DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Harrison Senior Living

DATE SURVEY COMPLETED: November 29, 2022

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and cites the findings specified in the Federal Report. An unannounced Complaint Survey was conducted at this facility from October 17, 2022, through November 29, 2022. The deficiencies contained in this report are based on observations, interviews, record reviews and other facility documentation as indicated. The facility census on the first day of the survey was one-hundred and three (103). The survey sample totaled nine (9) residents.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state, and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by the following:** Cross refer to CMS 2567-L survey completed November 29, 2022: F609, F689 and F690.		

Provider's Signature Lisa M. Foley, LNHA Title Administrator Date 12/29/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085029	A. BUILDING _____ B. WING _____	C 11/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON SENIOR LIVING OF GEORGETOWN, LLC	110 W. NORTH STREET GEORGETOWN, DE 19947

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F 000	INITIAL COMMENTS An unannounced Complaint Survey was conducted at this facility from October 17, 2022, through November 29, 2022. The deficiencies contained in this report are based on observations, interviews, record reviews and other facility documentation as indicated. The facility census on the first day of the survey was one-hundred and three (103). The survey sample totaled nine (9) residents. Abbreviations and definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; CT scan - imaging test that takes detailed pictures of the inside of the body. Delirium - an acutely disturbed state of mind from illness or intoxication; DON - Director of Nursing; ER - Emergency Room; Hematoma - a collection of blood as a result of trauma, such as a black eye; Incontinence - loss of control of bladder and/or bowel function; LPN - Licensed Practical Nurse; Lucency - bright, clear; MD - Medical Doctor; Minimum Data Set (MDS) - standardized assessment forms used in nursing homes; Neurological (neuro) assessment - examination that assesses vital signs and oxygen level, level of consciousness (includes verbal response), orientation to person, place and time, ability to open eyes, pupil check, speech, strength in upper and lower limbs and motor responses, such as withdrawal to touch and extension of limb(s);	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/28/2022

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.

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F 000	Continued From page 1 NHA - Nursing Home Administrator; NP - Nurse Practitioner; Orthostatic blood pressures - monitoring of a patient's blood pressure to discern if blood pressure is getting lower when standing, after sitting or lying down. Orthostatic hypotension - a form of low blood pressure that happens when standing after sitting or lying down; Psychosis - loss of contact/touch with reality; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; UM - Unit Manager.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, 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, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		1/23/23

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F 609	Continued From page 2 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other facility documentation, it was determined that for one (R2) out of three sampled residents reviewed for accidents, the facility failed to report a bruise to the head of unknown origin. Findings include: Review of R2's clinical record revealed: 11/29/21 3:21 PM - A facility incident report documented that R2 had a bruise to the right side of the forehead measuring 3 cm (centimeter) x 3 cm. Due to impaired cognition, R2 was unable to explain the source of the bruise. 11/29/21 3:35 PM - A nursing progress note documented that R2 was observed with a "3 cm x 3 cm bruise to the right side of the forehead of unknown origin." 10/21/22 11:55 AM - During an interview, E1 (NHA) confirmed the injury to the forehead was reportable and the facility failed to report the incident to the State Agency. 10/21/22 1:15 PM - Findings were reviewed with E1 and E2 (RNAC) during the exit conference.	F 609	A. R2 No longer resides in the facility. Therapy consult was completed on R2. The facility was unable to correct. B. Potential affected residents will be identified by completing an audit of facility reports during the last 2 weeks. (Completed on 1/7/2023) C. Root cause analysis was completed and identified lack of knowledge and education by all staff regarding mandatory reporting. Mandatory staff education will be completed by all staff regarding reporting incidences. D. Administrator, DON or designee will conduct audits on all incidents initially daily X 7 days, then decrease to weekly X4, then decrease to monthly X 4, then quarterly X2 while maintaining 100% compliance.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		1/27/23

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F 689	Continued From page 3 §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 record review and interview, it was determined that for one (R8) out of three residents reviewed for accidents, the facility failed to adequately supervise, accurately evaluate and identify R8's risk for falling, analyze R8's recurrent falls, do complete neurological (neuro) checks and implement new interventions after R8 sustained multiple recurrent unwitnessed falls, including four within a 12- hour span. For two of the falls, R8 sustained harm and was hospitalized. One fall resulted in a left side brain bleed and in another he sustained a finger fracture. An additional fall with injury occurred when R8 sustained a hematoma to the right side of his forehead which resulted in a transfer to the Emergency Department. Findings include: Cross refer F690 A facility policy (last revised 4/2006) entitled Urinary Continence and Incontinence - Assessment and Management included: - The staff and practitioner will appropriately screen for, and manage, individuals with urinary incontinence. - As appropriate, based on assessing the category and causes of incontinence, the staff will	F 689	A. Facility unable to correct past deficient practices related to R8. Currently, R8 has an effective plan of care, which includes one to one supervision 24 hours a day 7 days per week and a toileting schedule that accommodates his toileting needs. B. All residents at risk for falls have the potential to be affected. The DON or designee will conduct the following facility wide audits; All newly admitted residents and all residents identified on the current facility Quality Measure- Lo Risk of Bowel/ Bladder report for the past 2 weeks will be audited for assessment completion, toileting plan initiation with analyzation and revision as indicated, and care plan revision with interventions as indicated. Toileting documentation for all falls within the last 7 days, including those that occurred at night, will be reviewed for completion and toileting programs and care plans will be analyzed and updated as indicated. All neurological assessments for all unwitnessed falls and falls in which the resident hit his/ her head recent falls	

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F 689	Continued From page 4 provide scheduled toileting, prompted voiding, or other interventions to try to manage incontinence. - Toileting programs will start with a 3-5 day toileting assistance trial. - Incontinence care should be individualized at night in order to maintain comfort and skin integrity and minimize sleep disruption. A facility policy (last revised 9/26/17) entitled Fall Management Policy and Procedure included: Neurological checks will be completed as follows: -every 15 minutes x (times) 4. -every 30 minutes x 2. -every 1 hour x 2. -every 4 hours x 5. -When a resident is sent to an acute care setting post fall for an evaluation, upon return to the facility neurological checks will begin at hourly intervals. A facility policy (last revised 3/2018) entitled Falls and Fall Risk, Managing included: Resident conditions that may contribute to the risk of falls include: - delirium and other cognitive impairment. - incontinence. Resident-Centered Approaches to Managing Falls and Fall Risk: - If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. A facility policy entitled Neurological Policy and Procedure (last revised 3/1/22) included:	F 689	within the past 7 days will be assessed for neurological assessment initiation and completion as indicated. All most recent resident fall risk assessments will be reviewed for accuracy and reassessed, if indicated. All fall care plans for all falls within the past 7 days will be audited for intervention appropriateness related to resident□s cognition and diagnoses. C. Root cause analysis was completed and identified a need for re-education of nursing staff. All nurses to receive re-education regarding: Bowel and bladder assessment completion with evaluation and analyzation of toileting program with care plan revision and intervention implementation. Neurological assessment implementation and thorough completion, including during hours of sleep. Completion and accuracy of fall risk assessments. Care planning and initiation of appropriate interventions post-fall. All CNAs to receive re-education regarding; Completion and accuracy of toileting documentation. D. The DON/ MDS Coordinator/ designee will conduct the following audits weekly x4, then monthly x4, and then quarterly: All newly admitted residents and all residents identified on the current facility	

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F 689	Continued From page 5 Neurological assessments are indicated: -Following an unwitnessed fall. Review of R8's clinical record revealed: 5/27/22 - R8 was admitted to the facility with dementia, psychosis, orthostatic hypotension, and a history of prostate cancer. 5/27/22 - R8's incontinence care plan included: -Bowel and Bladder assessment on admission, significant changes and prn (as needed). -Toileting plan as ordered. Monitor for effectiveness and revise as needed. -Three day trial bowel and bladder diary schedule. Offer toileting every two hours. -Complete voiding diary on admission and as needed for changes in condition. -Check and change pads/briefs as appropriate. 5/27/22 - R8's impaired mobility care plan included: -Walk in room with one staff assistance with rolling walker. 5/27/22 - R8's fall care plan included: -Attempt to engage resident in meaningful activities such as music, companionship, crafts, 1 on 1 interactions, etc. -Encourage non-skid footwear/non-skid socks. -Reinforce the need to call for assistance. -Provide a well lit, clutter free environment as able. -Provide and encourage resident to use handrails or assistive devices properly as ordered. 5/27/22 4:28 PM - R8's fall risk assessment documented a score of 15 which indicated that R8 was at moderate risk for falls. R8 sustained	F 689	Quality Measure- Lo Risk of Bowel/ Bladder report will be audited for assessment completion, toileting plan initiation with analyzation and revision as indicated, and care plan revision with interventions as indicated. Toileting documentation for all falls, including those that occurred at night, will be reviewed for completion and toileting programs and care plans will be analyzed and updated as indicated. All neurological assessments for falls will be assessed for neurological assessment initiation and completion as indicated. All resident fall risk assessments will be reviewed for accuracy and reassessed, if indicated. All fall care plans will be audited for intervention appropriateness related to resident□s cognition and diagnoses.	

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F 689	Continued From page 6 multiple falls prior to admission to the facility. 5/27/22 - Review of R8's clinical record revealed that the facility had evidence of a three day voiding diary on admission, but the facility lacked evidence that a bowel and bladder assessment was completed at that time. In addition, after R8's voiding diary was completed, the facility lacked evidence that the voiding trial diary was analyzed and that an individualized toileting plan was developed and implemented for R8. 5/31/22 - R8's admission MDS assessment documented that R8 was severely cognitively impaired, he required extensive assistance of two staff members for bed mobility and transfers, assistance of one staff member for walking, extensive assistance of one staff member for toileting, he was not steady for transfers and ambulation and was only able to stabilize with staff assistance. R8 was also frequently incontinent of bowel and bladder. 6/1/22 9:56 AM - An interdisciplinary progress note documented: Review of event: (R8 had an) unwitnessed fall 6/1/22 at 2:00 AM from bed attempting to get up, no injuries noted. Current interventions included: -gripper socks; -bed/chair pad alarm; -diagnosis of orthostatic hypotension with medications. Follow-up action: -education provided to call for assistance (R8 is cognitively impaired and has memory problems); -ensure call bell within reach (R8 is cognitively impaired and has memory problems); -hipsters (impact-absorbing pads worn under clothes to minimize potential damage that can	F 689		

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F 689	Continued From page 7 occur from a fall); -keep bed at appropriate height for transfers; -provided reacher (R8 is cognitively impaired and has memory problems); -currently on PT (Physical Therapy) caseload; -neuros initiated (neurological checks); -s/p (status post) fall assessment in place; -Ortho (orthostatic) BPs (blood pressures) for three days. Although interventions were put into place, some were not appropriate due to R8's dementia. 6/1/22 - Review of R8's clinical record revealed that the facility lacked evidence that R8 was toileted for many hours and he sustained a fall at 2:00 AM. 8/10/22 and 8/13/22 - R8 was assessed to be at high risk for falls with scores of 23 and 21 consecutively. 8/10/22 12:40 AM - A facility incident review note documented that R8 sustained an unwitnessed fall attempting to toilet himself. R8 was hospitalized after the fall and found to have a subdural hematoma (brain bleed). The facility lacked evidence that R8 was toileted on the 11-7 shift and he sustained harm at the time of the fall. Although baseline vital signs (temperature, pulse, blood pressure and respirations) were obtained at the time of the fall, the clinical record lacked evidence of an initial neurological assessment (neurocheck). 8/12/22 - A new approach was added to R8's careplan although R8 remained in the hospital after his 8/10/22 fall.	F 689		

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F 689	Continued From page 8 8/13/22 8:30 PM - R8 returned from the hospital. In response to R8's 8/10/22 fall, his care plan was revised to include the following new interventions: - Bed at appropriate height when resident in bed; - Encourage use of soft helmet for safety; - Bed/chair pad alarm (different from a clip alarm). 8/15/22 - A facility Bowel and Bladder screening assessment revealed that R8 was a candidate for scheduled toileting. This was the first bowel and bladder assessment that was completed for R8 since admission. 8/17/22 - R8's care plan was revised to include: Safety hazard to self as evidenced by attempting to get out of bed/transfer/ambulate without assistance. 8/17/22 - A therapy screen was sent for OT (Occupational Therapy) to "focus on toileting." The facility failed to identify that R8's fall on 8/10/22 occurred while there was not a toileting plan in place. 8/22/22 12:42 PM - A Physician's progress note documented: "Patient still requires staff assistance with adl's (activities of daily living)." 8/23/22 - A Physician's order included: monthly bowel and bladder program and offer toileting last rounds 11-7 shift, before lunch, after lunch, before dinner and at bedtime. The intervention was added to R8's care plan. This was the first time since 5/27/22 when R8 was admitted to the facility that an individualized toileting plan was implemented.	F 689		

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F 689	Continued From page 9 8/24/22 - A quarterly MDS assessment documented that R8 was moderately cognitively impaired, required assistance of one for activities of daily living (including toileting) and was occasionally incontinent of urine. 9/6/22 7:37 PM - An incident report to the State Agency documented that R8 sustained an unwitnessed fall on the floor "face downward" and was documented as stating that he "slipped on his floor" (in his room). R8 required the assistance of one staff for transfers (although R8's initial MDS assessment, dated 5/31/22, listed that he required extensive assistance of two staff for transfers) and for ambulation (walking). R8 sustained a mouth injury and was bleeding from his nose. R8 was hospitalized and returned to the facility on 9/9/22. The hospital assessment notes documented that R8 had a small laceration to the inside surface of his upper lip and some blood in his right nostril. Although baseline vital signs were obtained at the time of the fall, R8's clinical record lacked evidence of an initial neurocheck despite obvious facial trauma. 9/7/22 12:18 AM - R8 was admitted to the first hospital and found to have a subacute left subdural hematoma (comparable to 28 milliliters of liquid) that had increased in size. R8 was transferred to another hospital for further evaluation. 9/7/22 4:24 AM - A hospital Physician's note documented: "Patient is an 81-year-old male ...who is presenting to the Emergency Department as a transfer from another hospital for a subdural hematoma following a fall. Physical exam is significant for a fourth right digit (finger) ecchymosis (bruising) and limited range of	F 689		

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F 689	Continued From page 10 motion, concern for fracture." 9/7/22 5:26 AM - A hospital Physician's assessment included: x-ray right hand. Disposition: "Admit to inpatient status ....Subdural hematoma. Plan: admit for observation. Chronic subdural hematoma." 9/7/22 7:15 AM - A hospital Physician's note documented: Hand x-ray showing evidence of fourth digit fracture. 9/9/22 - Review of R8's fall risk reassessment revealed that his high risk medications weren't listed and consequently, R8 had a low and inaccurate fall risk score of 15 which indicated that R8 was only at moderate risk for falling, although he was at high risk on 8/10/22 and 8/13/22 with scores of 23 and 21 consecutively a month ago. 9/12/22 4:27 PM - A Physician's progress note documented: "...ambulatory dysfunction due to recent hip surgery." 9/13/22 - A five day MDS assessment documented that R8 was occasionally incontinent of urine. Although R8's incontinence improved, the facility failed to identify that the resident continued to fall during the night with further falls occurring on 9/28/22 and 9/29/22 related to attempting to toilet himself unassisted. The facility failed to review and revise his care plan for nighttime toileting after continuation of R8's attempts with unassisted toileting at night. 9/22/22 1:49 AM - A nursing progress note documented: "Resident was witnessed getting OOB (out of bed) and standing at bedside using	F 689		

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F 689	Continued From page 11 the urinal then sitting back down. Resident redirected and assisted for toileting." The facility failed to recognize the need for R8 to have a nighttime toileting schedule. 9/28/22 3:06 AM - R8 sustained an unwitnessed fall. R8 was documented as stating, "I rolled out of bed trying to go pee." R8 was noted to have a hematoma to the right side of his forehead. R8 was transferred to the ER and returned the same morning at 7:00 AM with a diagnosis of a large right scalp hematoma. The facility lacked evidence that R8 was toileted from 9/27/22 at 8:06 PM until 9/28/22 at 3:06 AM (at the time of the fall 7 hours later) and they failed to identify the need for R8 to have a nighttime toileting schedule. Although neurochecks were not ordered by the Physician, the facility failed to reinitiate hourly neurochecks per facility policy upon R8's return from the hospital. 9/29/22 11:04 PM - R8 sustained an unwitnessed fall without injury. R8 was documented as stating that "He was standing up to use the urinal and drink water." 9/29/22 1:04 AM, 2:04 AM and 3:04 AM - The facility lacked evidence that R8's neurochecks were completed; "sleeping" was documented. 9/30/22 1:20 PM - A physician's progress note documented: "Patient with noted recurrent falls, noted with left orbital eye black/blue bruises from a previous fall when seen and examined today. Patient is very impulsive, fixated on going to the bathroom frequently per nursing staff." 9/30/22 5:14 PM: A Physician's order included: Orthostatic blood pressures for 3 days.	F 689		

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F 689	Continued From page 12 10/3/22 2:17 - A facility Physician progress note documented: "Patient of this facility who presented (name of second hospital) as a transfer from (name of first hospital) after sustaining an unwitnessed fall here at the nursing facility, found to have a left sided subdural hematoma measuring 5-6 mm in thickness without midline shift or herniation. CT was repeated on arrival and was stable ...Hospital stay was complicated by left hip pain: Incidental finding of lucency (an area on an x-ray where the bone is less dense) of hip prosthesis in CAT (CT) scan ...left hip suspicious of loosening." 10/7/22 1:39 PM - A nursing progress note documented: "Resident found by nurse supervisor on the floor (in his room) while responding to bed alarm and hearing resident call out for help. Unwitnessed (fall), resident states he did not hit his head. Upon inspection, no bruising/skin tears present, c/o (complained of) pain to buttock and back." R8 was documented as stating that he was "walking from the door." Review of R8's toileting records revealed that the resident had not been toileted prior to or after lunch per his Physician's ordered toileting schedule on 8/23/22. 10/7/22 2:00 PM - A facility Fall Scene Investigation Report documented that R8's fall on 10/7/22 at 1:39 PM was due to R8's "behavior." 10/15/22 4:57 PM - A nursing progress note documented that R8 sustained an unwitnessed fall in his room next to his bed and was noted to have a skin tear on his left elbow. 10/18/22 12:17 AM - A nursing progress note	F 689		

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F 689	Continued From page 13 documented that R8 sustained an unwitnessed fall in his room without noted injury and stated he was "Trying to get up but was unaware of where he was going." 10/18/22 5:10 AM (approximately five hours since last fall) - A nursing progress note documented that R8 sustained an unwitnessed fall in his room without injury and stated, "He was going to the sofa." R8 did not have a couch in his room. The facility lacked evidence that R8 was toileted on the 11-7 shift. 10/18/22 7:15 AM (approximately two hours since last fall) - A nursing progress note documented that R8 sustained an unwitnessed fall without injury attempting to "Transfer from bed to couch." 10/18/22 11:30 AM (this was the 4th fall in less than 12 hours) - A nursing progress note documented that R8 sustained an unwitnessed fall and was transferred to the ER. R8 stated that "He was trying to go to the park." The facility survey started on 10/17/22 so Surveyors were onsite for some of the 10/18/22 falls. 10/18/22 11:50 AM - During an interview, E2 (RNAC) confirmed that R8 had not had his toileting program re-evaluated since 8/23/22. 10/18/22 2:35 PM - During an interview, E2 (RNAC) confirmed missing entries, not applicable entries, and long intervals of missed toileting in R8's toileting documentation. 10/18/22 4:59 PM - A Physician's order included: "Location checks every fifteen minutes." The	F 689		

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F 689	Continued From page 14 facility lacked evidence of increased supervision despite multiple falls, some requiring hospitalization, until this order was obtained. 10/18/22 8:30 PM - R8 returned from the hospital. R8 sustained 11 falls, all of which were unwitnessed, from 6/1/22 through 10/18/22. Four of the falls occurred on 10/18/22 in less than 12 hours. Three of R8's falls were related to attempting to toilet himself unassisted. R8 was transferred three times to the hospital due to significant injury. There was lack of evidence that the facility not only failed to provide adequate supervision, but they also failed to analyze and implement interventions accordingly to prevent falls. 10/21/22 10:05 AM - During an interview, E1 (NHA) confirmed the neurochecks were not completed, were incomplete or were not reinitiated upon return from the hospital as per facility policy. 11/29/22 8:50 AM- During an interview, E3 (DON) confirmed that although R8 had a three day voiding diary completed on admission, the facility lacked evidence of R8 having a bowel and bladder assessment completed on admission. 11/29/22 11:00 AM - During an interview, E3 confirmed R8's clinical record lacked evidence of consistent toileting as per the Physician's order. Additionally, E3 confirmed that on 10/7/22 the resident record lacked evidence of toileting at 11:00 AM and 1:30 PM and that R8 sustained a fall at approximately 1:30 PM.	F 689		

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F 689	Continued From page 15 11/29/2022 12:55 - During an interview, E3 (DON) confirmed the correlation of the falls and the lack of toileting. 11/29/22 approximately 4:00 PM - Findings were reviewed with E1 (NHA) and E3 during the exit conference.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal	F 690		1/25/23

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F 690	Continued From page 16 incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that for one (R8) out of one resident reviewed for incontinence, the facility failed to assess and initiate new interventions for R8 who required assistance to the bathroom to maintain bladder function. Findings include: Cross refer F689 A facility policy (last revised 4/2006) entitled Urinary Continence and Incontinence - Assessment and Management included: - The staff and practitioner will appropriately screen for, and manage, individuals with urinary incontinence. - As appropriate, based on assessing the category and causes of incontinence, the staff will provide scheduled toileting, prompted voiding, or other interventions to try to manage incontinence. - Toileting programs will start with a 3-5 day toileting assistance trial. - Incontinence care should be individualized at night in order to maintain comfort and skin integrity and minimize sleep disruption. Review of R8's clinical record revealed: 5/27/22 - R8 was admitted to the facility with dementia and psychosis.	F 690	A. R8 currently resides at facility. His care plan is effective and includes a toileting schedule that accommodates his need to toilet anytime with the one-to-one supervision, including any nighttime toileting needs. The facility initiated one-to-one supervision 24 hours a day, 7 days per week on 10/20/2022. B. Newly admitted residents and residents identified on the current facility Quality Measure- Lo Risk of Bowel/ Bladder report have the potential to be affected. All newly admitted residents and all residents identified on the current facility Quality Measure- Lo Risk of Bowel/Bladder for the past two weeks will be audited by the MDS Coordinators or designee for assessment completion, toileting plan initiation, analyzation and revision as indicated, and care plan revision with interventions as indicated. C. Root cause analysis was completed and identified lack of nursing education regarding 3 day diary and bowel & bladder assessment completion, reevaluation of toileting plans, analyzation and lack of care plan revisions. All nursing staff to receive education.	

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F 690	Continued From page 17 5/27/22 - R8's care plan included: - Potential for incontinence: - Bowel and bladder assessment on admission, significant change and as needed. - Complete voiding diary on admission, and as needed for a change in condition (R8 had an initial assessment). - Toileting plan as ordered. Monitor for effectiveness and revise as needed. - Three day trial bowel and bladder schedule. Offer toileting every 2 hours. - Check and change briefs/pads as appropriate. 5/31/22 - An Admission MDS assessment documented that R8 was cognitively impaired, required extensive assistance for toileting, was frequently incontinent of bowel and bladder and that a toileting program was initiated. 8/10/22 12:40 AM - R8 sustained a fall attempting to toilet himself without staff assistance. 8/10/22 - A discharge return anticipated MDS assessment documented that R8 was cognitively impaired, independent with toileting and always continent of bowel and bladder. 8/23/22 - A bowel and bladder assessment included: 3 (three) day bowel and bladder schedule (a voiding diary for three days). Offer toileting every two hours. Review of R8's bladder incontinence documentation lacked evidence of an every two hour voiding diary. 8/23/22 - Although the facility lacked evidence of a voiding diary to evaluate the data for a toileting plan, a Physician's order included: Monthly bowel and bladder program. Offer toileting last rounds 11-7 shift, before lunch, after lunch, before dinner	F 690	D. The DON or designee will audit newly admitted residents and residents who are due for quarterly assessment that trigger on the Quality Measures Lo Risk of Bowel/ Bladder report. Audit for 4 weeks until 100 % compliance is achieved for 4 consecutive weeks then monthly X2. The weekly audits will be submitted and discussed during QAPI and the committee will decide if further audits will be needed.	

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F 690	Continued From page 18 and at bedtime. This intervention was included in the care plan. 8/23/22 - R8's care plan was revised to include the above Physician's order. 8/24/22 - A quarterly MDS assessment documented R8 was moderately cognitively impaired, required assistance of one for activities of daily living (including toileting), and was occasionally incontinent of urine. 9/6/22 10:19 PM - R8 sustained an unwitnessed fall on the floor "face downward" and was documented as stating that he slipped on the floor (in his room). 9/6/22 - A discharge return anticipated MDS assessment documented that R8 was moderately cognitively impaired, required assistance to go to the bathroom and was always continent of bowel and bladder (as documented in his CNA bladder documentation).. 9/28/22 3:00 AM - R8 sustained a fall attempting to toilet himself without staff assistance. 9/29/22 11:04 PM - R8 sustained a fall attempting to toilet himself without staff assistance. There was no evidence that the facility re-evaluated R8's toileting program. 10/7/22 at 6:00 AM through 10/8/22 at 5:27 AM - Review of R8's CNA documentation revealed that the facility lacked evidence of R8 being toileted or was marked as NA (not applicable). R8 fell on 10/7/22 at 1:30 PM.	F 690		

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F 690	Continued From page 19 10/18/22 11:50 AM - During an interview, E2 (RNAC) confirmed R8 had not had his toileting program re-evaluated since 8/23/22. 10/18/22 2:35 PM - During an interview, E2 (RNAC) confirmed missing entries, not applicable entries, and long intervals of missed toileting in R8's toileting program documentation. 10/21/22 11:10 AM - During an interview, E1 NHA confirmed the inconsistent documentation in R8's toileting schedule, that R8 had falls related to unassisted toileting and that R8's toileting schedule had not been reevaluated to revise R8's plan of care for unassisted toileting at night to prevent falls. R8's patterns of toileting were not analyzed, reevaluated and interventions initiated to maintain urinary continence and prevent falls. Although R8 had a toileting plan initiated 8/23/22 after his first fall on 8/10/22 attempting to toilet himself, R8's needs for toileting were not being met at night. R8 continued to have a pattern of falling at night attempting to toilet himself unassisted. 10/24/22 1:15 PM - Findings were reviewed with E1 (NHA) and E2 (RNAC) during the exit conference.	F 690		