Citation Numbe	er:			Date:			
5431				Novem	ber 3, 2021		
Facility Name:		•	Survey Dates:				
Sunrise Hill Care Center			October	October 12 - 21, 2021			
Facility Address/City/State/Zip							
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Rule or					Correction		
Code Section Nat		e of Violation	Class	Fine Amount	date		

58.28(3)e	481—58.28(135C) Safety. The licensee of a nursing facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III) 58.28(3) <i>Resident safety</i> .	I	\$5,000 (Collected)	Upon Receipt
+	<i>e.</i> Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III)			
58.19(1)	481—58.19(135C) Required nursing services for residents. The resident shall receive and the facility shall provide, as appropriate, the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules:			
	58.19(1) <i>Activities of daily living.</i> <i>g.</i> Ambulation with equipment if applicable, or transferring, or positioning; (I, II, III)			

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DESCRIPTION:		
Based on observation, clinical record review, and interview, the facility failed to provide adequate supervision to protect against self, others, or hazards in the environment for 3 of 4 residents reviewed (Resident #1, #2, #3). On 5/20/21, Staff J, Certified Nursing Assistant (CNA) walked with the resident toward the bed without using a gait belt around the resident's waist in accordance with facility policy. As Staff J pulled back the covers on the bed, the resident stumbled backward, fell into a cabinet, and slid to the floor. On 5/22/21, Resident #1 could not bear weight on the right leg and exhibited facial grimacing and staff sent Resident #1 to the Emergency Room (ER). The resident subsequently admitted to the hospital with a right hip fracture. The facility reported a census of 48 residents.		
Findings include: 1. According to the Minimum Data Set (MDS) assessment tool dated 4/15/21, Resident #1 had		

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	diagnoses that included Alzheimer's Disease and non-
	Alzheimer's dementia. The MDS documented staff
	could not administer the Brief Interview for Mental
	Status (BIMS) test because they could rarely/never
	understand the resident. The MDS also documented
	Resident #1 required extensive assist of 1 staff for bed
	mobility and dressing, and extensive assist of 2 staff
	for transfers, ambulation (walking), toilet use, and
	personal hygiene.
	The care plan initiated 2/5/21 documented Resident
	#1 required assistance with all activities of daily living
	(ADLs). An intervention updated on 4/23/21 directed
	to transfer the resident with assist of 1 staff.
	The progress notes contained the following entries:
	a. On 5/20/21 at 7:45 PM - Nurse summoned to unit.
	Staff reported they were walking the resident to bed
	and staff stopped to pull back the bedding. The
	resident then stumbled backward, their left shoulder
	fell into a cabinet, and the resident slid to floor. Staff
	assessed the resident's range of motion (ROM) as
	within normal limits (WNL) and found no
	signs/symptoms (s/s) of injury or skin issues. Two (2)

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staff then assisted the resident to transfer from the		
floor to the bed and noted no facial s/s of discomfort		
with movement and weight bearing.		
b. On 5/22/21 at 12:30 PM - Staff reported resident		
the required assist of 2 staff, needed a wheelchair to		
transport, and could not to bear weight on the right		
leg. The nurse documented the resident winced and		
exhibited facial grimacing with ROM to right leg, but		
able to perform ROM to left leg without difficulties.		
c. On 5/22/21 at 2:30 PM - Physician on call ordered		
staff to send Resident #1 to ER to evaluate and treat.		
d. On 5/22/21 at 5:48 PM - Staff placed call to hospital		
ER and spoke with staff: "She has a broken hip, we are		
admitting her."		
A Fall/Incident Report dated 5/20/21 7:45 PM,		
documented when staff walked Resident #1 to bed		
and then pulled the bedding back, the resident		
stumbled backwards, right shoulder fell against		
cabinet, and the resident slid to floor.		

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A Radiology Report dated 5/22/21, documented an x- ray of Resident #1's right hip contained findings of a mid-cervical fracture, right femoral neck (fracture of right hip).		
During an interview on 10/14/21 at 3:16 PM, Staff J, CNA stated she was in Resident #1's room with the resident and was going to assist the resident to bed. Staff J, CNA stated the resident flared with her arms, lost her balance, fell, and landed on her right hip: more on her side than her bottom. Staff J stated she did not have a gait belt on the resident, did not know the resident needed assist of 2 staff. She added she thought Resident #1 needed stand-by assistance only. Staff J, CNA stated, "I probably should have put a gait belt on her."		
The Gait Belt facility policy updated 7/29/06 directed staff to use a gait belt for all residents requiring assistance with transfers and/or ambulation. It serves as a handle to grasp if the resident begins to fall, to help prevent the fall, or control the resident's descent.		

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During an interview on 10/14/21 at 11:25 AM, Staff L, CNA stated prior to fracturing her hip, Resident #1 required assist of 1 staff with a gait belt, for transfers and ambulation.			
During an interview on 10/14/21 at 11:58 AM, Staff M, CNA stated prior to fracturing her hip, Resident #1 required assist of 1 staff with a gait belt, for transfers and ambulation.			
During an interview on 10/19/21 at 12:10 PM, Staff K, CNA stated if she needed to know how to transfer a resident, she would review the care plan books located at the nurses' station. Staff K, CNA stated she does not carry a CNA information sheet for her hall.			
During an interview on 10/19/21 at 12:45 PM, the Assistant Director of Nursing (ADON) stated the facility provides CNAs information hall sheets if they want them, although some CNAs do not carry them. The information sheets contain directives related to whether or not a resident experiences urinary incontinence or uses Ted Hose, glasses, or dentures,			
	 CNA stated prior to fracturing her hip, Resident #1 required assist of 1 staff with a gait belt, for transfers and ambulation. During an interview on 10/14/21 at 11:58 AM, Staff M, CNA stated prior to fracturing her hip, Resident #1 required assist of 1 staff with a gait belt, for transfers and ambulation. During an interview on 10/19/21 at 12:10 PM, Staff K, CNA stated if she needed to know how to transfer a resident, she would review the care plan books located at the nurses' station. Staff K, CNA stated she does not carry a CNA information sheet for her hall. During an interview on 10/19/21 at 12:45 PM, the Assistant Director of Nursing (ADON) stated the facility provides CNAs information hall sheets if they want them, although some CNAs do not carry them. The information sheets contain directives related to whether or not a resident experiences urinary 	CNA stated prior to fracturing her hip, Resident #1 required assist of 1 staff with a gait belt, for transfers and ambulation. During an interview on 10/14/21 at 11:58 AM, Staff M, CNA stated prior to fracturing her hip, Resident #1 required assist of 1 staff with a gait belt, for transfers and ambulation. During an interview on 10/19/21 at 12:10 PM, Staff K, CNA stated if she needed to know how to transfer a resident, she would review the care plan books located at the nurses' station. Staff K, CNA stated she does not carry a CNA information sheet for her hall. During an interview on 10/19/21 at 12:45 PM, the Assistant Director of Nursing (ADON) stated the facility provides CNAs information hall sheets if they want them, although some CNAs do not carry them. The information sheets contain directives related to whether or not a resident experiences urinary incontinence or uses Ted Hose, glasses, or dentures,	CNA stated prior to fracturing her hip, Resident #1 required assist of 1 staff with a gait belt, for transfers and ambulation. During an interview on 10/14/21 at 11:58 AM, Staff M, CNA stated prior to fracturing her hip, Resident #1 required assist of 1 staff with a gait belt, for transfers and ambulation. During an interview on 10/19/21 at 12:10 PM, Staff K, CNA stated if she needed to know how to transfer a resident, she would review the care plan books located at the nurses' station. Staff K, CNA stated she does not carry a CNA information sheet for her hall. During an interview on 10/19/21 at 12:45 PM, the Assistant Director of Nursing (ADON) stated the facility provides CNAs information hall sheets if they want them, although some CNAs do not carry them. The information sheets contain directives related to whether or not a resident experiences urinary incontinence or uses Ted Hose, glasses, or dentures,

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5431				Nov	vember 3, 2021
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Code Section Nat		re of Violation	Class	Fine Amou	nt date
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	ADON stated expectat	n 10/18/21 at 12:12 PM, the ion that anytime staff have to			

ADON stated expectation that anytime staff have to help a resident to transfer, the staff are to use a gait belt and if a resident is care planned for assist of 1 or 2 for transfers, should always use a gait belt.		
Review of statement signed by ADON, dated 10/19/21, documented the ADON spoke with the Director of Nursing (DON) and the DON stated she discussed Resident#1's fall with Staff J, CNA and Staff J, CNA admitted she should not have let go of the resident and did not have a gait belt on the resident.		
2. According to the MDS assessment dated 9/16/21, Resident #2 had diagnoses that included diagnoses of Alzheimer's disease and diabetes. The MDS documented the resident needed extensive assist of 1 staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS revealed the resident scored 3 of 15 possible points on the BIMS test, which meant the resident demonstrated severely impaired cognitive abilities.		

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During an observation in the living room on 10/12/21 at 11:22 AM, Staff A, CNA transferred Resident #2 from the couch to a wheelchair by placing their hand/arm under the resident's arm and pulling up on the resident. Staff A, CNA did not use a gait belt to transfer the resident.		
Review of Resident #2's care plan initiated 7/1/21 documented a focus of ADL/Falls with an intervention updated on 8/19/21 that directed staff to transfer the resident with assist of 1 person.		
During an interview on 10/19/21 at 2:30 PM, the ADON reported the facility's expectation for staff to transfer Resident #2 with a gait belt and assist of 1 staff.		
3. According to the MDS assessment dated 8/5/21, Resident #3 had diagnoses that included anxiety disorder, depression, and other fracture. The MDS documented the resident needed limited assist of 1 staff for transfers and extensive assist of 1 staff for bed mobility, ambulation, dressing, toilet use, and		
personal hygiene. The MDS also documented the resident scored 12 of 15 possible points on the BIMS		

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	test which meant the resident displayed moderate
	cognitive impairment.
	Review of a care plan initiated 8/12/21 documented a
	focus of self-care/ambulation/falls with a history of
	left femur (upper leg bone) fracture from a fall prior
	to admission. A care plan updated 9/2/21
	documented Resident #3's has been transferring by
	themselves and also taking themselves to the toilet,
	despite education regarding the need for assist and
	alarm placed for safety. A care plan intervention
	added 9/2/21 directed staff to ensure
	placement/functioning of alarms every shift.
	An observation on $10/10/21$ at $10/10 = 0.004$ revealed
	An observation on 10/19/21 at 10:50 AM revealed
	Resident #3 sat in her wheelchair in the living room
	with a pressure alarm pad under her which flashed
	green.
	The progress notes contained the following entries:
	a. 10/4/21 at 1:45 PM - Nurse summoned to Resident
	#3's room by staff and found the resident on both
	(bilateral) knees on the floor in front of the bed;
	resident not sure what she was doing and denies pain
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or hitting head. Resident placed in wheelchair with alarm on and functioning correctly, and taken to the living room for an activity.		
 b. 10/5/21 at 10:19 AM - Resident noted with intact red/purple bruise which measured 2.5 centimeters (cm) x 8.5 cm to lateral left hip related to fall sustained on 10/4/21. 		
c. 10/6/21 at 8:49 AM - Resident noted with intact purple bruise that measured 8 cm x 4.3 cm to medial right hand related to fall that occurred 10/4/21.		
Review of the fall/incident report, dated 10/4/21 at 1:45 PM, documented Resident #3 found on bilateral knees in front of bed.		
During an interview on 10/14/21 at 11:40 AM, Staff L, CNA, stated on 10/4/21 a resident in the hallway reported Resident #3 was on the floor. Staff L reported she went to Resident#3's room with Staff N,		
CNA and observed the resident on the floor. Staff L reported she was unsure if the resident's alarm positioned in her recliner was going off or not. Staff L		

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	stated there is a freque	ent beep when the alarm				

stated there is a frequent beep when the alarm		
battery is going dead and then the battery is replaced.		
During an interview on 10/14/21 at 2:22 PM, Staff O,		
LPN stated on 10/4/21, she found Resident #3 on the		
floor on both of her knees. Staff O stated the alarm		
was not going off when she found the resident and		
the alarm did not go off while it was in the recliner.		
Staff O stated after caring for the resident, she		
changed the batteries in the alarm and the alarm did		
work. Staff O stated they check alarms on rounds and		
at shift change and the nurses sign off to show the		
alarms are working every shift, because they are		
supposed to be checked every shift.		
During an interview on 10/19/21 at 10:53 AM, Staff N,		
CNA stated on 10/4/21 she was walking by Resident		
#3's room and observed the resident on the floor on		
her knees. Staff N, CNA stated the alarm was in the		
resident's recliner but was not going off, and she		
reported the alarm not going off to Staff P, LPN.		
Roview of facility's "Personal Alarm Monitor Sheet"		
Review of facility's "Personal Alarm Monitor Sheet"		
for Resident #3 documented, signature acknowledges		
 alarm is correctly placed and functioning, and	ļ	

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	appropriate use for thi initialed by Staff O, LPN	s resident with 10/4/21 days N.			

During an interview on 10/14/21 at 2:45 PM, Staff P, LPN stated alarms are checked at the beginning of the shift to make sure in place, but she does not always check to be sure the alarms are turned on. Staff P, LPN also stated she documented in the book every night that alarms were on and present, but she does not always verify the alarms are in working order every shift even though she signs off in the book as completed.		
During an interview on 10/19/21 at 11:10 AM, Staff O,		
LPN stated on 10/4/21, she checked Resident #3's		
alarm at the beginning of her shift (6 AM-10 PM) and		
heard the alarm going off when staff got the resident		
up that morning and other times throughout the day.		
Staff O, LPN stated CNAs from the 2 shifts, at shift		
change, check the alarms together, then she walks		
the halls later in her shift to check the alarms and		
checks the alarms again at bedtime. Staff O, LPN		
stated she always checks the alarms herself and signs		
off in the book, as the facility has a policy to check		
 alarms.		

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Review of facility's policy titled "Personal Alert Monitors", updated 8/28/06, documented: Purpose to alert staff to any potential risky behaviors a resident may have that could result in a fall. Each shift, the charge nurse documents that the monitor is present and functioning properly. Be aware when the monitor seems to be sounding weaker as this could indicate the battery needs to be changed.		
FACILITY RESPONSE:		

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