STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087184	A. BUILDING: _____ B. WING _____	04/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD HOME	1425 N STRATFORD LANE WICHITA, KS 67206

(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) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey at the above named facility on 4/8/19, 4/9/19, 4/10/19, and 4/11/19.	S 000		
S5028 SS=E	26-42-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the home as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(f)(A)(B)(C)(D)(E)(F)	S5028		

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

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S5028	Continued From page 1 The facility identified a census of 5 residents. The sample included 3 residents. Based on record review, interview, and observations for 1 (#100) of 3 residents sampled, the licensed nurse failed to ensure each allegation of abuse, neglect, or exploitation was reported to the operator as soon as staff aware of allegation and to the department within 24 hours, an investigation started, immediate measure taken to prevent further potential abuse or neglect or exploitation while investigation in progress, and written report of each investigation was maintained. Findings recorded: - Record review for resident #100 revealed an admit date of 9/17/18 with diagnoses of alzheimer's disease, dementia, and chronic obstructive pulmonary disease. The Functional Capacity Screen (FCS) dated 9/14/18 recorded resident required supervision for transfer, physical assistance for walking/mobility, unable to assist with bathing, dressing, toileting, incontinent of bowel and bladder control, experienced short-term memory loss, memory recall, long term memory loss, decision making, impaired decision making, wandering, and socially disruptive inappropriate behaviors. The FCS recorded resident had not experienced falls in last six months. The Negotiated Service Agreement (NSA) dated 9/14/18 recorded resident required physical assistance with bathing dressing, toileting, supervise and assist with walking/mobility, wears	S5028		

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S5028	Continued From page 2	S5028		

depends, provide incontinent care, speaks Spanish only, head gear on at all times daily due to seizures, resident will take off. Staff to attempt to keep on. Resident may refuse to wear. Resident wanders redirect for wandering.

The Health Care Plan (HCP) dated 9/17/18 recorded resident ambulated per self with staff supervision, hourly checks, monitor in room, one staff for bathing, grooming, toileting, dressing, and wears briefs/depends. Seizure precautions in place, head gear on at all times, resident may refuse.

The resident service notes recorded the following falls:

10/3/18 2:30 p.m. This nurse heard a bang went into hallway beside dining room and observed resident lying on left side with small amount of blood to left side of head under hairline 3/4-inch-long laceration. Pressure applied. Blood Pressure (B/P) 138/74, Pulse (P) 90, Respirations (R) 22, Oxygen Saturation (O2 Sat) 98%. No complaint of pain. Family notified and did not want resident sent to the emergency room. Medical care provider notified. Signed operator/licensed nurse A.

Operator/licensed nurse failed to report potential allegation of abuse or neglect to the department or investigate unwitnessed fall.

10/7/18 11:50 a.m. Nurse on call visit made due to fall and right knee being swollen and painful

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S5028	Continued From page 3 after fall. Resident will get up and bear weight on knee but does limp. Had staff medicate for pain and restlessness. Waiting on phone call from medical care provider. Signed hospice nurse D. Operator/licensed nurse failed to report potential allegation of abuse or neglect to the department or investigate unwitnessed fall. 11/7/18 8:15 a.m. resident ambulating in activity room, walked up to chest on ground by big window, hit chest with shins, fell onto right side hitting head on window sill causing a 1- and 1/2-inch gash to back of head. B/P 88/49, P 62, Temperature (T) 97.3, R 18, O2 Sat 98%. Neuro checks normal. Hospice nurse and this nurse cleansed area call medical care provider with orders to send to emergency room. Signed operator/licensed nurse A. 11/7/18 1:10 p.m. Resident returned to facility with three staples to back of head and to be removed in ten days. Signed operator/licensed nurse. Operator/licensed nurse failed to report potential allegation of abuse or neglect to the department or investigate unwitnessed fall. 11/12/18 7:00 a.m. Certified staff called this nurse and stated resident's right arm is swollen and resident complained of pain. B/P 98/68, P 86, T 97.3, R 22, O2 Sat 96%. Resident has increased swelling noted by this nurse with bruising to posterior shoulder and down to elbow. Warm to	S5028		

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S5028	Continued From page 4 touch. Resident denied pain when touching arm and stated hurts when not touched. Resident holding right arm when ambulating. Able to raise right arm and shrug. States hurts worse when moves. Medical care provider and hospice notified and order for x-ray obtained. Signed operator/licensed nurse A. 11/12/18 1:00 p.m. Medical care provider called facility and family at facility. X-rays show fracture of proximal humerus with soft tissue swelling distally. Orders for resident to wear sling. Sling ordered. Family informed. Signed operator/licensed nurse A. The Mobil X-ray dated 11/12/18 at 12:41 revealed Findings: Views of shoulder in internal and external rotation with scapular Y-view demonstrate fracture of the neck of the humerus with moderate mild impaction, slight rotation and approximately 1.2 Centimeter displacement. Impression: Fracture proximal humerus as discussed in findings. Views of humerus demonstrate the fracture of the proximal humerus. Soft tissue swelling noted over the mid and distal humerus. Impression: Fracture proximal humerus and soft tissue swelling distally. Operator/licensed nurse failed to report potential allegation of abuse or neglect to the department or investigate unwitnessed fall. The hospice visit summary notes recorded the following falls not recorded in the nurses notes:	S5028		

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S5028	Continued From page 5 12/26/18 (not time) Resident has had several falls and two falls while this nurse present and one with injury this a.m. Had several falls yesterday. Signed licensed nurse H. 12/28/18 (no time) Resident agitated, Ativan given, resident still in constant motion and not wanting to let staff obtain vital signs. Resident had two falls before 9:30 a.m. and had two additional falls during visit. Medications changed to address agitation. Signed licensed nurse I. 1/15/19 (no time) Resident lying down upon arrival. Continues to hit and wander around. Gait continued to be unsteady but seem to be better than before. Signed licensed nurse H. 2/15/19 (no time) Resident showered, hair washed, skin care provided. Clothes changed. Resident has skin scrap on back upper right shoulder, scrape on forehead and nose with bruise from fall on 2/14/19. Signed hospice aide J. Operator/licensed nurse failed to report potential allegation of abuse or neglect to the department or investigate unwitnessed fall. 4/8/19 11:10 a.m. observed certified staff B speak in Spanish to resident. Certified staff B assisted resident up off couch and ambulated with resident while standing behind him/her. Resident leans into staff while ambulating.	S5028		

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S5028	Continued From page 6 Interview on 4/8/19 at 11:00 a.m. with certified staff C stated resident is unable to wander and required physical assistance for ambulation. Resident used to wander through out the facility until recently. Interview on 4/9/19 at 11:25 a.m. with operator/licensed nurse A stated resident used to ambulate all over the facility with a fast pace from 5:00 a.m. to 10:00 p.m. until a fall in January 2019. Resident would take alarms off. Operator/licensed nurse A stated he/she did not report unwitnessed falls to the Department. Investigation reports provided not completed. For resident #100, the licensed nurse failed to ensure each allegation of abuse, neglect, or exploitation was reported to the operator as soon as staff aware of allegation and to the department within 24 hours, an investigation started, immediate measures taken to prevent further potential abuse or neglect or exploitation while investigation in progress, and written report of each investigation was maintained.	S5028		
S5085 SS=D	26-42-201 (c) Functional Capacity Screen Reassessment (c) Designated staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant.	S5085		

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S5085	Continued From page 7 This REQUIREMENT is not met as evidenced by: KAR 26-42-201(c) The facility identified a census 5 residents. The sample included 3 residents. Based on record review, interview, and observation for 1 (#100) of 3 residents sample, designated staff faled to conduct a screening to determine each Functional Capacity Screening (FCS) following any significant change in condition as defined in K.A.R. 26-39-100. Findings recorded: - Record review for resident #100 revealed an admit date of 9/17/18 with diagnoses of alzheimer's disease, dementia, and chronic obstructive pulmonary disease. The FCS dated 9/14/18 recorded resident required supervision for transfer, physical assistance for walking/mobility, unable to assist with bathing, dressing, toileting, incontinent of bowel and bladder control, experienced short-term memory loss, memory recall, long term memory loss, decision making, impaired decision making, wandering, and socially disruptive inappropriate behaviors. The FCS recorded resident had not experienced falls in last six months. The Negotiated Service Agreement (NSA) dated 9/14/18 recorded resident required physical	S5085		

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S5085	Continued From page 8	S5085		

assistance with bathing dressing, toileting, supervise and assist with walking/mobility, wears depends, provide incontinent care, speaks Spanish only, head gear on at all times daily due to seizures, resident will take off. Staff to attempt to keep on. Resident may refuse to wear. Resident wanders redirect for wandering.

The Health Care Plan (HCP) dated 9/17/18 recorded resident ambulated per self with staff supervision, hourly checks, monitor in room, one staff for bathing, grooming, toileting, dressing, and wears briefs/depends. Seizure precautions in place, head gear on at all times, resident may refuse.

The resident service notes recorded the following falls:

10/3/18 2:30 p.m. This nurse heard a bang went into hallway beside dining room and observed resident lying on left side with small amount of blood to left side of head under hairline 3/4-inch-long laceration. Pressure applied. Blood Pressure (B/P) 138/74, Pulse (P) 90, Respirations (R) 22, Oxygen Saturation (O2 Sat) 98%. No complaint of pain. Family notified and did not want resident sent to the emergency room. Medical care provider notified. Signed operator/licensed nurse A.

10/7/18 11:50 a.m. Nurse on call visit made due to fall and right knee being swollen and painful after fall. Resident will get up and bear weight on knee but does limp. Had staff medicate for pain and restlessness. Waiting on phone call from

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S5085	Continued From page 9 medical care provider. Signed hospice nurse D. 11/7/18 8:15 a.m. resident ambulating in activity room, walked up to chest on ground by big window, hit chest with shins, fell onto right side hitting head on window sill causing a 1- and 1/2-inch gash to back of head. B/P 88/49, P 62, Temperature (T) 97.3, R 18, O2 Sat 98%. Neuro checks normal. Hospice nurse and this nurse cleansed area call medical care provider with orders to send to emergency room. Signed operator/licensed nurse A. 11/7/18 1:10 p.m. Resident returned to facility with three staples to back of head and to be removed in ten days. Signed operator/licensed nurse. 11/12/18 7:00 a.m. Certified staff called this nurse and stated resident's right arm is swollen and resident complained of pain. B/P 98/68, P 86, T 97.3, R 22, O2 Sat 96%. Resident has increased swelling noted by this nurse with bruising to posterior shoulder and down to elbow. Warm to touch. Resident denied pain when touching arm and stated hurts when not touched. Resident holding right arm when ambulating. Able to raise right arm and shrug. States hurts worse when moves. Medical care provider and hospice notified and order for x-ray obtained. Signed operator/licensed nurse A. 11/12/18 1:00 p.m. Medical care provider called facility and family at facility. X-rays show fracture	S5085		

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S5085	Continued From page 10	S5085		

of proximal humerus with soft tissue swelling distally. Orders for resident to wear sling. Sling ordered. Family informed. Signed operator/licensed nurse A.

The Mobil X-ray dated 11/12/18 at 12:41 revealed Findings: Views of shoulder in internal and external rotation with scapular Y-view demonstrate fracture of the neck of the humerus with moderate mild impaction, slight rotation and approximately 1.2 Centimeter displacement. Impression: Fracture proximal humerus as discussed in findings. Views of humerus demonstrate the fracture of the proximal humerus. Soft tissue swelling noted over the mid and distal humerus. Impression: Fracture proximal humerus and soft tissue swelling distally.

The hospice visit summary notes recorded the following falls not recorded in the nurses notes:

12/26/18 (not time) Resident has had several falls and two falls while this nurse present and one with injury this a.m. Had several falls yesterday. Signed licensed nurse H.

12/28/18 (no time) Resident agitated, Ativan given, resident still in constant motion and not wanting to let staff obtain vital signs. Resident had two falls before 9:30 a.m. and had two additional falls during visit. Medications changed to address agitation. Signed licensed nurse I.

1/15/19 (no time) Resident lying down upon arrival. Continues to hit and wander around. Gait

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S5085	Continued From page 11 continued to be unsteady but seem to be better than before. Signed licensed nurse H. 2/15/19 (no time) Resident showered, hair washed, skin care provided. Clothes changed. Resident has skin scrap on back upper right shoulder, scrape on forehead and nose with bruise from fall on 2/14/19. Signed hospice aide J. 4/8/19 11:10 a.m. observed certified staff B speak in Spanish to resident. Certified staff B assisted resident up off couch and ambulated with resident while standing behind him/her. Resident leans into staff while ambulating. Interview on 4/8/19 at 11:00 a.m. with certified staff C stated resident is unable to wander and required physical assistance for ambulation. Resident used to wander through out the facility until recently. Interview on 4/9/19 at 11:25 a.m. with operator/licensed nurse A stated resident used to ambulate all over the facility with a fast pace from 5:00 a.m. to 10:00 p.m. until a fall in January 2019. Resident would take alarms off. Operator/licensed nurse A stated he/she did not conduct a significant change after falls with significan changes in condition. For resident #100, designated staff faled to conduct a screening to determine each FCS following any significant change in condition as defined in K.A.R. 26-39-100.	S5085		
S5130 SS=D	26-42-202 (j) NSA Outside Resources	S5130		

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S5130	Continued From page 12 (j) If a resident's negotiated service agreement includes the use of outside resources, the designated staff shall perform the following: (1) Provide the resident, the resident's legal representative, the case manager, and, if agreed to by the resident or resident ' s legal representative, the resident ' s family, with a list of providers available to provide needed services; (2) assist the resident, if requested, in contacting outside resources for services; and (3) monitor the services provided by outside resources and act as an advocate for the resident if services do not meet professional standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(j)(3) The facility identified a census of 5 residents. The sample included 3 residents. Based on record review, interview, and observation for 1 (#100) of 3 residents sampled, the designated staff failed to monitor the services provided by outside resources and act as an advocate for the resident if services do not meet the professional standards of practice. Findings included: - Record review for resident #100 revealed an admit date of 9/17/18 with diagnoses of alzheimer's disease, dementia, and chronic obstructive pulmonary disease. The Functional Capacity Screen (FCS) dated 9/14/18 recorded resident required supervision for transfer, physical assistance for walking/mobility, unable to assist with bathing, dressing, toileting, incontinent of bowel and	S5130		

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S5130	Continued From page 13	S5130		

bladder control, experienced short-term memory loss, memory recall, long term memory loss, decision making, impaired decision making, wandering, and socially disruptive inappropriate behaviors. The FCS recorded resident had not experienced falls in last six months.

The Negotiated Service Agreement (NSA) dated 9/14/18 recorded resident required physical assistance with bathing dressing, toileting, supervise and assist with walking/mobility, wears depends, provide incontinent care, speaks Spanish only, head gear on at all times daily due to seizures, resident will take off. Staff to attempt to keep on. Resident may refuse to wear. Resident wanders.

The Health Care Plan (HCP) dated 9/17/18 recorded resident ambulated per self with staff supervision, hourly checks, monitor in room, one staff for bathing, grooming, toileting, dressing, and wears briefs/depends. Seizure precautions in place.

The resident service notes recorded the following:

11/7/18 at 8:15 a.m. resident ambulating in activity room, walked up to chest on ground by big window, hit chest with shins, fell onto right side hitting head on window seals causing a 1- and 1/2-inch gash to back of head. Blood Pressure (B/P) 88/49, Pulse (P) 62, Temperature (T) 97.3, Respiration (R) 18, Oxygen Saturation (O2 Sat) 98%. Neuro checks normal. Hospice nurse and this nurse cleansed area call medical care provider with orders to send to emergency room. Signed operator/licensed nurse.

11/7/18 at 1:10 p.m. Resident returned to facility with three staples to back of head and to be

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	B087184	A. BUILDING: _____ B. WING _____	04/11/2019

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S5130	Continued From page 14 removed in ten days. Signed operator/licensed nurse. 11/19/18 (no time) Staples to head removed. This nurse removed three staples. Resident tolerated well. Area red with no drainage. Signed hospice nurse. Interview on 4/9/19 at 11:25 a.m. with operator/licensed nurse stated and confirmed hospice nurse did not remove staples in ten days as ordered by medical care provider but did remove staples from head in twelve days. The operator/licensed nurse was not aware staples not removed in 10 days. For resident #100, the designated staff failed to monitor the services provided by outside resources and act as an advocate for the resident if services do not meet the professional standards of practice.	S5130		
S5155 SS=G	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-204 (a)	S5155		

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The facility identified a census of 5 residents. The sample included 3 residents. Based on record review, interview, and observations for 1 (#100) of 3 residents sampled, the licensed nurse failed provide and coordinate necessary health care services to meet the needs of this resident who experience multiple falls including falls with significant injuries.

Findings recorded:

- Record review for resident #100 revealed an admit date of 9/17/18 with diagnoses of alzheimer's disease, dementia, and chronic obstructive pulmonary disease.

The Functional Capacity Screen (FCS) dated 9/14/18 recorded resident required supervision for transfer, physical assistance for walking/mobility, unable to assist with bathing, dressing, toileting, incontinent of bowel and bladder control, experienced short-term memory loss, memory recall, long term memory loss, decision making, impaired decision making, wandering, and socially disruptive inappropriate behaviors. The FCS recorded resident had not experienced falls in last six months.

The Negotiated Service Agreement (NSA) dated 9/14/18 recorded resident required physical assistance with bathing dressing, toileting, supervise and assist with walking/mobility, wears depends, provide incontinent care, speaks Spanish only, head gear on at all times daily due

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to seizures, resident will take off. Staff to attempt to keep on. Resident may refuse to wear. Resident wanders redirect for wandering.

The Health Care Plan (HCP) dated 9/17/18 recorded resident ambulated per self with staff supervision, hourly checks, monitor in room, one staff for bathing, grooming, toileting, dressing, and wears briefs/depends. Seizure precautions in place, head gear on at all times, resident may refuse.

The resident service notes recorded the following falls:

10/3/18 2:30 p.m. This nurse heard a bang went into hallway beside dining room and observed resident lying on left side with small amount of blood to left side of head under hairline 3/4-inch-long laceration. Pressure applied. Blood Pressure (B/P) 138/74, Pulse (P) 90, Respirations (R) 22, Oxygen Saturation (O2 Sat) 98%. No complaint of pain. Family notified and did not want resident sent to the emergency room. Medical care provider notified. Signed operator/licensed nurse A.

10/7/18 11:50 a.m. Nurse on call visit made due to fall and right knee being swollen and painful after fall. Resident will get up and bear weight on knee but does limp. Had staff medicate for pain and restlessness. Waiting on phone call from medical care provider. Signed hospice nurse D.

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S5155	Continued From page 17 The HCP lacked interventions to address the residents ongoing risk for falls. 11/7/18 8:15 a.m. resident ambulating in activity room, walked up to chest on ground by big window, hit chest with shins, fell onto right side hitting head on window seas causing a 1- and 1/2-inch gash to back of head. B/P 88/49, P 62, Temperature (T) 97.3, R 18, O2 Sat 98%. Neuro checks normal. Hospice nurse and this nurse cleansed area call medical care provider with orders to send to emergency room. Signed operator/licensed nurse A. 11/7/18 1:10 p.m. Resident returned to facility with three staples to back of head and to be removed in ten days. Signed operator/licensed nurse. The HCP lacked interventions to address the resident's ongoing risk for falls or directions for staff on care of laceration repaired by staples. 11/8/18 2:00 p.m. B/P 96/60, P 80, R 18, O2 Sat 97%. Resident complained of right arm pain. Slight swelling to upper right arm. Family stated resident grabbing left arm instead of right. Denied need for another emergency room visit and stated, "most likely due to being cold." Resident raised right arm without difficulty. Signed operator/licensed nurse A. 11/12/18 7:00 a.m. Certified staff called this nurse and stated resident's right arm is swollen and resident complained of pain. B/P 98/68, P 86, T	S5155		

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S5155	Continued From page 18 97.3, R 22, O2 Sat 96%. Resident has increased swelling noted by this nurse with bruising to posterior shoulder and down to elbow. Warm to touch. Resident denied pain when touching arm and stated hurts when not touched. Resident holding right arm when ambulating. Able to raise right arm and shrug. States hurts worse when moves. Medical care provider and hospice notified and order for x-ray obtained. Signed operator/licensed nurse A. 11/12/18 1:00 p.m. Medical care provider called facility and family at facility. X-rays show fracture of proximal humerus with soft tissue swelling distally. Orders for resident to wear sling. Sling ordered. Family informed. Signed operator/licensed nurse A. The Mobil X-ray dated 11/12/18 at 12:41 revealed Findings: Views of shoulder in internal and external rotation with scapular Y-view demonstrate fracture of the neck of the humerus with moderate mild impaction, slight rotation and approximately 1.2 Centimeter displacement. Impression: Fracture proximal humerus as discussed in findings. Views of humerus demonstrate the fracture of the proximal humerus. Soft tissue swelling noted over the mid and distal humerus. Impression: Fracture proximal humerus and soft tissue swelling distally. 11/12/18 5:00 p.m. "Family discussed and feel resident got fracture on 11/7/18 and due to pain they did not feel it was fractured and not really complaining." Family understands resident may not wear sling at all times but staff and family will	S5155		

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continue to encourage resident to wear sling. Hospice ordered Ativan (for anxiety) prior to showers due to resident hitting at staff during care. Signed operator/licensed nurse A.

The HCP lacked interventions to address care of resident related to shoulder fracture.

1/1/19 12:00 midnight, Staff called and stated assisting resident to bathroom. Resident would not stand still, tripped and fell into bath tub and staff unable to catch resident. This nurse assessed resident who was face down in bath tub, alert, oriented to self. Resident has two bumps to forehead with one of them red and one re-opened area under right eye two CM red area under left eye with pinpoint red open area to right side of nose. Three CM by two CM bruised area to left shoulder, skin tear laceration one half inch to right elbow. Areas cleansed with normal saline and triple antibiotic applied. Resident had fuzzy socks on by family. Family educated about no fuzzy socks due to fall risk. Family requested resident to be changed in bed due to resident unable to stand still and does not have good balance at night. Medical care provider notified. Signed operator/licensed nurse A.

The HCP lacked interventions to address ongoing risk for falls.

The hospice visit summary notes recorded the following falls not recorded in the nurses notes:

12/26/18 (not time) Resident has had several falls

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and two falls while this nurse present and one with injury this a.m. Had several falls yesterday. Signed licensed nurse H.

12/28/18 (no time) Resident agitated, Ativan given, resident still in constant motion and not wanting to let staff obtain vital signs. Resident had two falls before 9:30 a.m. and had two additional falls during visit. Medications changed to address agitation. Signed licensed nurse I.

1/15/19 (no time) Resident lying down upon arrival. Continues to hit and wander around. Gait continued to be unsteady but seem to be better than before. Signed licensed nurse H.

2/15/19 (no time) Resident showered, hair washed, skin care provided. Clothes changed. Resident has skin scrap on back upper right shoulder, scrape on forehead and nose with bruise from fall on 2/14/19. Signed hospice aide J.

The HCP lacked interventions to address ongoing risk for falls.

4/8/19 11:10 a.m. observed certified staff B speak in Spanish to resident. Certified staff B assisted resident up off couch and ambulated with resident while standing behind him/her. Resident leans into staff while ambulating.

Interview on 4/8/19 at 11:00 a.m. with certified staff C stated resident is unable to wander and required physical assistance for ambulation. Resident used to wander through out the facility

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S5155	Continued From page 21 until recently. Interview on 4/9/19 at 11:25 a.m. with operator/licensed nurse A stated resident used to ambulate all over the facility with a fast pace from 5:00 a.m. to 10:00 p.m. until a fall in January 2019. Resident would take alarms off. For resident #100, the licensed nurse failed provide and coordinate necessary health care services to meet the needs of this resident who experience multiple falls including falls with significant injuries.	S5155		