at that time. He said due to his experience at other facilities he has worked, he believed the standard of practice was when a resident goes to their dialysis treatment the facility will fill out a dialysis communication form and the dialysis center will complete the dialysis communication form to inform the facility how the resident's dialysis treatment went that day. The RD reviewed Resident #34's dialysis communication folder and confirmed the HCFs, dated 6/22, 6/27, 7/01, 7/04, 7/08, 7/11, and 7/22 for 2022, the facility's documentation was incomplete prior to Resident #34 going to the dialysis center for treatment, and the dialysis center did not complete the HCF by documenting Resident #34 pre and post dialysis treatment vital signs, any patient complication during dialysis, any nutritional concerns, mediation given during dialysis treatment, laboratory values, post-dialysis instructions and any new physician orders on the HCF. He said he was unaware the HCFs were not being completed by the nursing home and dialysis center staff after Resident #34 dialysis treatments. On 7/28/22 review of the facility's Dialysis Guidelines policy stated both the facility and dialysis center are responsible for collaborative communication regarding the residents receiving dialysis services using the Hemodialysis Communication Form (CLS187). Collaborative communication includes information regarding; medication administration by the center and/or dialysis center, physician orders, laboratory values, vital signs, code status, nutritional/fluid management, dialysis treatment provided and response to treatment, and changes in the patient's condition. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/28/22 at 2:25 p.m., the Director of Nursing (DON) said, Resident #34 received dialysis treatments on Monday, Wednesday, and Friday each week. He confirmed the facility's Dialysis Guidelines stated the facility and dialysis center are responsible for shared communication regarding the residents receiving dialysis services, either offsite or onsite. The Hemodialysis Communication Form (CLS187) is to be used. Collaborative communication includes information regarding; medication administration by the center and/or dialysis center, physician orders, laboratory values, vital signs, code status, nutritional/fluid management, dialysis treatment provided and response to treatment, and changes in the patient's condition. The DON reviewed Resident #34's dialysis communication binder and confirmed the Hemodialysis Communication Forms (CLS187) dated 6/22, 6/27, 7/01, 7/04, 7/08, 7/11, 7/22 for 2022 were not completed with the required documentation by the facility staff and dialysis center as required per their Dialysis Guideline policy. 30599 2. Review of the clinical record for Resident #25 revealed an admitted [DATE]. The resident received outpatient hemodialysis on Tuesdays, Thursdays and Saturdays. The facility utilizes a hemodialysis communication form to ensure ongoing assessment, communication, and collaboration with the dialysis facility regarding care and services. A review of the Hemodialysis Communication Form for resident #25 from 5/11/2022 through 7/28/2022 revealed the following: Section 1 to be completed by the facility staff which included vital signs, weight, dialysis access site evaluation, patient status, lab tests, diet order and current medication was not filled out on 5/12/2022, 5/14/22, 5/19/22, 5/24/22, 5/26/22, 5/31/22, 6/2/22, 7/2/22, 7/9/22, 7/14/22, 7/19/22, 7/21/22, 7/23/22, 7/26/22 and 7/28/22. Section 2 to be completed by dialysis center which included vital signs pre and post dialysis, complications during dialysis, medication given during dialysis, laboratory values, post dialysis instructions, new physician's orders and patient status was not completed on 7/7/22. On 7/28/22 at 2:25 p.m., the DON confirmed the facility's Dialysis Guidelines stated the facility and dialysis center are responsible for shared communication regarding the residents receiving dialysis services, either offsite or onsite. The Hemodialysis Communication Form (CLS187) is to be used. Collaborative communication includes information regarding; medication administration by the center and/or dialysis center, physician orders, laboratory values, vital signs, code status, nutritional/fluid management, dialysis treatment provided and response to treatment, and changes in the patient's condition.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 41905 Based on record review and interviews, the facility failed to ensure sufficient staffing to provide nursing and related services to assure resident safety and highest practicable physical and mental well-being for 5 residents (#60, #56, #16, #34 and #20) of 19 residents reviewed. The findings included: Review of the Centers for Medicaid and Medicare Services (CMS) Staff Posting Report dated 7/24/22 indicated Resident Census was 94 during the 7:00 a.m. through 3:00 p.m. shift. Review of the Florida Calculating State Minimum Nursing Staff for Long Term Care Facilities form for 7/24/22 indicated Resident Census was 93. The Daily average of 1.8587 CNA hours per resident. On 7/25/22 at 11:49 a.m. Resident #60 said call bell response is at between 15 to 20 minutes. On 7/24/22 at 2:02 p.m., Resident #56 said she was left on the toilet for a long time. Resident #56 said it takes staff a while to answer the call light because they are short-staffed. She said it depends on how many staff are at the facility, it can take 20 minutes or longer for them to answer. On 7/25/22 at 12:06 p.m., Resident #16 said it can take two hours for staff to get to her when she uses the call bell. On 7/25/22 at 11:33 a.m., Resident #34 said staff doesn't always answer her call light timely, and she can wait sometimes up to an hour before staff answer her call light. Review of the grievance filed by Resident #20 on 5/19/22, noted staff can never find two Certified Nursing Assistants to help with her care and she has to wait. The concern is documented as resolved on 5/26/22. On 7/28/22 at 11:03 a.m., Resident #20 said it takes staff as long as two hours to get to her when she needs someone to help her. She said it takes a long time to get to her because they need two staff to be there for her. She said even now, sometimes they will only use one staff when they are aware they need to have two. Review of the grievance log from 5/1/22 through 7/28/22 revealed 16 concerns related to care and treatment, including not receiving showers, not being shaved, call light response. On 7/27/22 at 9:18 a.m., Staffing and Scheduling Coordinator Staff T confirmed the CNA hours were 1.8587 on 7/24/22. Staff T said she was aware the facility was below its mandatory staffing for CNAs on that day (for State requirements).

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Capri Health and Rehabilitation Center	1450 East Venice Avenue Venice, FL 34292

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45645 Based on record review, review of facility policy and procedure and staff interviews, the facility failed to ensure 2 licensed Practical Nurses (LPN) (LPN E and LPN F) of 4 LPN nursing staff had the appropriate competencies and skill set to administer intravenous (IV) medications. The findings included: Review of Florida Nursing Board Chapter 64B9-12 Competency and Knowledge Requirements Necessary to Qualify Licensed Practical Nurse (LPN) to Administer IV Therapy. Contents: the board endorses the Intravenous Therapy Course Guidelines issued by the Education Department of the National Federation of Licensed Practical Nurse November 1983. With specific education and competency requirements for LPNs to administer IV medications. The facility policy IIA4 Infusion Therapy Products, General Information (undated) stated Licensed staff are responsible for following applicable state laws, practice act, .issued by the state licensing board; as well as, applicable Pro-[NAME] Senior Care policy, to assist in exercising professional judgment and determining whether the performance of a procedure is within their scope of practice. On 7/25/22 at 2:55 p.m., a review of Resident #24's clinical record showed the resident was receiving the intravenous (IV) antibiotic Daptomycin Solution Reconstituted 425 milligrams (mg) once a day for history of right hip prosthetic joint infection. The clinical record showed during the month of May 2022, Resident #24 had received the following IV antibiotics, Ceftriaxone Sodium 1 gram, Vancomycin HCL 1000 mg, and Vancomycin HCL 750 mg. Review of the medication administration record (MAR) documented LPN Staff F administered IV medications to Resident #24 on 5/1/22, 5/2/22, 5/6/22, 5/7/22, 5/8/22, 5/9/22, 5/13/22, 5/14/22, 5/16/22, 5/20/22, 5/21/22, 5/22/22, 7/8/22, 7/9/22, 7/16/22, 7/17/22, and 7/22/22. The MAR documented LPN Staff E administered IV medication to Resident #24 on 5/12/22 and 7/24/22 and administered a saline flush via the IV on 5/10/22 and 5/13/22. On 7/26/22 at 2:30 p.m., review of LPN Staff F's and LPN Staff E's personnel file failed to reveal documentation of the state required certification to administer IV medications. On 7/26/22 at 12:09 p.m., the Assistant Director of Nursing (ADON) confirmed LPN Staff E and LPN Staff F did not have the required IV certification to administer the medications to Resident #24. On 7/28/22 at 2:18 p.m., LPN Staff E confirmed she did not have the required training and competencies to administer IV medications. On 7/29/22 at 3:02 p.m., LPN Staff F confirmed she did not have the required training and competencies to administer IV medications. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/27/22 at 5:24 p.m., the Director of Nursing confirmed LPN Staff E and LPN Staff F had administered IV medications to Resident #24 without the required training and competencies to administer the IV medications.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 41905 Based on observation and staff interview, the facility failed to ensure the required up-to-date nurse staffing information was posted and readily available to residents and visitors. The findings included: On 7/24/22 at 9:10 a.m., observed facility lobby with the nurse staffing information on the wall and out-of-date. The information was dated 7/21/22 and did not include the number of residents currently at the facility (resident census). On 7/24/22 at 9:45 a.m., during an observation of the first-floor nursing station, the nurse staffing information was located in a closed binder behind the desk that was not readily accessible to residents and visitors. The staffing information did not contain the nursing staff directly responsible for resident care. Licensed Practical Nurse (LPN) Staff L confirmed the nurse staffing information was not readily accessible to residents and visitors and did not include accurate information. On 7/29/22 at 1:43 p.m., the Staffing and Scheduling Coordinator Staff T said she was responsible to post the Nurse Staffing information in the facility lobby. Staff T said she does not post the Nurse Staffing information on the weekends because she does not work the weekends.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 41905 Based on record review, policy review and staff interviews, the facility failed to act on consultant pharmacy recommendations for 1 (Resident #17) of 5 residents reviewed for unnecessary medications. This has the potential for delay of treatment and use of unnecessary medications. The findings included: Review of the Policy Medication Regimen Review (MRR) (effective date 1/1/08, revised 8/2018) showed the Nursing Center's Consultant Pharmacist will present MRR recommendations on individual patient specific reports on the day of their review. The process to ensure MRR recommendations are addressed timely. Review of physician's orders for Resident #17 indicated an active order for Paxil 40 milligrams(mg), 1 tablet a day on 9/28/21. Review of MRR for Resident #17 revealed a Gradual Dose Reduction (GDR) recommendation on 3/28/22: Consider a trial gradual dose reduction to Paxil 30 milligrams (mg) daily. Review of Resident #17's Medication Administration Records for March 2022 thru July 2022 revealed no dose reduction for Paxil 40 mg. On 7/26/22 at 11:02 a.m., the Director of Nursing (DON) said the GDR recommendations could be in the hard chart, medical record department, or sometimes in a binder in his office. Review of Resident #17 hard chart and progress notes from 3/2022 to 7/28/22 revealed no evidence the GDR for 3/28/22 for Paxil was acted upon. On 7/26/22 at 11:10 a.m., the DON confirmed he did not have the GDR response for 3/28/22 in his office. On 7/26/22 at 11:18 a.m., the medical records director said the GDR recommendation for Resident #17 for Paxil on 3/28/22 was not in the medical records in her office. On 7/27/22 at 10:42 a.m., the DON said there is no record the physician was made aware of the recommendation for the reduction of the Paxil for Resident #17 in March 2022. On 07/28/22 at 6:06 p.m., Social Services Coordinator Staff T said she spoke with the Advanced Practice Registered Nurse (APRN) responsible for adjusting the GDR for Paxil for Resident #17. She said the APRN said she was not aware there was a GDR recommendation for the Paxil for Resident #17.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25618 Based on observation, record review, resident and staff interview, the facility failed to ensure the safe storage of medications left at residents' bedside for 3 (Resident #144, #62 and #20) of 3 residents observed with unsecured medications at the bedside. The findings included: Review of facility policy Medication and Treatment Administration Guidelines policy dated 7/2006 and updated 3/2018 stated on page 3, under Medication Storage and Security, . Self-administered medication stored in a patient's room must be secured in a locked storage unit. On 7/24/22 at 12:09 p.m., observed one Fluticasone Propionate (Flonase) 50 micrograms nasal spray, two Albuterol Sulfate HFA inhalers, and one tube Nystatin Triamcinolone Acetonide (antifungal) cream unsecured on Resident #144's bedside table. On 7/25/22 at 1:34 p.m., observed one Fluticasone Propionate 50 mcg nasal spray, two Albuterol Sulfate HFA inhalers, and one tube Nystatin Triamcinolone Acetonide cream unsecured on Resident #144's bedside table. Resident #144 was not in her room during the observation. On 7/25/22 at 2:45 p.m., Registered Nurse (RN) Staff K said she has been working at the facility for five months and is Resident #144's nurse. She said some of the residents are allowed to self-administer their medications and keep them at their bedside. She said she was aware Resident #144 had medications in her room, which she can take at any time when she thinks she needs too. She said she didn't know the facility's policy related to residents' self-administering their medications and how the medications should be stored in the resident's room. On 7/25/22 at 2:50 p.m., a joint observation of Resident #144's room with RN Staff K revealed the bottle of Fluticasone Propionate, the two Albuterol inhalers and the tube of Nystatin Triamcinolone cream remained stored, unsecured on the resident's bedside table. RN Staff K verified the medications were unlabeled. RN Staff K said she did not document when the resident used the medications or if they were effective. After reviewing Resident #144's clinical record, RN Staff K said she was not able to find documentation the interdisciplinary team evaluated the resident's ability to safely self-administer the Fluticasone Propionate, the Albuterol inhaler and apply the Nystatin Triamcinolone Acetonide cream. On 7/25/22 RN Staff K completed and signed an interdisciplinary team evaluation and granted approval for Resident #144 to fully self-administer medications. The evaluation form documented Resident #144 was able to demonstrate secure storage for the medications kept in her room. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/28/22 at 2:02 p.m., a joint observation of Resident #144's room with the Director of Nursing revealed the bottle of Fluticasone Propionate 50 mcg nasal spray, two Albuterol Sulfate HFA inhalers, and one tube Nystatin Triamcinolone Acetonide cream remained unsecured on Resident #144's bedside table. The Director of Nursing (DON) said medications stored in a resident's room should be stored in a locked compartment in the resident's room. The DON verified the facility had not provided Resident #144 with a locked box or a locked drawer to ensure the safe storage and prevent unauthorized access to the medications. 41905 2. On 7/24/22 at 10:33 a.m., Resident #20 was observed in her room lying in bed. The bedside table to the right of resident #20 has an unsecured plastic medicine cup on top of the table containing three pink tablets and one green tablet. Resident #20 said the tablets were medication to control acid reflux. Resident #20 said the nurses give her the medication and she takes it when she needs it, usually before meals. Resident #20 then took one of the pink tablets out of the cup and put it in her mouth. Review of medication order for resident #20 revealed an active order dated 6/16/22 for TUMS tablet chewable 500 mg (calcium carbonate antacid) give 1 tablet by mouth 4 times a day for Gastric Esophageal Reflux Disease 30 minutes before meals and bedtime. Review of the medical records for Resident #20 revealed no evaluation determining resident #20 had the ability to safely administer self-medication. 45645 3. On 7/24/22 at 10:50 a.m., and 7/29/22 at 1:02 p.m., a bottle of Calcium Carbonate was observed on Resident #62's nightstand. Photographic evidence obtained. On 7/29/22 at 1:02 p.m., Resident #62 said, I've had this for a while now. On 07/25/22 at 10:46 a.m., Clinical record review showed Resident #62 was admitted on [DATE] with diagnoses of Encephalopathy, Dementia, and Urinary Tract Infection The clinical record showed Resident #62 had no physician's order for Calcium carbonate On 7/29/22 at 1:13 p.m., Licensed Practical Nurse (LPN) Staff P said Resident #62 there was no order for Calcium Carbonate, and it should not be in the resident's room. On 07/29/22 at 1:15 p.m. Registered Nurse (RN) Minimum Data Set (MDS) Staff D said this medication should not have been with Resident #62.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45645 Based on observation, review of facility policy and procedure and staff interviews, the facility failed to label and date food in 1 (first floor) of 2 nourishment rooms. The facility failed to ensure food was prepared in a sanitary manner. The failure to label and date foods stored in the refrigerator can cause residents to consume food that may have expired. The findings included: The facility policy Food from Outside Sources and In-Room Refrigerators (revised ,d+[DATE]) documented Food requiring refrigeration and non-perishable items are stored in labeled (with patient's name and date) closed containers. 1. On [DATE] at 11:39 a.m., observation of the first-floor nourishment room, reach-in refrigerator with the Dietary Manager revealed the following: Three unlabeled and undated sandwiches. Photographic evidence obtained. The Dietary Manager confirmed the observations and said, the sandwiches should not be in the refrigerator without a label and date. On [DATE] at 11:50 a.m., the Dietary Manager said the dietary staff were trained upon hire and as needed, on dating and labeling food items, the expectation was to discard expired food items twice weekly. On [DATE] at 12:23 p.m., Dietary Aide Staff G confirmed she was assigned the task of removing expired items from the reach-in refrigerators. Staff G said she was aware of facility food label policy and indicated that she checked the food twice a week. Dietary Aide Staff G said she did not set aside a specific time during the day to inspect the refrigerators and remove the expired food items. On [DATE] at 12:31 p.m., Registered Nurse (RN) Staff B said food items should be labeled with the name and date and should be used within three days or discarded. On [DATE] at 2:45 p.m., in an interview, Dietary Manager said the task of discarding items was assigned to dietary staff daily. 2. The facility policy Safe food handling/Glove Usage (revised ,d+[DATE]) specified, Disposable gloves are worn when hands come in direct contact with food or eating surfaces. On [DATE] at 11:57 a.m., during an observation of the lunch meal preparation, Dietary [NAME] Staff J was observed preparing cheese sandwiches, a ready-to-eat food, with her bare hands. Staff J was not wearing gloves. Dietary [NAME] Staff J did not wash her hands prior to preparing the food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Dietary Manager was present during the observation and said it was not acceptable to handle the food without use of gloves.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30599 Based on record review, staff, and resident interview the facility administration failed to use its resources effectively to ensure consistent and ongoing implementation of effective measures to prevent avoidable falls and fall related injuries. Resident #193 was admitted to the facility on [DATE] after a fall, and repair of right hip fracture. On 1/10/22 the resident sustained a fall resulting in dislocation of the right hip prosthesis. On 1/22/22 Resident #20 sustained a nasal bone fracture when she was improperly turned in bed and fell . Resident #85 sustained multiple falls at the facility on 1/28/22, 2/5/22, 3/26/22, 3/30/22 and 5/14/22. On 2/5/22 Resident #85 was diagnosed with a left femoral neck, and left wrist fracture, left facial abrasion and contusion. On 5/14/22 Resident #85 was sent to the hospital after the fall and diagnosed with an acute head injury. On 2/20/22 the facility developed a performance improvement plan to address the increase in falls and fall related injuries. The facility administration failed to ensure implementation, and monitoring of the approaches in the performance improvement plan to minimize the risk of falls and fall related injuries. The failure of the facility's administration to implement and monitor effective fall preventive measures resulted in noncompliance at the Immediate Jeopardy level starting on 4/20/22. The Administrator was informed to the determination of ongoing Immediate Jeopardy on 7/30/22 at 6:29 p.m. and provided the Immediate Jeopardy templates. The findings included: Cross reference to F689 and F867. Review of the Administrator's job description signed on 5/10/19 revealed the Administrator, . Manages all business-related activity the HCR (Health Care and Retirement Corporation) Manorcare vision and supporting strategies and assures that . high-quality provider of health services is maintained . follows established safety policies and procedures. Ensures potential safety/health hazards are eliminated . Directs the staff to provide high quality in daily care which meets/exceeds all internal/external standards. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Director of Nursing Job Description signed on 6/21/21 showed the Director of Nursing is responsible to, . Follow established safety policies and procedures . Communicates care delivery trends, issues and opportunities to administration, medical director, and the quality assurance committee. Anticipates customer's needs and works to minimize potential problems. Establishes and manages goals and objects for the nursing department through analysis and strategic planning consistent with the company's mission. Promotes nursing process and critical thinking in nursing care delivery . Participates in clinical risk identification, strategy planning, and risk reduction. Ensures and evaluates systems to plan, promote, develop, assess, interpret, validate, and evaluated the implementation of clinical programs, policies and procedures and forms. Ensures personnel are adequately educated to care for acute events, chronic illnesses of the frail elderly, cognitive impairment, end of life . The facility's incident log showed a total of 157 falls from January 1,2022 through July 22, 2022. Review of a sample of 10 residents with falls and fall related serious injuries revealed four residents sustained serious injuries (broken bones) and one resident sustained a head laceration. Two residents sustained multiple falls without documentation of an investigation to prevent reoccurrence. Review of the Performance Improvement Project (PIP) titled Falls Management dated 2/2/22 noted the overall goal of the improvement project was to reduce the trends of falls and falls with major injury. The target end date was April 20, 2022. The summary of the findings of the root cause analysis noted a Knowledge deficit related to the process steps for identification of resident falls risks, interventions and systems to minimize fall risks while promoting quality of care. The measures included: 1 The facility will identify a subcommittee related to falls management reduction. The team consisted of two nurses, one therapist, two CNAs (Certified Nursing Assistants) and one leadership team member preference would be Activities Director. The committee will be tasked to review all current residents who have had more than three falls in 90 days or one major fall with injury. Discuss for each: Any with possible sleep deprivation/up frequently during night/awake most of the night. On February 28, 2022, the DON documented increased rounding/observation education provide to all nursing staff with refresher on fall, documentation, interventions and preventions. On March 18, 2022, the DON documented Ongoing review during Eagle Room standup and stand-down. Falls decreased and interventions in place. Monitoring of results of interventions completed. On March 29, 2022, the DON documented Medication review and causes associated with recent falls and correlation of effectiveness of interventions since PIP initiation. The result of the intervention was documented as In progress. 2 The Administrator/Designee will educate the interdisciplinary team and set expectations for the review of falls during Eagle Room and the completion of the Eagle Room QA (Quality Assurance) tool. On 2/28/2022, the DON documented education provided on fall interventions and preventions with implementation of increased rounding and monitoring by all nursing staff. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 3/29/22 the DON documented ongoing reminders and plan for fall documentation review. New falls added to monitoring list for IDT review of causes and preventions. The result of the intervention was documented as Successful. 3 The DON/Designee will educate CNAs and licensed nurses on post fall process review utilizing the FYI (For Your Information) post fall evaluation. On 2/28/22 the DON documented education provided to all nursing staff at mandatory meeting/education on 2/23, 2/24 and 2/25. On 3/18/22 the DON documented reminders to all staff based on situation and likelihood of falls or recurrent falls. Staff continue to monitor and implement fall preventions and interventions. On 3/29/22 the DON documented ongoing education and re-evaluation of fall risks including new admissions. Early prevention and rounding remain priority. The result of the intervention was documented as Successful. 4. The DON/Designee will educate licensed nurses on initial evaluation of residents past history or experiences of falls. Completing the admission/readmission screen with accuracy. On 3/18/22 the DON documented ongoing education and re-evaluation of fall risks including new admissions. Early prevention and rounding remain priority. The result of the intervention was Successful. The DON/Designee will educate licensed nurses on completing incident reports timely (Incident reports will be in incident report management by the end of the shift the incident occurred providing an accurate tracking process). On 3/29/22 the DON documented Monitoring of incident reports, review of preventions in place and new interventions added. The result of the intervention was Successful. The facility QAPI (Quality Assurance and Performance Improvement) team will conduct a trend review of falls to identify residents with falls and falls with major injury utilizing the Eagle Room QA tool to identify areas that are not completed weekly for four weeks then monthly for two months. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 7/29/22 at 2:19 p.m. The DON said the PIP was to last 30 days and the time counted during the PIP for the falls was from 3/1/22 to 3/31/22. The DON stated he thought there was a 50% reduction in falls during that period. He said he noticed the biggest trend was he thought there were more falls on the weekend. He counted the falls over the weekend on each Monday and noticed more falls occurred on the weekend than during the week. The DON verified there was no documentation in QAPI or the PIP regarding the trending of weekend falls. The DON verified there was no documented intervention put in place to reduce falls on the weekend. He stated the intervention put in place were activities were more involved in giving residents stuffed animals to calm them. The DON said he implement increased rounding for both him and the staff caring for the residents. The DON said there was no policy or minimum requirements for how often the staff were to round or when they were to round. The DON said he asked the staff to round more frequently. On 4/20/22 at the end of the PIP the DON said he spoke to staff regarding increased rounding and told them to keep up the increased rounding. No other interventions were put in place due to the PIP. The DON said he had educated all staff on expectations of completing incident reports and fall protocols. He said he did one to one education verbally back and forth. He said he could not remember at the time any nurse he had spoken to or educated. The DON said there was no post fall education he just used the incident reports he said he had copies in an education book, but it was not a fill out form, just informative. He said he would have to look for additional documentation for education. On 7/29/22 at 2:39 p.m., and on 7/29/22 at 3:29 p.m., the DON said he did not have any additional documentation of education provided to the licensed nurses or CNAs related to the interventions listed in the performance improvement plan for falls. On 7/29/22 at 2:30 p.m., the Administrator said there was no documentation of education of the interdisciplinary team and the set expectations for the review of falls. The Administrator and the DON said they could not provide documentation of subcommittee meetings with review of residents with multiple falls or major injury. The DON said the meetings were held in the Eagle room daily and the only documentation they could provide was the Eagle room tool and the MDS Coordinator's documentation of interventions put in place after each fall was reviewed that same day. The facility provided documentation 32 staff members were educated on March 3, 2022. The topic was falls, falls prevention and incident reporting. Fall management initiatives which included post fall evaluation, vital signs, mental status, and assessment, and medication. There was no documentation the five Registered Nurses employed at the facility were educated. Seven of 18 Licensed Practical Nurses (LPNs) were educated. Eight of 32 Certified Nursing Assistants received the education. An active employee list provided by the facility showed on 3/3/22 five RNs, 13 LPNs, and 30 CNAs were listed on the active roster. (continued on next page)

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	105965	A. Building B. Wing	08/01/2022

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Capri Health and Rehabilitation Center	1450 East Venice Avenue Venice, FL 34292

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 7/29/22 at 3:00 p.m., the Administrator and the DON said the interdisciplinary team (IDT) reviewed the falls every morning and afternoon, Mondays through Fridays through the Eagle Room process. The Eagle Room process consists of a check list to ensure the following areas were completed after a fall: Neurological checks, Medication review, Notification of physician and family, electronic incident report, Investigation complete, reportable, fall evaluation completed, Pain evaluation completed, Referral or new intervention, Calcium and Vitamin D protocol, root cause IDT management document, care plan and task list (updated). A sample of 10 residents with falls from March 2022 through 7/28/2022 showed: Resident #293 sustained a fall on 3/24/22. There was no incident report completed. The resident reported he fell and sat on the floor. Review of the Eagle room process shows interventions circled in red. The DON said they added the interventions but did not update the Eagle Room tool. Resident #294 sustained an unwitnessed fall in the bathroom on 3/30/22. An incident report was initiated but was incomplete. The Eagle Room tool was not updated. Resident #295 sustained a fall on 6/15/22. The resident suffered head trauma. An incident report started but lacked an investigation of the fall. No new interventions were noted in the care plan at that time. The Eagle Room tool was checked as completed. Resident#296 sustained a witnessed fall on 4/19/22 at the nurse's station. An incident report initiated but not completed. The Eagle Room tool was checked as completed. Resident #85 was observed on the floor on 5/14/22. The resident reported she slid off the wheelchair. The incident report was initiated but not completed. Care plan updated with an intervention. The Eagle Room process checked off as completed. Resident #146 sustained a fall on 6/22/22. She was observed on the floor in front of her wheelchair at the nurse's station. An incident report was initiated but not completed. The care plan was updated. The Eagle Room tool was checked off as completed. Resident #26 was observed on the floor on 7/3/22. An Investigation was initiated but not complete. There was no update to the fall care plan noted. The Eagle room tool was checked off as completed. Resident #6 was observed on the floor on 7/3/22. An incident report was partially completed and did not include an investigation of the fall. The Care plan was updated with an intervention. The Eagle Room tool was checked off as being completed. On 7/24/22 at 10:33 a.m., Resident #20 said she was rolled out of bed by a Certified Nursing Assistant (CNA) who was changing her. She said she told the CNA she was too close to the edge of the bed, but the CNA did it anyway. Resident #20 said she fell off the edge of the bed and landed face down on the floor. Resident #20 said she sustained a broken nose from the fall. On 7/29/22 at 2:29 p.m. the DON said he had no documentation of rounding on residents or any auditing for resident falls he completed. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The DON said the only intervention put in place during the time of the PIP was he increased his rounding of residents and he asked the staff to increase rounding of residents. He said he did not have documentation of the rounds he or the staff completed. He did not have documentation of which residents they increased rounds for or how often the staff was to round. The DON said he did not have documentation he reviewed the results of the rounds to evaluate the effectiveness of the intervention. The Administrator who was present during the interview said there were no minimum standards for rounding at the facility.

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30599 Based on record review and interview the facility failed to develop and implement appropriate plans of action to correct identified quality deficiencies related to prevention of avoidable falls and fall related serious injuries. On 1/22/22 Resident #20 sustained a nasal bone fracture when she was improperly turned in bed and fell . Resident #193 was admitted to the facility on [DATE] after a fall, and repair of right hip fracture. On 1/10/22 the resident sustained a fall resulting in dislocation of the right hip prosthesis. Resident #85 sustained multiple falls at the facility on 1/28/22, 2/5/22, 3/26/22, 3/30/22 and 5/14/22. On 2/5/22 Resident #85 sustained a fall, was sent to the hospital and diagnosed with a left femoral neck fracture, left wrist fracture, left facial abrasion and contusion. On 5/14/22 Resident #85 was sent to the hospital after the fall and diagnosed with an acute head injury. Resident #292 was admitted to the facility on [DATE]. The resident was assessed to be at risk for falls. On 6/11/22 the resident was sent to an acute care hospital after he was found on the floor with a head wound actively bleeding, requiring staples. On 2/20/22 the facility developed a performance improvement plan to address the increase in falls and fall related injuries. The facility failed to ensure implementation, and monitoring of the approaches in the performance improvement plan to minimize the risk of falls and fall related injuries. The facility failure to implement effective corrective actions and monitor results, created a likelihood other residents suffer from falls resulting in serious harm, and resulted in noncompliance at the Immediate Jeopardy level starting on 4/20/22. The Administrator was informed to the determination of ongoing Immediate Jeopardy on 7/30/22 at 6:29 p.m. and provided the Immediate Jeopardy templates. The findings included: Cross reference to F689 and F835. (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 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's QAPI (Quality Assurance and Performance Improvement) plan with an effective date of May 16, 2022, noted, . The purpose of QAPI is to take a pro-active approach to continually improve the quality of care we provide . Eagle Room is a twice daily interdisciplinary care and service management process that functions as an on-going ad-hoc (for this situation) meeting of the center's QAPI Committee with a primary focus on clinical care and services . The scope of QAPI program encompasses all types and segments of care and services that impact clinical care. These include . patient safety .Aspects of service and care are measured against established performance goals and key measures are monitored and trended on a quarterly and/or annual basis . The Administrator, as the chair of the QAPI Committee, is responsible and accountable for ensuring that the QAPI program . is defined, implemented, maintained and addresses identified priorities . corrective actions address gaps in systems and are evaluated for effectiveness . The QAPI committee is responsible and accountable for . ensuring corrective actions are effective . analyzing QAPI program performance to identify and follow up on areas of concern or opportunities for improvement .The QAPI plan addresses the elements of systematic analysis and systemic action through the use of the following processes and systems: root cause analysis, use of a continuous cycle to evaluate the effectiveness of performance improvement initiatives, communication of performance improvement project efforts . On 7/29/22 at 2:39 p.m., the Administrator said the company's corporate office directed them to develop a performance improvement plan (PIP) since they had identified an increase in falls at different facilities. The Administrator said the PIP was initiated at the facility on 2/20/22 and lasted until 4/20/22. Review of the Performance Improvement Plan(PIP) titled Falls Management dated 2/2/22 noted the overall goal of the improvement project was to reduce the trends of falls and falls with major injury. The target end date was April 20, 2022. The summary of the findings of the root cause analysis noted a Knowledge deficit related to the process steps for identification of resident falls risks, interventions and systems to minimize fall risks while promoting quality of care. The measures included: 1. The facility will identify a subcommittee related to falls management reduction. The team consisted of two nurses, one therapist, two CNAs (Certified Nursing Assistants) and one leadership team member preference would be Activities Director. The committee will be tasked to review all current residents who have had more than three falls in 90 days or one major fall with injury. Discuss for each: Any with possible sleep deprivation/up frequently during night/awake most of the night. On March 29, 2022, the DON documented Medication review and causes associated with recent falls and correlation of effectiveness of interventions since PIP initiation. The result of the intervention was documented as In progress. 2. The Administrator/Designee will educate the interdisciplinary team and set expectations for the review of falls during Eagle Room and the completion of the Eagle Room QA (Quality Assurance) tool. On 2/28/2022, the DON documented education provided on fall interventions and preventions with implementation of increased rounding and monitoring by all nursing staff. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 3/29/22 the DON documented ongoing reminders and plan for fall documentation review. New falls added to monitoring list for IDT review of causes and preventions. The result of the interventions was documented as Successful. 3. The DON/Designee will educate CNAs and licensed nurses on post fall process review utilizing the FYI (For Your Information) post fall evaluation. On 2/28/22 the DON documented education provided to all nursing staff at mandatory meeting/education on 2/23, 2/24 and 2/25. On 3/18/22 the DON documented reminders to all staff based on situation and likelihood of falls or recurrent falls. Staff continue to monitor and implement fall preventions and interventions. On 3/29/22 the DON documented ongoing education and re-evaluation of fall risks including new admissions. Early prevention and rounding remain priority. The result of the interventions was documented as Successful. 4. The DON/Designee will educate licensed nurses on initial evaluation of residents past history or experiences of falls. Completing the admission/readmission screen with accuracy. On 3/18/22 the DON documented ongoing education and re-evaluation of fall risks including new admissions. Early prevention and rounding remain priority. The result of the interventions was Successful. The DON/Designee will educate licensed nurses on completing incident reports timely (Incident reports will be in incident report management by the end of the shift the incident occurred providing an accurate tracking process). On 3/29/22 the DON documented Monitoring of incident reports, review of preventions in place and new interventions added. The result of the intervention was Successful. The facility QAPI (Quality Assurance and Performance Improvement) team will conduct a trend review of falls to identify residents with falls and falls with major injury utilizing the Eagle Room QA tool to identify areas that are not completed weekly for four weeks then monthly for two months. The facility's incident log showed a total of 157 falls from January 1,2022 through July 22, 2022. Review of a sample of 10 residents with falls and fall related serious injuries revealed four residents sustained serious injuries (broken bones) and one resident sustained a head laceration. Two residents sustained multiple falls without documentation of an investigation to prevent recurrence. On 7/29/22 at 2:39 p.m. the Administrator said there was no documentation a trend review of falls in the building during the time of the PIP. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 7/29/22 at 2:19 p.m. The DON said the PIP was to last 30 days from 3/1/22 to 3/31/22. The DON stated he thought there was a 50% reduction in falls during that period. He said he noticed the biggest trend was that there were more falls on the weekend. Each Monday he counted the falls over the weekend and noticed more falls occurred on the weekend than during the week. The DON said there was no documentation in QAPI or the PIP regarding the trending of weekend falls. The DON said there was no documented intervention put in place to reduce falls on the weekend. He said the intervention put in place were activities was more involved and we tried to give stuffed animals for them it calms them. The DON said he also directed the direct care staff to increase their rounds. He also increased his rounds. The DON said there was no policy or minimum requirements for when and how often the staff were to round. He asked the staff to round more frequently. The DON said on 4/20/22 at the end of the PIP he told staff to keep up the increased rounding. No other interventions related to the PIP were put into place. The DON said did one to one education verbally back and forth and educated all staff on expectations for completing incident reports and fall protocols. He said he could not remember which nurses he spoke to or educated. The DON said there was no post fall education, he just used copies of incident reports which he kept in an education book. The education was just informative but not a fill out form. He said he would have to look for additional documentation for education. On 7/29/22 at 2:39 p.m., and on 7/29/22 at 3:29 p.m., the DON said he did not have any additional documentation of education provided to the licensed nurses or CNAs related to the interventions listed in the performance improvement plan for falls. Review of Quality Assurance and Performance Improvement Committee Meeting (QAPICM) dated 2/18/22 documents a PIP was in place for falls. The QAPICM minutes dated 3/11/22 shows a fall PIP was in progress and was due to be completed on 3/31/22. The The QAPI Committee Summary Findings dated March reads, Fall PIP updated 2/28/22 Please see attached Tracking and Trending. A Floor plan with red dots of the first and second floor, A graph of the regional number of falls dated 2/28/22, and documentation of 6 falls Resident #27 had during the month of February form 2/9/22 to 2/27/22 are noted at this time. The QAPICM minutes dated 4/8/22 show audits were being conducted for falls. There was no further QAPICM minutes regarding falls after 4/8/22. A form titled Abaqis shows the PIP had a target end date of 4/20/22. The goal of the PIP is documented as a less than 5% reduction in falls. The DON documented on the PIP form on three dates, 2/28/22, 3/18/22, and 3/29/22. On 2/28/22 the DON documented, Audits continue of recent falls indication adherence to previous fall interventions in place. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 3/18/22 the DON documented Monitoring for effectiveness . Repeated falls associated with one resident and has improved fall likelihood and occurrences. None to report at this time. Ongoing review during Eagle Room standup and stand down . Falls decreased and interventions in place. Monitoring or results of interventions completed .Reminders to staff based on situation and likelihood of falls or recurrent falls. Staff continue to monitor and implement fall prevention interventions .Completed initial and ongoing .Great success with anticipation of exceeding goal of 50% reductions in falls. Monitoring ER tool shows 7 falls since implementation of PIP and increased monitoring, Audits, and education. 2 of the current falls are from the same residents for a total of 6 residents with 7 falls in 19 days . Conclusions Was PIP successful? Yes Final notes Fall reduction was greater than 50% during the last 30 days Increased Monitoring and early detection of fall risks at the time of admission has decreased falls and the risk of falls. Several of the falls counted in this PIP were the same resident with repeated falls. Resident fall risks were greatly increased due to resident confusion which has increased since admission. Resident has been placed at the nursing station during the day and while awake to increase integration and monitoring. The Medical Director on 7/30/22 at 5:30 p.m. said, I have had had discussion with the administrator about incomplete incident reports and making sure they were completing the incident reports and notifying the physicians about any falls. The physician was asked if these discussions were in QAPI, she said it was when she had seen things were missed was when she had had these discussions with the administrator. The Medical Director was asked about staffing issues at the facility, she said, Overall, we do discuss staffing because the past year has been very difficult. They try to fill in the staffing with minimum as required. The pandemic has impacted staffing as well. We need to work more as a team have a more team approach into these issues. The physician said at other facilities there had been fall committees. The Medical Director was asked if she was aware of a fall committee at the facility, she said she was not aware of the facility having a fall committee during the last year.