DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165235	A. BUILDING ______ B. WING ______	C 01/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOX CARE CENTER	111 EAST VAN BUREN LENOX, IA 50851

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date 02/01/2019 Complaints # 79754-C and # 79771-C were substantiated. Investigation of facility's reported incident #79879-I resulted in deficiency. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	This plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal Law. F000: Deficiencies Corrected by 02/01/2019	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F 623	It is the practice of the facility to ensure that residents being involuntarily discharged from facility received required notice of that discharge. F623 1.Resident # 3 was discharged from the center on 11/10/18.No further action can be taken at this time. 2.On January 28, 2019 the Administrator performed an audit of current residents of the facility for the need to consider transfer/discharge options. 3. The Administrator provided in service education between January 28, 2019 and anuary 30, 2019 to department supervisors related to the requirements and expectations of transfer/discharge of facility resident's. 4. The Administrator and/or designee will conduct random audits to validate staff are following policy and procedures as required 3 times per week for 3 weeks, then weekly for a minimum of 3 months, quarterly thereafter if need continues. The administrator or designee will report findings of above monitoring system monthly times 3 months to the facility quality assurance program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed. 5. Date of Compliance: 1/31/19	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	2-1-19

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.

POC accepted 3/4/19 VV [illegible]

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F 623	Continued From page 1 before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with	F 623		

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F 623	Continued From page 2	F 623		

developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, facility policy review and staff interview, the facility failed to notify a resident of an involuntary discharge from the facility for one of five residents reviewed (Resident #3). The facility reported a census of 28 residents.

Findings include:

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F 623	Continued From page 3 According to the Minimum Data Set (MDS) assessment dated 10/26/18, Resident #3 had diagnoses of dementia, Parkinson's disease and bipolar disorder. A Brief Mental Status (BIMS) documented a score of 9, indicating moderate cognitive and memory impairment. The MDS documented the resident did not display physical, verbal or other behavioral symptoms during the 7-day assessment period. The resident's Care Plan documented a focus area dated 5/7/18 of Parkinson's disease with interventions directing staff to monitor for signs and symptoms of depression and consult with mental health as needed. Staff should provide emotional support, encouragement and encourage the resident to vent her feelings about her disease. A focus area dated 5/7/18 documented Resident #3 had a behavior problem related to bipolar disorder with the goal to have fewer episodes by the review time. Progress Notes dated 10/1/18 4:04 a.m. - 10/3/18 at 1:01 p.m. documented Resident #3 would refuse to take her medications. An entry on 10/4/18 at 10:08 a.m. documented facility staff contacted the resident's previous inpatient treatment center to update them on the resident's behavior and to notify them of the facility's attempt at placement with another facility. Progress Notes dated 10/4/18 at 2:10 p.m. - 10/10/18 at 1:58 p.m. documented the resident's continual refusal of medication, a decline in activities of daily living (ADL's) and refusal of assistance from staff. A note dated 10/11/18 at 5:42 p.m. documented Resident #3 hit her roommate. The resident's roommate was	F 623		

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F 623	Continued From page 4 removed from the room and assigned to a different room. Staff provided 1:1 supervision for Resident #3. An entry dated 10/17/18 at 3:11 p.m. documented the facility received a new preadmission screening and resident review evaluation (PASRR). The Medical Director reported the resident as not appropriate to reside at the facility and she required inpatient psychiatric evaluation and treatment. A Progress Notes dated 10/17/18 at 4:16 documented the resident transferred to a local hospital emergency room for evaluation and treatment. The Emergency Room note dated 10/18/18 at 11:00 a.m. documented the resident in ER due to suicidal ideation. The resident stated she didn't know why she was in ER and babbled things about the nursing home trying to poison her and sprinkle her with angel dust. A Progress Note dated 10/18/18 at 12:20 p.m. documented the resident returned to the facility. Staff transferred # 3 to her room and to bed. Notes of the same date at 2:01 p.m. documented the resident medically stable and able to be transferred to a psychiatric institution for inpatient evaluation and treatment. An entry at 4:58 PM documented the nurse called multiple facilities for the resident's placement without success so far. Progress Notes dated 10/18/18 at 4:48 p.m. - 10/26/18 at 4:00 p.m. documented the resident continued with 1:1 staff supervision and showed manic behaviors. Progress notes dated 10/30/18 documented staff from an out of state behavioral health inpatient facility would have an open bed the following morning; on 10/31/18 at 1:12 p.m.	F 623		

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F 623	Continued From page 5	F 623		

Resident #3 transferred to the out of state inpatient facility. The facility Administrator continued to assist in finding long term placement for the resident that met PASRR identified needs after inpatient treatment.

A Progress Note dated 11/9/18 at 4:47 p.m. documented the Administrator spoke to staff from the out of state inpatient who reported they were discharging the resident back to the facility. The Administrator reported they would not accept #3 Resident citing there wasn't a private room available, the resident can't have a roommate due to a history of aggression toward residents and the facility's inability to provide the care needs identified in the PASRR.

Review of the resident's clinical record did not reveal staff provided the resident with a Notice of Involuntary Discharge.

The facility's Administrative Manual, revised 7/15, instructed staff to provide a written notice of at least 30 days when the facility wishes to discharge a resident. The written notice must include the reason for transfer/discharge, the effective date, the location of discharge or transfer, and the right of appeal and notification of how to reach the long-term ombudsman and/or the appropriate protection and advocacy agency. Further, the facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

During an interview dated 1/8/18 at 3:30 p.m. the Administrator reported the PASRR completed 10/17/18 identified specialized services for the resident's behavioral health and/or development

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F 623	Continued From page 6 condition the facility could not provide. The facility did not issue a Notice of Involuntary Discharge to the resident or her representative.	F 623		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document	F 656	It is the practice of the facility to implement and/or establish a care plan reflective that identified each resident's need for medical, nursing, mental and psychosocial care. F656 1. On January 28, 2019 the MDS/ Care plan coordinator has updated/revised the care plan for resident number one to reflect the residents need for medical, nursing, mental and psychosocial care and resident number three no longer resides at facility. 2. Between January 28, 2019 and January 31, 2019. The Director of Nursing and/or designee completed an audit on current resident careplans to ensure they reflect each resident's need for medical, nursing, mental and psychosocial care. 3. On January 30, 2019 the Director of Nursing re-educated the Interdisciplinary Team regarding the requirement to maintain the plan of care to reflect the resident's current medical, nursing, mental and psychosocial needs.	

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F 656	Continued From page 7 whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and staff interviews, the facility failed to implement and/or establish a care plan reflective that identified each resident's need for medical, nursing, mental and psychosocial care for two of five residents reviewed (Residents #1 and #3) reviewed. The facility reported a census of 28 residents. Findings include: 1. Resident #1's Minimum Data Set (MDS) assessment dated 9/4/18 recorded diagnoses that included dementia and Parkinson's disease. The assessment documented he experienced severe cognitive impairment. The MDS documented Resident #1 the assistance of two staff with transfers and walking, had range of motion impairment in both upper extremities and used a wheelchair with staff assistance for locomotion. The resident's Care Plan dated 3/16/18 identified a high risk for falls related to confusion, gait/balance problems due to Parkinson's disease and lack of awareness for safety needs. Interventions included placing the resident in a recliner at the nurse's station when restless, placement of a modified lap buddy when in the	F 656	4. The Director of Nursing and/or designee will review scheduled care plans weekly times 3 weeks and monthly times 3 months to validate needed revisions are reflected on the resident's plan of care. The Director of Nursing and/or designee will report findings of the above monitoring system monthly times 3 months through the facility quality assurance program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed. 5. Date of Compliance: 1/31/19	

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wheelchair for positioning, to monitor him every 30 minutes, remove the lab buddy every two hours for toileting and ambulation and place a non-skid tube to wheelchair seat between resident and cushion. The Care Plan did not establish interventions to address the resident's repetitive action of removing his lap buddy from his wheelchair and for staff to monitor the resident when sitting in his wheelchair.

The Incident Report dated 8/14/18 at 6:32 a.m. documented an aide reported the resident held onto the dining room table and lowered himself to his knees on the floor. Staff assessed the resident and noted no injuries.

The Incident Report dated 10/2/18 at 7:45 a.m. documented several staff were present when the resident, sitting in his wheelchair in the front lobby with the lap buddy in place, removed the lap buddy and fell forward out of the wheelchair on to the floor. An assessment revealed no injuries.

The Incident Report dated 11/9/18 at 11:00 a.m. documented Staff A, a licensed practical nurse (LPN) heard a loud noise and saw the resident had tipped his wheelchair forward with him lying on his right side on the floor in front of the nurse's desk. The nurse documented one side of the lap buddy was on.

During an interview dated 1/7/19 at 10:58 a.m., Staff A stated the resident has a history of moving the lap buddy when sitting in the wheelchair.

On 1/7/19 at 11:31 a.m., Staff B, LPN reported the resident fidgets and leans forward when sitting in the wheelchair. The resident has a history of falling out of the wheelchair and staff

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F 656	Continued From page 9 are to keep their eyes on him at all times. During an interview on 1/719 at 11:45 a.m., Staff C, a certified nursing assistant (CNA) reported staff at the nurse's station were to keep their eyes on the resident as he has a history of removing the lap buddy and a history of falling from his wheelchair. During an interview on 1/7/18 at 12:00 p.m., Staff D, LPN reported he had worked the day shift 6:00 a.m. - 2:00 p.m. on 11/9/18. He reported the fall could have been prevented if staff had put the resident down to rest. Staff have been directed to keep eyes on him at all times. Staff C reported when the resident fell, he was sitting at the nurse's station with his back toward the resident. During an interview on 1/7/19 at 1:10 p.m., the Director of Nursing reported the fall of 8/4/18 occurred when the resident self-transferred from his wheelchair during a meal and lowered himself to the floor. The last two falls, 10/8/18 and 11/9/18 occurred when he sat in his wheelchair and fell forward on to the floor. These falls could have been avoided if staff had positioned the resident behind the nurse's station where nurses were positioned. 2. According to the MDS assessment dated 10/26/18, Resident #3 had diagnoses of dementia, Parkinson's disease and bipolar disorder. The assessment documented a Brief Interview for Mental Status score of 9, indicating moderate cognitive and memory impairment. The MDS documented the resident did not display physical, verbal or other behavioral symptoms during the 7-day assessment period. The MDS indicated a significant change in status which	F 656		

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required an updated assessment. The assessment identified increased extensive assistance two staff with transfer, bed mobility, toilet use and dependence with bathing. Additionally the resident needed extensive assistance of one staff with dressing and personal hygiene.

The Care Plan contained focus areas dated 5/7/18 and 8/10/18 with interventions related to Parkinson's disease, the use of anti-anxiety, psychotropic medications related to bipolar disease and behavioral problems. The care plan did not reflect the physical care needs and behavioral changes identified from the MDS assessment of 10/26/18. Interventions were not established giving staff specific directions in performing the need cares and behavioral actions of the resident.

A Progress Note dated 10/17/18 at 3:11 p.m. documented the facility received a new preadmission screening and resident review evaluation (PASRR). The Medical Director reported the resident as not appropriate to reside at the facility and she required inpatient psychiatric evaluation and treatment.

During an interview on 1/7/19 at 4:10 p.m. the Administrator reported the PASRR completed 10/17/18 identified specialized services for the resident's behavioral health and/or development condition the facility could not provide.

During an interview on 1/9/18 at 11:10 a.m. the Director of Nursing reported the care plan had not been updated despite changes in the resident's behavior and care needs. She reported a PASRR outlining additional focus areas and interventions

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F 656	Continued From page 11 could not be implemented. The facility had been trying to seek inpatient treatment during this period and it would have been impossible to establish interventions with all of the physical and behavioral changes the resident had presented.	F 656		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff and resident interviews, the facility failed to provide adequate supervision to prevent an accident causing injury for one of five residents reviewed (Resident #1). The facility reported a census of 28 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated 9/4/18 indicated he had diagnoses that included dementia and Parkinson's disease. The assessment documented Resident #1 had severe cognitive impairment. The resident needed the assistance of two staff with transfers, had impaired range of motion in both upper extremities and used a wheelchair with staff assistance for locomotion. The resident's Care Plan contained a focus area	F 689	It is the practice of the facility to provide supervision to prevent an accident causing injury. F689 1. Resident #1's fall plan of care was reviewed and revised to reflect current fall interventions and the plan was communicated to the Interdisciplinary Team on January 25, 2019 by the Director of Nursing/designee. 2. The Director of Nursing completed an audit on January 25, 2019 to identify current residents of the facility who are at risk of injury related to falls. The DON and MDS coordinator will review and revise the care plans of the residents who were identified on January 25th who are in need of fall prevention and will include communication to staff. 3. Staff were in-serviced between on January 17, 2019 to January 25, 2019 by Administrator and DON related to fall prevention policies and expectations, including providing supervision to prevent accidents causing injury for resident #1 and current residents.	

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F 689	Continued From page 12 dated 3/16/18 that identified the resident as at high risk for falls related to confusion, gait/balance due h/her Parkinson's and lack of awareness of h/her safety. Interventions included placing the resident in a recliner at the nurse's station when restless, placement of a modified lap buddy when in h/her wheelchair for positioning, for staff to monitor h/her every 30 minutes and remove the lab buddy every two hours for toileting and ambulation and place a non-skid tube to wheelchair seat between resident and cushion. Physical therapy recommended to lower the back of the wheelchair seat to prevent the resident from falling forward. The Incident Report dated 8/14/18 at 6:32 a.m. documented an aide reported the resident held onto the dining room table and lowered himself to his knees on the floor and started to crawl. Staff assessed the resident and noted no injuries. Staff reported they were unable to reach the resident when the resident lowered h/herself to the floor. The Incident Report dated 10/2/18 at 7:45 a.m. documented several staff were present when the resident, sitting in his wheelchair in the front lobby with the lap buddy in place, removed the lap buddy and fell forward out of the wheelchair on to the floor. An assessment revealed no injuries. The Incident Report dated 11/9/18 at 11:00 a.m. documented Staff A, a licensed practical nurse (LPN) heard a loud noise and saw the resident had tipped his wheelchair forward with him lying on his right side on the floor in front of the nurse's desk. The nurse documented one side of the lap buddy was on. but one of two sides of the	F 689	4. The Director of Nursing or designee will conduct random audits to ensure staff continue to follow policy and procedures as required 3 times per week for 3 weeks, then weekly for a minimum of 3 months, quarterly thereafter. Results of the audits will be reported monthly for a minimum of 3 months to the facility QAPI committee for tracking/trending to validate ongoing compliance. The plan will be reviewed and revised as indicated and staff will be re-educated as need. 5. Date of Compliance: 1/25/19	

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F 689	Continued From page 13 modified lap buddy had moved from normal position. The resident attempted to sit upright and moved all extremities independently. An assessment revealed no injuries. Staff assisted the resident from the floor with the use of a Hoyer back into his wheelchair. The resident appeared restless and was required to be placed next to the nurse until lunch time. A Progress Note dated 11/9/18 at 6:00 p.m. documented staff reported the resident showed signs of pain. Staff A entered the resident's room and found him to be awake and alert to his name. She asked the resident if he hurt and had difficulty understanding the resident. The resident grimaced when she assisted with his incontinent brief and when rolling from side to side, Resident #1 grimaced again, moaned and stated his hip and right groin hurt. The resident reported his back hurt. Staff positioned the resident to a seated position on the edge of the bed and the resident once again grimaced. Upon standing for stand a pivot transfer, Resident #1 placed weight on his left leg and used the toes on the right leg and moaned when he sat down. Staff completed range of motion to both hips and knees and the resident stated it hurt only with right hip movement. Staff contacted the resident's physician who ordered an evaluation/treatment at a local hospital emergency room. The resident transported to the hospital via ambulance and prior to transport staff administered pain medication. An X-ray of both hips on 11/9/18 at the hospital revealed no hip or pelvic fractures. The X-ray showed chronic heterotopic ossification noted with lower lumbar degenerative changes similar to prior images.	F 689		

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F 689	Continued From page 14 Progress Notes dated 11/10/18 at 11:31 p.m. recorded Resident #1 displayed pain when repositioning but when asked denied having pain. Progress notes dated 11/11/18 at 7:58 p.m. documented staff administered Acetaminophen 650 milligram (mg) as the resident showed signs of pain during evening cares. Progress notes dated 11/14/18 at 1:26 a.m. documented pain medication given he displayed non-verbal indications of pain (facial grimacing and grabbing his leg) during repositioning related to the right leg/hip area. Progress Notes dated 11/14/18 at 3:54 p.m. documented he showed signs of discomfort by rubbing the right thigh. While walking from the bathroom to bed with two assist, it appeared his pelvis and left hip or the curvature of the back or hip had greater protrusion. The resident walked differently with his right leg and acted as if it had been painful to bear weight. Progress Notes dated 11/15/18 at 9:49 a.m. documented the resident's speech can be mumbled at times and hard to understand. At times he is able to make his needs known but doesn't always make sense when speaking and at times is confused. The residents usually understands what is being said to him, but has difficulty comprehending and following through with requests or cues at times. Progress Notes dated 11/20/18 at 3:56 p.m. documented MDS charting, noting resident is not physically restrained but had a lap buddy to assist with sitting up due to his Parkinson's disease. The resident could not sit up and had increased pain.	F 689		

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F 689	Continued From page 15 Progress Notes dated 11/20/18 at 5:45 p.m. documented staff sent a fax to CHI Health center as Resident #1 had increased pain while walking during therapy. The resident raised his leg when attempting to walk. Staff are questioning a pelvic X-ray. An X-ray report dated 1/21/18 documented the reason for the imaging was recent fall, pain and inability to walk. Findings of the X-ray revealed a displaced fracture of the proximal femur (hip), likely involving the right femoral neck. Progress Notes dated 11/21/18 at 3:09 p.m. documented Resident #1 denied pain but non-verbal cues are opposite. An entry at 5:48 p.m. documented during a staff transfer from bed to a gurney, he had facial grimacing and kept his knees flexed. Staff administered Acetaminophen 650 mg for pain. Progress notes dated 11/21/18 at 6:31 p.m. noted the resident's primary physician reported she was getting a second opinion about the resident's fracture. The resident's physicians believed the resident needed a surgical consult. Staff notified the resident's family and they agreed to have him sent to the hospital emergency room and then to another facility for a surgical consult. Medication Administration Records (MARs) for 11/1/18-11/30/18 revealed Acetaminophen 650 mg every four (4) hours prescribed as needed (prn) for pain. This record documented this medication hadn't been administered 11/1/18 - 11/8/18, but had been administered with increased frequency or a total of 20 times beginning 11/9/18 - 11/30/18 for pain.	F 689		

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F 689	Continued From page 16 An Internal Investigation-Injury of unknown origin documented the resident fell from his wheelchair on 11/9/18. X-ray results on 11/9/18 revealed no fracture seen. The resident received physical therapy on 11/13/18. The resident would, at times, show signs of pain with pain medication administered as needed. On 11/20/18 the resident walked with therapy and nurses observed he did not walk very well. Staff requested an order for another X-ray. Results of the X-ray showed a right basiccervical hip fracture. During an interview dated 1/7/19 at 10:58 a.m., Staff A reported the fall the resident sustained on 11/9/18 was preventable. Resident #1 had been sitting in his wheelchair with a lap buddy placed in front of him and sat in the front lobby approximately 15 feet from the nurse's station. Staff A reported the resident is to be placed adjacent to staff at all times. Resident #1 has had previous falls and is not to be left unattended. The morning of 11/9/18 she had directed staff to lay the resident in bed but had seen him sitting in his wheelchair. When she asked staff why they hadn't laid him down as directed, staff reported another nurse told them to keep the resident up. Staff A recalled that she and Staff D, LPN sat at the nurse's station talking to another resident's family members when she heard a loud noise. She stated she had charted her observation in a progress note on 11/9/18 at 1:22 p.m. The progress note recorded Resident #1 tipped his wheelchair forward and laid on the floor on the right side. It appeared one side of the lap buddy was in place on one side but not the other. She reported the resident has a history of moving the lap buddy when sitting in his wheelchair. Staff are directed to keep eyes on him at all times.	F 689		

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During an interview on 1/7/19 at 11:31 a.m., Staff B, LPN reported she didn't work on 11//9/18 and hadn't witnessed the fall. She recalled that Resident #1 fidgeted and leaned forward when sitting in the wheelchair. The resident has a history of falling out of the wheelchair and staff are to keep their eyes on him at all times. Staff are to put the resident to bed mid-morning until lunch time. Staff are directed to get him up last for meals as he becomes restless. The resident could move the lap buddy as he has strong upper body strength.

During an interview on 1/719 at 11:45 a.m., Staff C, a certified nursing assistant (CNA) reported there are four CNA's scheduled for days. On 11/9/18 there were only two CNA's working that morning. She and another staff got the resident up from bed and placed him in a wheelchair before lunch and placed him in front of the television. Staff at the nurse's station were to keep their eyes on him as Resident #1 had a history of removing the lap buddy and of falling from the wheelchair.

During a phone interview on 1/7/18 at 12:00 p.m., Staff D, LPN (former) reported he worked the day shift 6:00 a.m. - 2:00 p.m. on 11/9/18. He reported Resident #1 has a history of falls, including falling out his wheelchair. A lap buddy had been previously used but was discontinued because it was considered a restraint. The lap buddy was put back into use to reduce the resident's back pain and also because he leaned forward and this reduced his ability to lean to far forward. The resident frequently removes the device and becomes increasingly restless. The morning of 11/9/18 Staff A had directed staff to lay

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the resident down in bed but another nurse had told staff to keep the resident up, as they were short CNA's. The fall could have been prevented if staff had put the resident down to rest. Staff have been directed to keep eyes on him at all times. Staff C reported when the resident fell, he was sitting at the nurse's station with his back toward the resident.

During an interview on 1/7/19 at 1:10 p.m., the Director of Nursing reported the resident fell on 8/4/18, 9/9/18, 10/8/18 at 11/9/18. The fall of 8/4/18 occurred when the resident self-transferred from the wheelchair during a meal and lowered himself to the floor. The fall of 9/9/18 occurred when the resident self-transferred from bed and staff found him in the bathroom. The last two falls, 10/8/18 and 11/9/18 occurred when he sat in his wheelchair and fell forward on to the floor. These falls could have been avoided if staff had positioned the resident behind the nurse's station where nurses were positioned. The lap buddy kept Resident #1 from leaning forward and it corrected his posture. She confirmed staff hadn't put the resident to bed to rest as they normally did.

During an interview on 1/8/18 at 2:30 p.m. the resident's wife stated staff informed her of the resident's fall on 11/9/18. Resident #1 went to the hospital for evaluation and treatment. An X-ray was negative for fracture but she believed the X-ray results were in error. She reported her spouse has a high tolerance for pain and doesn't communicate clearly due to Parkinson's disease.