STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265638	A. Building B. Wing	06/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baptist Homes, Tri-County	601 North Galloway Road Vandalia, MO 63382

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 41412 See Event id# E4E212 This deficiency is uncorrected. For previous examples, refer to the Statement of Deficiencies dated 3/2/22. Based on interview, and record review, the facility failed to take into consideration resident rights for one resident (Resident #500) of eight sampled residents, when staff restricted the resident from attending outings and doctor appointments he/she and his/her family wished to attend and controlled the resident's life more than necessary. The facility census was 56. Review of the Nursing Home Residents' Rights, showed the following: -Residents of nursing homes have rights that are guaranteed by the federal Nursing Home Reform Law. The law requires nursing homes to promote and protect the rights of each resident and stresses individual dignity and self-determination. Many states also include residents' rights in state law or regulation; -Right to a Dignified Existence: -Be treated with consideration, respect, and dignity, recognizing each resident's individuality; -Quality of life is maintained or improved; -Exercise rights without interference, coercion, discrimination, or reprisal; -Equal access to quality care; -Right to Self-Determination: -Choice of activities, schedules, health care, and providers, including attending physician; -Request, refuse and/or discontinue treatment; -Right of Access to: (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Individuals, services, community members and activities inside and outside the facility; -His/Her personal physician; -Participate in social, religious and community activities. Review of the undated facility policy, titled Resident's Rights, showed the following: These resident rights ensure that at least, each resident admitted to this facility: -5. Is encouraged and assisted, throughout his/her period of stay, to exercise his/her rights as a resident and as a citizen, and to this end may voice grievances and recommend changes in policies and services to facility staff and/or outside representatives of his/her choice free from restraint, interference, coercion, discrimination or reprisal; -9. Is treated with consideration, respect and full recognition of his/her dignity and individuality, including privacy in treatment and care for his personal needs. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 1. Review of Resident #500's closed record showed an admission MDS, completed by facility staff, dated 4/13/22 with the resident assessed as follows: -admitted from an acute hospital on 4/6/22 under a Medicare, Part-A stay; -Cognitively intact; -It was very important to have his/her family involved with his/her care; -Somewhat important to do favorite activities; -On a scheduled pain medication regimen; -Not receiving PRN pain medications; -Not receiving non-medication interventions for pain; -Almost constant, moderate pain presence; -No opioid use; -Occupational therapy services began 4/12/22; -Physical therapy services began on 4/6/22. Review of the resident's care plan, last updated 4/21/22, showed the following: -Provide nursing rehab as needed; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Pain management section, alteration in comfort: pain related to constant moderate back pain; -On-going assessment of the resident's pain with emphasis on the onset, location, description, intensity of pain and alleviating and aggravating factors; -Administer medications as ordered; -Refer to rehab services as needed; -Discuss with resident pain management; -Monitor behavior and assess for pain/discomfort; -Pain consult as ordered. Review of the resident's May 2022 physician order sheets (POS) showed orders for the following: -Diagnoses included arthritis and low back pain; -Admit to the facility; Medicare Part A, order date of 4/6/22; -May have leave of absence with medications, order date of 4/6/22; -May participate in planned activities as tolerated, order date of 4/6/22; -Physical therapy evaluation and treatment, order date of 4/6/22; clarification on 5/16/22, therapy once daily for five days/week for 30 days until 6/12/22; -Occupational therapy evaluation and treatment, order date of 4/6/22; clarification on 5/27/22, therapy once daily for four days/week for four week until 6/23/22. Review of the resident's pain management physician's progress note, dated 5/2/22 showed the following: -Resident presented with complaint of low back pain; occurring in intermittent pattern for years and located in the lower back and right buttocks; pain score seven out of 10; resident reported rubbing did help; -Received a L3-4 lumbar epidural (injection into ones back) steroid injection (an injection of medication for pain into the epidural space that surrounds the spinal cord and nerve roots) per the physician in the hospital and the resident reported it helped quite a bit; happy with the results; -Resident to continue drug regimen as ordered. During an interview on 6/7/22 at 7:45 P.M., the resident's Family Member B said the following: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident was admitted to the facility from the hospital due to a baclofen (pain medication) overdose; prior to his/her hospitalization , he/she lived at home and he/she went to the facility for therapy; -The resident had an appointment with the pain management specialist (physician) on May 2nd, 2022 at 3:15 P.M. Family Member B met the resident and the facility driver at the clinic. The physician said the resident could have another injection within 30 days of this appointment without an additional consult. The pain management specialist also said that it was normal to have the second of the four annually, allowable injections, closer together and recommended getting the second shot within the 30 days to avoid a lapse in pain management, especially because the resident was doing therapy. Family Member A was told by the administrator and the DON that the resident would not be allowed to have the injection while at the facility because it was not related directly to his/her diagnosis. The resident was in the hospital for 16 days due to an accidental Baclofen overdose prescribed by a doctor attempting to manage his/her back pain. While in the hospital, the resident received an injection in his/her back to help manage the pain. The hospital discharged the resident and he/she went to the facility for rehab. The family could not see any way that a follow up injection to manage the resident's back pain would not be directly related to his/her diagnosis. The facility violated the resident's rights by not allowing him/her to see a physician he/she had chosen and treatment he/she wanted. During an interview on 6/9/22 at 9:15 A.M., Family Member A said the following: -The resident had seen the pain specialist on 5/2/22 as a follow-up from being seen while the resident was in-patient at the hospital. While in the hospital, the resident had received an injection for pain. At the follow up, it was recommended for the resident to have a second injection and best time to administer it would be within 30 days of the first injection. The family had planned to make a follow-up appointment from this appointment, after checking schedules, for the resident to receive the second injection for pain control. The pain management specialist had also said the resident's blood thinner would need to be held for three days prior to the injection and the facility would have to be made aware; -When he/she was trying to discuss with the administrator about the injection and the need to hold the blood thinner (which he/she would have had the provider send the facility notification about once the date for injection was determined), the administrator told him/her the resident could not return to the clinic to receive this injection because everything about the resident's stay had to be related to his/her diagnoses. To receive the injection, the resident would have to come off Medicare Part-A if he/she wanted it; -This was confusing to him/her as the resident was at the facility for therapy, but also as a result of an overdose to pain medication, so he/she felt like pain control was part of the resident's diagnoses and reason for the facility stay. During an interview on 6/9/22 at 1:10 P.M., the pain management specialists office staff (Registered Nurse) said the following: -He/She was present when the resident was seen in clinic on 5/2/22; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The provider had said it is common practice for patients to have a regimen of multiple steroid injections, usually up to four times a year; -After the first injection, a follow-up is held to see if the first injection was successful in relieving pain, and if so, best practice is that the second injection is given around 30 days or so from the first injection and the patient could just come in for the injection without being seen again; -It was stated at the appointment by the provider, that if the patient (the resident) and family felt like they wanted to pursue a second injection, no official order was needed, and that the injection would be completed at an office appointment; an appointment would have to be made for a later date because the resident was on a blood thinner and the medication needed to be held for three days prior to the injection; -The provider was in agreement with continued injections for pain control for the patient. During an interview on 6/7/22 at 7:45 P.M., the resident's Family Member B said the following: -At admission, the resident and family were told that the resident could leave for special occasions as long as all of his/her therapy was done and he/she was back by midnight. Family Member B told the therapist that the family planned to take the resident to a senior tea at a local high school (where the resident had two senior grandchildren) on Monday, May 9th 2022 at 2:00 P.M. and that the family would have the resident back by 3:00 P.M. The therapist said that it would work because he/she had to work in another town that morning and could do the resident's therapy in the afternoon. The family also notified the Social Services Director of the trip. Monday morning, May 9th, 2022, the resident had his/her hair done, put on his/her black outfit and waited for Family Member B to give him/her a ride. About mid-morning Family Member B got a call from Family Member A saying the facility told him/her that if the family took the resident to any non-medical events that his/her Medicare would be canceled and that the family would have to pay all of the back pay for the time the resident had already spent there. Family Member B went to the facility at 1:00 P.M. as planned and explained to the resident that he/she was not going to be able to go to the tea (the resident was very disappointed as he/she had been looking forward to it) Family Member B spent the rest of the afternoon on the phone with Medicare (the resident had therapy on Monday at 4:00 P.M. as planned). Tuesday, May 10th 2022, at 8:00 A.M., Family Member B called the administrator and he/she (Family Member B) had a conference call with the administrator and the director of nursing (DON). Family Member B explained to them that he/she believed that they had misread the Medicare rules and that if Medicare refused to pay any portion, Family Member B would gladly pay for it. The facility then agreed that the Medicare rules did not prohibit the resident from attending these milestone events. The issue was that the facility restricted the resident from attending events (May 9th) that he/she would have enjoyed doing and had every right to attend. Review of text messages between Family Member A and the Social Services Director that were sent on 5/8/22 at 8:15 P.M. showed the following: -Family Member A sent a picture of three upcoming dates and times of events the resident wanted to attend and that the family would take the resident to; this list included May 9th, 2022, showing Family Member B would pick the resident up at 1:00 P.M. and return at 4:00 P.M.; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The Social Services Director texted back, ok, will let (the administrator) know usually skilled not allowed to that much. Skilled only doctor appointments and spec (special) occasions .or they can deny pymt (payment). Will show (the administrator); -Family Member A responded (the resident) has two grandkids graduating and these are all senior award, senior tea and graduation special events. Please let me know if it's a problem. Thanks!; -The Social Services Director responded, I will .think those may qualify. If it were my grandkids I would want to go. During an interview on 6/9/22 at 9:15 A.M., Family Member A said the following: -The resident had really been looking to forward the graduation event; -It was disappointing to the resident that the facility told him/her he/she could not attend the event; -The resident had been tearful that he/she could not attend and said it was not fair; -The family had been told that if the resident missed too many days at the facility and kept coming and going to appointments and events when he/she was on Medicare Part-A, that Medicare Part-A would not pay for his/her facility stay; -The family had told the Social Service Director, who the facility requested all the communication go through, that if for some reason Medicare Part-A did not pay for any part of the stay, the family would be willing to pay private pay. During an interview on 6/10/22 at 4:28 P.M., the facility physical therapist said the following: -There was no set time for a resident to have therapy; times varied and therapy could be worked around the resident's cares and needs; -It was his/her understanding from the facility that they preferred for the resident to have their therapy services completed before they went out on outings; -Family had approached him/her about the resident going on an outing on May 9th and he/she had told the family he/she could do the therapy with the resident when he/she returned from the outing; he/she was going to be at another facility earlier in the day, so that was fine; -One May 9th, he/she had performed the resident's physical therapy between 4:20 P.M. and 5:05 P.M.; -The occupational therapy notes showed that care team worked with the resident twice that day, once from 3:04 P.M. to 3:19 P.M. and 10:30 A.M. to 11:20 A.M. During an interview on 6/8/22 at 2:15 P.M., the Social Services Director said the following: -Residents who are on Med-A cannot be coming and going from the facility all of the time or their stay will not be paid for; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident's family had said that if Med-A did not pay for any reason that they would pay the private pay rate; this was not discussed at admission so she did not know how that could be handled; it would reflect bad on the facility with Medicare if they let the resident attend all of these things; if the resident attended all of these things Medicare would question why he/she was at the facility; -It just had always been his/her understanding that resident's getting therapy services and who were on Med-A were not to leave the facility and if they did, therapies had to be done first and no overnight stays; the family never requested overnight stays but were taking or wanting to take him/her to all of these social events and doctor appointments. Record review of the Medicare Benefit Policy Manual, Chapter 8, dated 08/06/2021, showed the following, The practical matter criterion should never be interpreted so strictly that it results in the automatic denial of coverage for patients who have been meeting all of the SNF level of care requirements, but who have occasion to be away from the SNF for a brief period of time. While most beneficiaries requiring a SNF level of care find that they are unable to leave the facility, the fact that a patient is granted an outside pass or short leave of absence for the purpose of attending a special religious service, holiday meal, family occasion, going on a car ride, or for a trial visit home, is not, by itself evidence that the individual no longer needs to be in a SNF for the receipt of required skilled care. During an interview on 6/10/22 at 9:06 A.M., the Director of Nursing said the following: -Resident #500 was admitted to the facility on Medicare Part-A services; -She had always been told that resident's on Medicare Part A stays could only go to appointments related to their skilled therapy or admission diagnoses; -If the resident was admitted for therapy due to a drug overdose from prescribed medication for pain, attending or seeking additional care from a pain management specialist might have been related to the resident's diagnoses; -If for some reason residents on Med A left the facility, their therapy services had to be completed first. During an interview on 6/8/22 at 2:45 P.M. and 6/10/22 at 9:06 A.M., the administrator said the following: -Residents on Medicare Part-A stays can only go to appointments and receive skilled cares related to their admission diagnoses; she was not sure what the resident's official admission diagnoses was but she thought the resident was admitted for therapy services; She would have to ask the DON if the resident's diagnoses was related to pain to say if he/she should have been approved to get the injection at the pain specialist clinic; -It had always been a rule that if a resident was there for therapy, therapy needed to be done before he/she left the facility for anything; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-If a resident was having his/her stay paid for by Medicare Part-A and coming and going as much from the facility as Resident #500 was, Medicare would probably ask if the resident needed to be at the facility.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41412 See event ID E4E212 This deficiency is uncorrected. For previous examples, refer to the Statement of Deficiencies dated 3/2/22. Based on observation, interview, and record review, the facility failed to provide reasonable access to call lights for five residents (Resident #13, #43, #44, #409, and #410), in a review of 20 sampled residents. The facility census was 56. Review of the facility, undated, Call light policy showed the following: -The facility will maintain a call light system in the facility for all residents and staff members to use for assistance and/or emergencies; -All nursing staff will be educated and trained on constant checking of the monitors to ensure call lights are being answered timely and each resident has their call light within reach for use. Review of the facility Call Light Assessment, dated 4/5/22, showed the following: -Fifty-nine residents were assessed for their ability to use a call light; -No names listed on the assessment form, only room numbers; -One resident needed a tent call light placed under his/her chin; -One resident needed a call light placed in his/her hand; -Fifty-seven residents documented as able to use push button call light. 1. Review of the facility's call light assessment, dated 4/15/22, showed Resident #13 could use a push button call light. Review of the resident's quarterly MDS, dated [DATE], showed the following: -He/She had severely impaired cognition; -He/She was totally dependent on one or more staff members for bed mobility, toilet use, personal hygiene, bathing, locomotion and transfers; -He/She used a wheelchair for locomotion; -He/She was always incontinent of bladder and bowel. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 6/8/22 at 8:22 A.M., showed the resident sat in his/her wheelchair next to the sink in the room. The call light was located on other side of the room on the head of bed and not within the resident's reach. Observation on 6/8/22 at 1:48 P.M., showed the resident lay in bed with eyes closed. The resident's call light was on the floor out of the resident's reach. 2. Review of Resident #44's quarterly MDS, dated [DATE], showed the following: -He/She had severely impaired cognition; -He/She had total dependence of one or more staff members for bed mobility, toilet use, personal hygiene, bathing, locomotion, and transfers; -He/She used wheelchair for locomotion; -He/She was always incontinent of bladder and bowel. Review of the facility's call light assessment, dated 4/15/22, showed the resident could use a push button call light. Observation on 6/8/22 at 8:25 A.M., showed the following: -The resident sat in his/her wheelchair and cried out as he/she uncovered himself/herself. The resident's call light was on the opposite side of the bed out of the resident's reach; -Certified Nurse Assistant (CNA) K entered the resident's room, covered the resident, then showed the resident pictures hanging on the wall; -When CNA K left the resident's room, the call light remained on the opposite side of the bed. During an interview on 6/8/22 at 1:53 P.M., CNA K said the following: -Staff received training about putting call light within resident's reach before leaving the room; -Staff received training about placement of tent call light and which residents needed to have the call light placed in their hand so it's easy to find; -He/She didn't realize the call light was on the opposite side of the bed from Resident #44 when he/she left the resident's room. 3. Review of Resident #409's quarterly MDS, dated [DATE], showed the following: -He/She had severely impaired cognition; -He/She had total dependence of one or more staff members for toilet use, personal hygiene, bathing, locomotion, and transfers; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She used wheelchair for locomotion; -He/She was always incontinent of bladder and bowel. Review of the facility's call light assessment, dated 4/15/22, showed the resident could use a push button call light. Observation on 6/8/22 at 8:28 A.M., showed the following: -The resident sat in his/her wheelchair with his/her eyes closed; -The resident's wheelchair was positioned between the resident's bed and the wall. The resident's call light was located on the opposite side of the bed and not within the resident's reach. 4. Review of Resident #43 significant change MDS, dated [DATE], showed the following: -He/She had severely impaired cognition; -He/She required extensive assistance from two or more staff members for bed mobility, personal hygiene, and dressing; -He/She had total dependence of one or more staff members for toilet use, bathing, locomotion, and transfers; -He/She was always incontinent of bladder and bowel. Review of the facility's call light assessment, dated 4/15/22, showed the resident could use a push button call light. Observation on 6/8/22 at 8:28 A.M., showed the resident lay in bed with his/her eyes closed and the call light was behind the bed out of the resident's reach. 5. Review of Resident #410's facility's call light assessment, dated 4/15/22, showed the resident could use a push button call light. Review of the resident's quarterly MDS, dated [DATE], showed the following: -He/She had severely impaired cognition; -He/She had extensive assistance of one or more staff members for bed mobility, personal hygiene, and dressing; -He/She had total dependence of one or more staff members for toilet use, bathing, locomotion, and transfers; -He/She used a wheelchair for locomotion; -He/She was always incontinent of bladder and bowel. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 6/8/22 at 1:48 P.M., showed the the resident lay in bed with eyes closed. The resident's call light was behind the head of bed and out of the resident's reach. 6. During interview on 6/8/22 at 10:30 A.M., Certified Medication Technician (CMT) R said the following: -Staff received training about putting call light within resident's reach before leaving the room; -Staff received training about placement of the tent call light and which residents needed to have the call light placed in their hand or pinned to the resident so it's easy to find; -He/She didn't know why residents wouldn't have a call light within reach or who left the residents without a call light within reach. 7. During interview on 6/10/22 at 8:25 A.M., the director of nursing (DON) said she expected all residents have call light within reach.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265638	A. Building B. Wing	06/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baptist Homes, Tri-County	601 North Galloway Road Vandalia, MO 63382

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 41412 See event ID E4E212 This deficiency is uncorrected. For previous examples, refer to the Statement of Deficiencies dated 3/2/22. Based on interview and record review, the facility failed to provide safe transfers as directed by the resident's plan of care for one resident (Resident #444) in a review of 11 sampled residents. Staff transferred the resident without the use of a gait belt (a device put on a patient who has mobility issues, by a caregiver prior to that caregiver moving the patient) and lifted/pulled on the resident's arms which resulted in a fractured humerus (bone of the upper arm). The facility census was 56. Review of the undated facility policy, titled Transfers, showed it did not address gait belt use. 1. Review of Resident #444's Fall Risk Assessment, dated 3/14/19 and completed by facility staff, showed the following: -Intermittent confusion; -History of one to two falls in the past three months; -Elimination with assistance; -Poor vision status; -Required use of assistive device; -Score totals equaled 15 which indicated high risk of falls. Review of the resident's physician orders showed for mobility/activities, resident to transfer with gait belt and assist of two with an order date 2/28/22. Review of the resident's care plan showed the following: -Falls: potential for injury, last updated 2/21/19; -On 8/5/19, the resident had had a fall onto the toilet due to loss of balance; -ADL's, transfer with gait belt and two assist, last updated 5/19/22. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 5/21/22, showed the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Cognitively impaired; -No upper extremity impairment; -Extensive assistance of two staff for transfers and toileting; -No falls since admission. Review of the resident's facility progress notes, dated 5/22/22 at 5:14 P.M., showed staff documented staff was toileting the resident when he/she lost his/her balance and sustained a skin tear to his/her right forearm measuring 7 centimeters (cm). Skin tear was cleansed, approximated and steri-strips applied and covered with tega-derm. Review of a facility accident report, dated 5/22/22 at 5:30 P.M. showed staff documented Certified Nurse Assistants (CNA)s were toileting the resident. Reported the resident was standing at the grab bar, body stiffened and he/she started to fall towards the toilet. Each CNA reported that they grabbed an arm to keep him/her from falling. A loud pop was heard from the right arm. Resident complained of pain. Blood was seen coming through his/her arm protector and a skin tear was sustained to his/her right forearm measuring 7 cm. Skin tear was cleansed, approximated, and steri-strips applied and covered with tegaderm. Review of the resident's X-ray report, dated 5/23/22 at 9:16 A.M., showed the following: -Procedure: X-ray of right shoulder; -History: right shoulder pain after being stopped from a fall after the nursing home aide grabbed the resident; -Findings: there was a pathological fracture (occurs when a bone breaks in an area that was already weakened by another disease) of the possible diaphysis (the main or midsection (shaft) of a long bone) of the humerus; -Impression: Pathological fracture through suspicious bone lesion in the proximal diaphysis of the humerus. Review of the resident's X-ray report, dated 5/23/22 at 9:16 A.M., showed the following: -Procedure: right X-ray humerus; -History: last night fell , humerus pain; -Findings: there was a transverse/obliquely oriented fracture of the proximal third diaphysis of the right humerus with approximately 7 millimeters (mm) of lateral and proximal 1 cm of superior displacement of the distal fracture fragment; -Impression: Proximal right humerus fracture. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's progress notes, dated 5/23/22 at 6:24 P.M., showed staff documented that the mobile x-ray service was at the facility for the resident to complete an x-ray of his/her right shoulder. X-ray showed the resident had a proximal right humerus fracture and suspicious bone lesion of proximal diaphysis humerus. The resident was having more pain in his/her right shoulder and orders for hydrocodone (narcotic pain medication) 5/325 milligram (mg), one tablet every six hours as needed for pain was received. Review of an undated written statement by CNA NN showed the following: -On 5/22/22, he/she and CNA J were assisting the resident with toileting; -The resident was standing at the grab bar, became stiff and started falling forward; -CNA J and he/she grabbed the resident's arms to get him/her on the toilet and they heard a popping sound; -Later the resident complained of right shoulder pain. Review of an undated written statement by CNA J showed the following: -On 5/22/22, resident was in the bathroom as another staff and CNA J were doing personal care; -As the resident stood facing the wall and held onto grab bar, he/she stiffened up and he/she began to fall; -Both staff members reached under the resident's armpits to try and lift the resident and a pop was heard. Observation on 6/7/22 at 11:30 A.M., showed the resident sat in his/her wheelchair in the dining room, he/she was noted to have a sling on his/her right arm. During an interview on 6/7/22 at 11:40 A.M., CNA J said the following: -The resident was wearing a sling because he/she had recently fractured his/her shoulder; -On 5/22/22 he/she had assisted the resident out of bed and into a wheelchair and noted him/her to be a little wobbly, so later, when the resident needed to be toileted, he/she had asked CNA NN for assistance; -During both of these transfers, a gait belt had not been used; he/she usually did not have to use a gait belt to assist the resident; gait belts were available for use; -He/She thought the resident was an assisted transfer of one staff and that his/her transfer status changed to assist of two after the incident of 5/22/22; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-During the bathroom transfer of the resident on 5/22/22, the resident was standing at the grab bar while he/she and CNA NN provided care; the resident began to fall forward and both he/she and CNA NN grabbed under the resident's arms to try and lift him/her back from the fall; it was at that time that a pop was heard but he/she was not sure where it came from; -The resident now experienced pain with movement and cares and required pain medication, was less active and required more assistance. During an interview on 6/7/22 at 12:15 P.M., CNA L said the following: -The resident used to self-propel in his/her wheelchair about the unit but since his/her arm was in a sling he/she was no longer doing that; -The resident also used to assist with toileting by using a grab bar to pull him/herself up and steady him/herself but either the sling or the pain medication was preventing him/her from doing that; -The resident had some definite changes since fracturing his/her arm. During an interview on 6/7/22 at 2:48 P.M. the administrator said the following: -Residents should be transferred according to how their care plan directs staff to transfer them; -On 5/22/22, staff should have transferred the resident using a gait belt and interviews of staff involved with his/her transfer showed a gait belt had not been used; -The use of a gait belt would have prevented staff from grabbing under the resident's arms when he/she began to fall forward; -Grabbing under the resident's arms could have been the cause of his/her fracture. MO201549 MO201528