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A 000	INITIAL COMMENTS An unannounced complaint survey (Event ID # MT00051249, MT000253, MT000254, MT00051273, and MT00057253) was completed on 9/30/21. Standard deficiencies were cited. Census was 99. Glossary a.m. morning DON Director of Nursing p.m. evenings NOC nights POA power of attorney	A 000		
A 131	PATIENT RIGHTS: INFORMED CONSENT CFR(s): 482.13(b)(2) The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the patient's representative were fully informed of treatment changes related to multiple falls for 1 (#1) of 2 sampled patients.	A 131		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/17/2021

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Findings include:

During an interview on 9/28/21 at 2:20 p.m., NFS1 stated she was never invited to any care meetings for patient #1. NFS1 stated she was not contacted by the facility for patient #1's falls. NFS1 stated she came to visit after patient #1 had fallen on 8/12/21, and was shocked to see patient #1 had a gash above his eyebrow. She was then told he had a fall. NFS1 stated she had told the facility that she wanted to be notified on his condition and all falls.

During an interview on 9/29/21 at 10:37 a.m., staff member A stated POAs and/or guardians were notified if the patient was hurt during a fall, but not always if there was no outcome.

Review of patient #1's falls in June, July, and August 2021, received from staff member C on 9/27/21 at 1:31 p.m., showed the patient fell in May, June, July, and August 2021, a total of 15 times. The dates were:

- 5/10/21 at 3:15 p.m. patient #1 fell out of bed. The patient said he hit his head;
- 5/14/21 a physician order was written for patient #1's bed to be in low position;
- 5/19/21 patient #1 fell twice, next to his bed. A physician's order was written for patient to not self-transfer;
- 6/10/21 patient #1 fell out of bed;
- 6/16/21, physician's order was written for 15-minute safety checks on patient #1; then the order was changed to 15-minute safety checks when in his bedroom;
- 6/23/21 at 5:10 p.m., an unwitnessed fall occurred for patient #1. The patient was found on his back, on the floor. There was no fall mat in

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place next to the bed;
- 6/23/21 at 7:45 p.m., patient #1 fell;
- 6/24/21 at 2:00 p.m., patient #1 reported self-transferring and fell to the side of the bed;
- 15-minute checks were initiated, per the incident report dated 6/24/21;
- 6/26/21 at 8:20 p.m., patient #1 had an unwitnessed fall;
There was no documentation in patient #1's medical record showing NFS1 was notified of any changes to the patient's treatment plan after his falls.
- 6/28/21 at 11:29 a.m., NFS1 was called about the fall and laceration patient #1 had over his eyebrow. The writer of the note explained the need for a new plan to prevent falls would be to leave wheelchair at the front of room or outside the room, "to discourage pt. [patient] from attempting to self-transfer."
- 7/30/21 at 2:35 p.m., patient #1 had a fall.
Review of Patient #1's physician orders for precautions, showed the patient was on 15-minute checks when in his room, with a start date of 6/28/21, and an ending date of 8/2/21.
- 8/4/21 at 2:15 p.m., patient #1 fell.
- 8/11/21 at 4:42 p.m., patient #1 fell.
- 8/12/21 at 12:40 p.m., patient #1 fell out of his wheelchair, in the TV room, after leaning forward in the wheelchair. The patient had a laceration on the left side of his forehead.
There was no documentation in patient #1's medical record showing NFS1 was notified at the time of patient #1's falls on 8/12/21.
- 8/13/21 at 9:35 a.m., the patient's fell out of bed and reopened his forehead laceration.

Review of patient #1's Comfort Treatment form, dated 8/6/21, showed NFS1 would be actively involved in patient #1's psychological and medical

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A 131	Continued From page 3 care. Review of the hospital's policy, "Informing/Communication Changes in Patient's Condition," effective date June 1, 2018, showed the purpose was to keep family members, guardians, or other appropriate people informed of significant changes in a patient's health status. The policy showed, "Significant changes in a patient's health status (physical or mental) should be communicated to family members, guardians, or other appropriate person." ..."Patients will be requested to identify the person...to whom they would like to have information conveyed, however, circumstances may require other notifications as well."	A 131		
A 145	PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT CFR(s): 482.13(c)(3) The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to thoroughly investigate the unexpected death to show that neglect did not occur for 1 (#3); and failed to ensure 1 to 1 staffing was maintained for fall prevention for 1 (#7) of 7 sampled patients. Findings include: 1. Review of a Facility Reported Incident, dated 8/19/21, showed patient #3 told nursing staff on the Spratt unit that she was unable to catch her breath. Nursing staff were alleged to have told patient #3 to "return to your room and stop being dramatic." Patient #3 was reportedly found deceased in her room 45 minutes later.	A 145		

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Review of a facility document titled "Abuse Investigation - Final Summary," dated 8/26/21, showed patient #3 was found unresponsive on 8/14/21 at 1:15 a.m. CPR was performed and not successful. Video footage was reviewed by facility staff, and showed the patient went into her room at 10:22 p.m. Staff performed routine 30 minute checks at 11:00 p.m., and 11:40 p.m., and at 1:15 a.m. when the patient was found unresponsive. Facility staff interviewed patient #3's roommate, who stated the patient got out of her bed, walked to the window, and stated she 'couldn't breath[e].' Staff member B was assigned as the In-House Investigator.

During an interview on 9/27/21 at 10:40 a.m., staff member H stated she had worked with patient #3 the prior day. The patient had no physical complaints, but staff member H thought her death could have been prevented. "We were very short staffed that day."

During an interview on 9/27/21 at 1:20 p.m., staff member G stated patient #3 did complain a lot and she could see where nurses might not take her seriously.

During an interview on 9/27/21 at 1:40 p.m., staff member B stated she had reviewed the video footage and had the staff on duty for 8/14/21 write statements regarding the events of patient #3's passing on the morning of 8/14/21. Staff member B stated she did not interview the staff, and the video footage was no longer available to be viewed, because it was accidentally recorded over by other video footage. She stated there was nothing notable after 3 p.m., regarding the video footage. Staff member B stated she had not kept

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her hand written notes regarding the video footage. Staff member B stated she did not interview staff regarding the complaint with patient #3 saying she could not catch her breath, and nursing staff telling her to go to bed.

During a phone interview on 9/28/21 at 4:15 p.m., staff member N stated he was not aware the staff on duty of the morning of 8/14/21 were not interviewed, and that it was a concern.

Review of the staff written statements for the incident on the morning of 8/14/21, and of the staff on the schedule, showed staff member U was not included in the investigation for a statement, and had worked the night of 8/13/21 to 8/14/21.

During an interview on 9/29/21 at 9:30 a.m., staff member B stated she did not know why staff member U did not have a written statement for the investigation.

During an interview on 9/30/21 at 9:00 a.m., staff member B stated she did not investigate why three of the 30-minute nightly checks were not completed for patient #3, as directed by the facility policy.

Review of the facility policy titled 'Patient Security and Unit Checks', dated 9/12/2018, showed "The whereabouts of each patient will be documented every hour 0700 through 2200, and every one-half hour between 1430 and 1500, and between 2200 and 0700."

During a phone interview on 9/28/21 at 9:30 a.m., staff member X stated she recalled no interactions with patient #3 until she was found

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dead.

During a phone interview on 9/28/21 at 9:43 a.m., staff member R stated she "peeked in" on patient #3 that night and she seemed ok, "but I was not paying that much attention."

During an interview on 9/30/21 at 9:42 a.m., staff member O stated she had not investigated why the 30 minutes checks were not completed for patient #3 on the night of 8/13/21, but the higher census on that night would put pressure on staff to complete them, because there were four patients on 1:1's and that left one staff to do the patient checks, and one staff to provide patient care. She stated she was not involved in the investigation of patient #3's death.

During a phone interview on 9/30/21 at 1:48 p.m., staff member U stated at some point during the medication pass on the night of 8/13/21, patient #3 stated she was constipated, and staff member U gave the patient a laxative. Later, patient #3 told staff member U she had a headache. Staff member U stated she told the patient to go to bed, and she "tucked her in." This was not noted on the video footage. Staff member U stated if she had to make a "wild guess," it was around 9:00 p.m.

Review of patient #3's Medical Record did not include a nursing progress note or assessment regarding the patient's stated health concerns to staff member U on 9/13/21. The last documented nursing progress note was dated 7/24/21. There was no documentation on patient #3 for nine weeks prior to her death.

Review off the facility "DEATH REVIEW" report,

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A 145	Continued From page 7 dated 9/16/21, showed the cause of death was listed as acute cardiovascular collapse. No autopsy report was completed because the MD signed off on the death. 2. Patient #7 was admitted to the facility on 8/6/21, and was residing on the Spratt unit at the time of her fall on 9/6/21. Review of facility's document "Incident Report Form," dated 9/6/21, showed the patient was a 1 to 1, which indicated the patient had been assigned a staff member to be with her at all times. The incident report showed the patient had been left unattended and had a fall. During an interview on 9/28/21 at 10:38 a.m., staff member C said a 1 to 1 meant one staff member had to be with the patient continuously. Staff member C said the medical director would order a 1 to 1, patient to staff, to prevent further falls for that patient. During an interview on 9/30/21 at 11:42 a.m., staff member C said there was no reason a patient should be left unattended if the patient was ordered to be on 1 to 1. Review of the facility's fall tracking report showed the patient had 10 falls from 8/8/21 to 9/7/21.	A 145		
A 392	STAFFING AND DELIVERY OF CARE CFR(s): 482.23(b) The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for	A 392		

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each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for care of any patient.
This STANDARD is not met as evidenced by:
Based on interview and record review, the facility failed to ensure adequate numbers of nursing staff were available on the Spratt unit to provide care, supervision, and one to one supervision for patients resulting in multiple falls and falls with injury, and failing to meet the needs for 3 patients (#s 1, 2, and 4) out of 9 sampled patients; and failed to provided adequate nursing staff for B-Unit and E-Unit, affecting all patient care on those units. Findings include:

1. During an interview on 9/28/21 at 4:20 p.m., staff member N stated the facility had been struggling with staffing for the past few months, and had been taking steps to get the resources needed. Beyond that, he stated, we have done the best we could.

During an interview on 9/29/21 at 11:00 a.m., staff member M stated it was the Medical Director's determination to use 1:1 staff for patients' safety. He stated staff member N had discussed this philosophy with the medical staff. He stated he understood that having 4 staff on 1:1s with 4 patients took away the resources to provide adequate patient care.

Review of the facility Fall Meeting Minutes, dated 8/26/21, showed, "Discussion about need for 1:1 staffing for high fall risk patient. While this does impact staffing numbers, it may also be necessary for those patients who continue to have falls despite several fall risk interventions being in place."

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Review of the facility Fall Log for June 2021 through September 16, 2021 showed 113 falls on the Spratt Unit.

Review of the facility Fall Meeting Minutes, dated 9/14/21, showed the possible contributors to the 29 falls in August could be new staff on the unit, and the high acuity on the Spratt unit.

Review of a complaint reported to the State Survey Agency showed that the Spratt unit had 2 direct care staff and 2 nurses; one other direct care staff were there for part of a shift, on the evening of 8/24/21. "Spratt is a high medical acuity unit with patients who have full ADL care needs."

During an interview on 9/27/21 at 10:50 a.m., staff member F stated the staffing department sends the Spratt unit the Daily Assignment Sheet. Staff member F stated, "It is not accurate - they do not take into account our 1:1s and those patients are no longer listed on the schedule. It makes the schedule look pretty."

During an interview on 9/29/21 at 11:40 a.m., staff member C stated "We are definitely short staffed. It gets extremely difficult."

During an interview on 9/28/21 at 11:35 a.m., staff member G stated that for the last few months she had been working as a Psych tech - "If 3 nurses are scheduled, one is usually on the floor helping with patient care, and we will also help with the hourly census checks. The nursing chart notes have fallen off, and we are not able to assess patients in a nursing note. I do not feel patients and staff are safe."

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During an interview on 9/28/21 at 2:45 p.m., staff member H stated, "Cares are not getting done and patients are dying from lack of care. We have had 5 deaths on Spratt in August. I have emailed the DON about the 1:1s but we still do not get help. The staff here also have to set up for meals and clean up after meals. Six patients need assist with meals. When the census is 40, patients go unchanged - pee and poop."

During an interview on 9/29/21 at 8:35 a.m., staff member W stated the Spratt unit was very short most of the time and staffing says 'sorry'. "Patient care has to be prioritized."

During an interview on 9/29/21 at 2:20 p.m., staff member I stated, "I've been alone in the med room with 2 techs on the floor on E-wing, and it can be scary. We have 4 treatment resistive patients and they know when we are short staffed, and there is no one to help if those patients get combative."

During an interview on 9/30/21 at 9:48 a.m., staff member V stated the "E-wing has staffing issues - we are short every day." She stated, "On 9/5/21 I was the only nurse on the floor, and there was no RN." Staff member V stated the DON did come by to check on us.

Review of the facility daily schedule for 9/5/21 showed staff member V was the only nurse scheduled for the day shift on E-wing.

Review of a facility e-mail, dated 8/3/21 at 2:10 a.m., showed patient #4 had been found on the floor in the Spratt unit with his attends and pants around his knees. The two CNAs picked him up, changed his clothes, and put him back to bed. A

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staff nurse was not notified of the fall until 5:56 a.m. Staff member F arrived to the patient's room at 7:14 a.m., and noted one hip looked twice the size of the other. The two staff members who put the resident back to bed after the fall stated they did not notify the nurse.

Review of patient #4's Admission Physician orders, dated 7/30/21, showed 15-minute checks were ordered for the patient. Documentation for the 15-minute checks were not found by the facility.

Review of patient #4's Post Fall Assessment Quality Assurance Review showed the patient had a history of falls, and was currently at risk for falls. The review also showed the patient was by himself at the time of the fall, and no neuro checks were completed. There was no documentation that proper care was given to the patient after the fall.

Review of a Medical Consult at 7:00 a.m. on 8/3/21, showed the provider was called to assess patient #4, because he was not able to bear weight. "The event [fall] was not notified to this provider." Patient #4 was transferred to the hospital with a left hip fracture.

Review of the 8/3/21 schedule showed 3 CNA's, 1 RN and 1 LPN were working the unit that night. The facility Unit Staffing Requirements showed the unit required 2 RN's, 1 LPN, and 6 CNAs/psych techs, for a census over 34 patients. The unit was short one RN and 3 psych techs/CNAs the morning of 8/3/21.

2.
a. Review of patient #1's medical records showed

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the patient had three falls in May 2021. The physician orders included;
- 5/15/21: 15-minute safety checks.

- Patient #1 had seven falls in June 2021. The physician changed the patient order on 6/16/21 for 15 minute safety checks to 15-minute safety checks while the patient in his room.

-Patient #1 had two falls recorded in July 2021 and;

- Patient #1 had four falls in August 2021.

- 8/4/21 at 2:15 p.m., patient #1 fell. On the afternoon shift, daily staffing sheets recorded 3 Nurses, 4 Techs, with 2 1:1 patient.

- 8/11/21 at 4:42 p.m., patient #1 fell. On the afternoon shift, daily staffing sheets recorded 2 Nurses, 4 Techs, and 4 1:1 patients.

-8/12/21 at 12:40 p.m., patient #1 fell out of his wheelchair, in the TV room, after leaning forward in the wheelchair. The patient had a laceration on the left side of his forehead. On the morning shift, daily staffing sheets recorded 4 Nurses, 6 Tech, with 4 1:1 patients.

b. Review of patient #2's medical records showed the patient had falls;
- 7/4/21 at 3:00 p.m.; Staff was at 3 nurses and 5 techs;
- 7/9/21 at 3:00 p.m., Review of the daily assignment sheet for 7/9/21 showed staff at 2.5 nurses, 5 techs for 7 a.m. until 3 p.m., and 2 nurses, 5 techs for the 3 p.m. to 11 p.m. shift;
- 7/12/21 at 7:30 a.m.; Staffing was 2 nurses and

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5 techs;
- 7/20/21 at 9:00 p.m.; Staffing was 4 nurses and 5 techs;
- 7/30/21 at 4:00 p.m.;
- 7/31/21 at 12:20 p.m. The physician stated patient #2 had a laceration on the back of her head.
- 8/3/21 at 9:40 a.m. On 8/5/21 the physician ordered to continue one on one observations.

Review of the facility's policy, "Close Observation," with an effective date of 5/24/16, showed the purpose was to promote safety of the specified patient. Close observation was to be used when acute behavior and or physical problems were continuing. A practitioner was to initiate and discontinue the close observations. Close observations were either one on one observation or every 15-minutes, a visual of the patient. One on one observations are where the patient is under constant observation, regardless of the other unit activity. The staff member always stays at proximity and in view of the patient. 15-minute checks mean the patient is viewed by the staff at a minimum of every 15 minutes. 15-minute observations are documented with time, where, and behavior of the patient observing. Staff are to carry the flow sheets with them for the duration of the assignment.

During a meeting on 9/29/21 at 11:00 a.m., staff member M stated the decision for one-on-one observations of patients were determined by the practitioners. "By stories heard, one on one observations on patients have been a routine practice for a very long time."

3. During an interview on 9/28/21 at 7:51 a.m.,

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staff member Z reviewed the facility's Daily Assignment Sheet for 8/1/21. The Daily Assignment Sheet showed E Unit had one nurse and two direct care staff for 23 patients; and Spratt unit had one nurse and 3 direct care staff members for 30 patients. Two of the patients on Spratt unit were 1 to 1 staffing, which left one direct care staff member for 28 patients. Staff member Z said the night shift was short that night.

During an interview on 9/28/21 at 7:48 a.m., staff member Y said the staffing numbers on the daily assignment sheets showed how many staff should be on each unit for each shift. Staff member Y said the staffing needs could vary sometimes based on the census of the unit, and the acuity of patient care.

Review of a Daily Assignment Sheet showed expected staffing levels should be:

- A Unit Day Shift: 3 nurses and 5 direct care staff,
- B Unit Day Shift: 3 nurses and 5 direct care staff,
- E Unit Day Shift: 3 nurses and 6 direct care staff, and
- Spratt Unit Day Shift: 3 nurses and 9 direct care staff.

- A Unit Afternoon Shift, 3 nurses and 5 direct care staff,
- B Unit Afternoon Shift: 3 nurses and 5 direct care staff,
- E Unit Afternoon Shift: 3 nurses and 6 direct care staff, and
- Spratt Unit Afternoon Shift: 3 nurses and 9 direct care staff.

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- A Unit NOC shift, 2 nurses and 4 direct care staff,
- B Unit NOC Shift: 1 nurse and 4 direct care staff,
- E Unit NOC Shift: 1 nurse and 5 direct care staff, and
- Spratt NOC Shift: 2 nurses and 9 direct care staff.

During an interview on 9/28/21 at 10:38 a.m., staff member C reviewed the facility's Daily Assignment Sheet for 8/8/21. The night staffing for Spratt Unit was five direct care staff members. Three patients were 1 to 1 staffing, one patient was discharge to a local hospital with 1 to 1 staffing from the facility, which left one direct care staff member to care for 28 patients. Staff member C said Spratt unit was short of direct care staff members that night. Staff member C said when a patient is transferred outside of the facility for care a staff member goes with the patient.

During an interview on 9/29/21 at 2:00 p.m., staff member C reviewed the facility's Daily Assignment Sheet for 8/14/21. The staffing on Spratt unit for that night was three registered nurses, one licensed practical nurse, and five direct care staff. Four of Spratt Unit's patients were 1 to 1 with direct care staff members, which left one direct care staff member to care for 28 patients. Staff member C said it was her expectation for the nursing staff to assist the direct care staff with caring for the patients. Staff member C said the Spratt Unit was a heavy care unit, basically a geriatric unit. The staff member said there were a number of patients on Spratt who needed to use a Hoyer for transfers. Staff

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member C said the Hoyer lifts required two staff members to operate them. The staff member said she had heard several of the certified nurse aides complain about using the Hoyer lifts by themselves, and that it had happened due to short staffing issues.

During an interview on 9/29/21 at 4:23 p.m., staff member BB said B Unit had a large number of patients with behavioral issues. The staff member said there were a number of times the B unit was not appropriately staffed. Staff member BB said if a patient was "going off" with physical behaviors and three direct care staff members and a nurse were working to contain that patient, there was not enough other direct care staff to supervisor the rest of the patients. Staff member BB said this scenario was frequently the case on B Unit.

Review of a random sample of the facility's Daily Assignment Sheets for August 2021 showed:

- August 1, Spratt Unit NOC: two nurses, three direct care staff, two 1 to 1 patients, with 30 patients,
- August 7, Spratt Unit NOC: two nurses, four direct care staff, three 1 to 1 patients, 1 patient in the hospital, with 30 patients,
- August 8, Spratt Unit NOC: two nurses, five direct care staff, three 1 to 1 patients, 1 patient in the hospital, with 30 patients,
- August 9, B Unit day shift: two nurses, three direct care staff, with 20 patients,
- August 15, B Unit day shift: two nurses, two direct care staff, with 20 patients,
- August 15, Spratt Unit NOC: one nurse, five direct care staff, three 1 to 1 patients, 1 patient in the hospital, with 33 patients,
- August 25, B Unit day shift: two nurses, three

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A 392	Continued From page 17 direct care staff, with 21 residents, - August 25, Spratt Unit NOC: two nurses, four direct care staff, four 1 to 1 patients, with 27 patients, - August 26, Spratt Unit NOC: three nurses, four direct care staff, three 1 to 1 patients, with 27 patients, and - August 30, Spratt Unit NOC: two nurses, four direct care staff, three 1 to 1 patients, with 26 residents. Review of a random sample of the facility's Daily Assignment Sheets for September 2021 showed: - September 9, B Unit day shift: 2 nurses, 3 direct care staff, with 16 patients, - September 19, Spratt Unit NOC: 2 nurses, 5 direct care staff, three 1 to 1 residents, with 25 residents.	A 392		
A 396	NURSING CARE PLAN CFR(s): 482.23(b)(4) The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient that reflects the patient's goals and the nursing care to be provided to meet the patient's needs. The nursing care plan may be part of an interdisciplinary care plan. This STANDARD is not met as evidenced by: Based on record review and staff and family interviews, the facility failed to revise care plans for 1 (#1) of 2 patients reviewed. Findings include: Review of patient #1's medical records showed: - Three falls in May 2021. The physician ordered 15-minute safety checks, a low bed, a fall mat at	A 396		

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patient #1's bedside, and no self-transfers, all related to patient #1's fall risk.

- Seven falls in June 2021. The physician changed the order for 15-minute safety checks to 15-minute safety checks while patient was in his room.

- One fall was recorded in July 2021. A post Fall Assessment Quality Assurance Review, dated 7/20/21 at 10:30 a.m., showed patient #1 had a history of falls and showed the fall assessment had been updated with the fall, but there was no action shown to correct the noted issues. The Treatment plan was not updated.

- Four falls in August 2021.

Review of patient #1's Treatment Plan dated 6/1/21, showed no fall concerns, no plans for safety, and no goals, related to falls. There were no updated Treatment Plans found in patient #1's medical records.