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F 000	INITIAL COMMENTS An unannounced onsite complaint investigation was conducted 10/20/2020 to 10/23/2020, 6 of 30 allegations were substantiated. Event # H69P11. A complaint investigation was conducted from 10/20/2020 through 10/23/2020. Past non compliance was identified at: CFR 483.12 at tag F600 at a scope and severity IJ. The tag F 600 constituted Substandard Quality of Care. A Partial extended survey was conducted. Event # H69P11. An onsite revisit was conducted on 10/20/2020 through 10/23/2020 and the facility is back into compliance effective 10/13/2020. The Directed Plan of Correction including the Root Cause Analysis were reviewed. Event # 1TS12.	F 000	Past noncompliance: no plan of correction required.	
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F 600		11/16/20

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

Electronically Signed | 11/16/2020

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F 600	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and observation, the facility neglected to document, report, assess and seek medical treatment for a resident who experienced a witnessed fall for one of one residents reviewed for falls (Resident # 11). Resident # 11 experienced a witnessed fall when she tried to sit down in her wheel chair in the small activity room. As a result of this fall Resident # 11 experienced pain and sustained a fracture of the distal diametaphysis (portion of a long bone) of the left ulna and radius (wrist) with tissue swelling and an acute nondisplaced fracture of the left acetabular (break in the socket portion of the "ball-and-socket" hip joint). Findings included: Resident # 11 was admitted to the facility on 06/10/2020 with diagnoses that included vascular dementia, depression and anxiety. A care plan dated 06/10/2020 recorded that Resident # 11 was at risk for falls with the goal that she would not have a serious fall related injury through the next review date. The care plan interventions included to maintain her bed in the lowest position, maintain a safe environment, keep the call light in reach and make certain non-skid socks or shoes were worn when she was out of bed and place a fall mat to the side of her bed that was not against the wall. A quarterly Minimum Data Set dated 09/02/2020 revealed that Resident # 11 had severe cognitive impairment and Resident # 11 usually understood and was able to usually be understood. She required limited assist of one staff for transfers	F 600	Past noncompliance: no plan of correction required.	

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and ambulation in her room. Resident # 11 had unsteady balance. Resident # 11 used a wheel chair for out of room mobility and she sustained one fall without injury since admission to the facility.

Review of a written statement dated 10/07/2020 by a floor tech (technician) that worked on the 500 hall on the evening of 10/06/2020 revealed that at about 8:00 PM or 8:30 PM he noticed Resident # 11 walking alone in the small dining area and he thought she should not be walking alone and remembered that he always saw her in a wheel chair. The floor tech told Resident # 11 to sit back down in the wheel chair and that she started to walk backwards toward the chair and reached back to sit down and the chair rolled away, and she fell to the floor onto her buttocks. The floor tech revealed that he stayed with the resident and called for help then 2 or 3 NAs came in the room. The floor tech explained what he saw to the NAs and one of them called "code green".

A phone interview was conducted on 10/21/2020 at 10:24 AM. The floor tech verified that he worked on the 500 hall the evening of 10/06/2020 and that sometime between 8:00 PM and 8:30 PM he observed Resident # 11 in the small ding or activity room and that she was walking around and there was no staff or other residents present. The floor tech noted Resident # 11 to be unsteady and knew that he always saw her in her wheel chair and that a wheel chair was a few feet behind her. The floor tech then reported that he told Resident # 11 to sit back down so that she would not fall and that Resident # 11 started to walk backward toward the wheel chair and reached behind her to sit down and she ended up

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missing the wheel chair seat and landed on her buttock, The floor tech described that he did not observe Resident # 11 hitting her head or her arm on anything and that she began to cry that she was in pain. The floor tech went to her and called out to the nurse staff that a resident fell in the little dining room. The floor tech then revealed that the first NA that came to the room called out loudly "code green" to alert all staff on the unit that a resident had a fall. The floor tech stated that when another NA came into the room that Resident # 11 was not moved and then the nurse came into the room and the floor tech turned to exit the room and heard the nurse say that the NAs should pick Resident # 11 up and take her to bed. The floor tech reported that he did not observe if the nurse assessed Resident # 11 or not.

A written statement by NA # 2 on 10/09/2020 revealed that she worked the evening of 10/06/2020 on the 500 hall and that about 8:30 PM or so the floor tech called out to nursing staff that a resident had fallen in the small dining room. NA #2 went to the dining area and saw Resident # 11 lying on her back on the floor and that another NA came in and 1 of them called a code green right away and they did not move Resident # 11. The nurse came to the room and the nurse instructed the NAs to put Resident # 11 to bed.

On 10/21/2020 at 4:41 PM an interview was conducted with NA # 2. NA # 2 confirmed that she did work on the 500 hall on 10/06/2020 and that at some point a code green, for a fall was called by another NA and that Resident # 11 was observed lying on her back on the floor of the small dining area. Resident # 11 was heard mumbling, but it made no sense to NA # 2. NA #2

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revealed that nurse # 1 came to the dining area after about 5 minutes and examined Resident #11 and told us to pick her up and put her to bed. NA # 2 revealed that a few minutes after that she observed the nurse entering Resident # 11's room and had no further information about any injury. NA # 2 revealed that she did not remember if Resident # 11 had any pain when she was placed into bed.

NA # 3 was interviewed at 3:38 PM on 10/21/2020. NA # 3 revealed that she worked on the 500 hall second shift on 10/06/2020. NA # 3 explained that resident # 11 always tried to transfer and ambulate without assistance and needed assist to be safe. NA #3 reported that on 10/06/2020 the floor tech called her to the small dining room about 8:30 PM or so because Resident # 11 fell and as NA #3 went to the resident, she yelled a code green to alert all staff that a resident had a fall. NA #3 revealed that when she entered the room the floor tech was near Resident # 11 and that the resident was lying on her back on the floor and she was awake the floor tech told NA # 3 he did not see her hit her head, but Resident # 11 cried that she was in pain and when the nurse came into the room he told us it was our fault that she fell because we did not monitor her close enough. The nurse instructed the NAs to put her in her wheel chair and take her to her room and put her to bed. NA # 3 revealed that nurse #1 told them he would take care of it and that they should just get back to work. NA # 3 added that she did not know any other details. NA # 3 revealed that the nurse just looked at Resident # 11 and was certain that nurse # 1 did not touch Resident # 11 or take any vital signs. NA # 3 revealed that when the NAs lifted Resident # 11 from the floor and took her in

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her wheel chair to bed that she did not recall that resident # 11 voiced any complaint of pain.

Review of nurse progress note dated 10/06/2020 at 9:35 PM written by nurse #1, revealed that Resident # 11 was alert to self and verbalized needs to staff. Resident # 11 was up in her wheel chair earlier that evening and wore non- skid foot wear to both feet. Resident # 11 propelled self in the wheel chair with no difficulty and was monitored by staff frequently. She had no signs and no complaints of pain. There was no documentation in Resident #11's medical record from 10/06/2020 at 7:00 PM to 10/07/2020 at 7:00 AM that indicated the resident had experienced a fall or incident.

A phone interview conducted with Nurse # 1 on 10/21/2020 at 2:05 PM. Nurse #1 explained that he did work 7:00 PM on 10/06/2020 until 7:00 AM on 10/07/2020 and he was assigned to the 500 hall where Resident # 11 resided. Nurse #1 reported that Resident # 11 was able to ambulate but was weak and sometimes wandered and needed redirection. He recalled that 10/06/2020 was hectic but there had been no falls that he was aware of. Nurse #1 also added that Resident # 11 had not had any complaints of pain and that if a code green was called, he would have immediately gone to the area to assess the resident, he would have written a progress note, called the DON, called the MD as well as called the resident RP. Nurse # 1 also revealed that he would complete an incident report, gather staff statements and followed MD (physician) or NP orders. Nurse # 1 denied that he was aware of any fall or injury being observed or reported to him. Nurse #1 reported that he spoke to the DON and told the DON that Resident # 11 did not have

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a fall or any pain. Nurse # 1 reported that during the conversation with the DON he was informed that he was suspended while an investigation was conducted. Nurse # 1 revealed that he believed it was on 10/12/2020 or 10/13/2020 he met with the DON and administrator and was informed that after a thorough investigation it was determined that Resident # 11 did fall, and he was aware of it and did not follow post fall policy and procedures. Nurse # 1 stated that they terminated his employment. When asked Nurse #1 added that it was NA responsibility to supervise and check on Resident # 11 at least every 20 to 25 minutes and he could not confirm that that happened.

An attempt was made to contact NA # 5 on 10/21/2020 at 10:46 AM because she had been scheduled to care for Resident # 11 from 11:00 PM on 10/06/2020 until 7:00 AM on 10/07/2020. The telephone number provided had been disconnected.

A written statement by nurse assistant (NA) # 1 dated 10/07/2020 at 11:00 AM revealed that she pulled the bed linens off Resident # 11 to begin daily care and noticed her left wrist was bruised and looked swollen. NA #1 called the nurse # 3 into the room to see the wrist.

On 10/20/2020 at 3:43 PM an interview was conducted with NA # 1. NA # 1 revealed that she had checked Resident # 11 earlier in the morning on 10/07/2020 and did not notice any injury or report any pain. The NA went back into Resident # 11's room at about 11:00 AM to give daily care but when she pulled back the bed covers, she noticed swelling and a bruise on the left wrist and hand of Resident # 11. NA # 1 called nurse # 3 to come into the room right away and when she

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showed the wrist to the nurse the nurse called the NP right away and started to examine Resident # 11. NA # 1 stated when she asked Resident # 11 what happened all Resident # 11 stated was that she fell. NA # 1 had taken care of Resident # 11 on day shift the previous day and her wrist did not look like that when she left at 3:00 PM. NA # 1 explained that if she witnessed a fall or skin tear or anything she reported it to the nurse right away and always called a code green loudly if there was a fall.NA # 1 stated that Resident # 11 was able to ambulate with one staff assist but often needed reminders to ask for assist.

A facility incident report dated 10/07/2020 at 12:38 PM revealed that NA # 1 called nurse # 3 to the room of Resident # 11 at 11:00 AM. The nurse observed a discoloration and swelling of the left wrist and some left-hand fingers. Resident # 11 complained of pain when nurse #3 touched the left hip and there was a small bruise on the left hip. Nurse # 3 was told by Resident # 11 that she fell last night. A form titled Incident Checklist attached to the incident report revealed that on 10/07/2020 the following items were marked as completed or initiated: incident report, begin to gather witness statements, complete an investigational summary, begin QAPI (Quality Assurance Performance Improvement).

Nurse # 3 wrote in a note dated 10/07/2020 at 12:54 PM that she called the nurse practitioner (NP) into the room to examine Resident # 11. The NP told the nurse to get x-rays as soon as possible of the left wrist and left hip, give Tylenol 650 mg (milligrams) po (orally) every 6 hours for pain, apply ice to the left wrist every 4 hours for 10 to 15 minutes as tolerated and apply an ace wrap to the left wrist to stabilize it. The note

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specified that nurse # 3 explained to the NP that she was not aware of Resident # 11 having a fall because it was not reported to her during shift change report from the 7:00 PM to 7:00 AM nurse that worked 10/06/2020 until 10/07/2020. The nurse notified the nurse supervisor, administrator and Director of Nurses (DON). The NP phoned the responsible party (RP) for Resident # 11 and explained the situation and pending treatment ordered for Resident # 11. The note specified the NP explained that she would call the RP back once the x- ray results were returned. Resident # 11 had a blood pressure of 168/88, pulse of 92, temperature of 98 degrees and an oxygen saturation of 99% on room air. Resident # 11 was to remain in bed and be log rolled to reposition until further orders received.

Nurse # 3 was interviewed on 10/20/2020 at 3:00 PM and revealed that she had not been asked to write a statement for the DON because her documentation was in the medical record and on the incident report dated 10/07/2020. Nurse # 3 explained that all licensed staff nurses worked 12 hour shifts and that she worked from 7: 00 AM to 7:00 PM on 10/06/2020 and again on 10/07/2020. Nurse # 3 recalled that about 11:00 AM on 10/07/2020 she was called to the room of Resident # 11 by NA #1 and that she observed the left wrist and fingers swollen and that a discolored bruise was appearing on the left wrist. Nurse # 3 revealed that on a full body exam she observed some bruising to the left hip and Resident # 11 cried out in pain when those areas were touched or moved. Nurse # 3 called the NP to the room immediately; the NP was in the facility and the NP came and examined Resident # 11. When the NP asked Resident # 11 what happened she replied that she fell last night, but

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nurse # 3 revealed that she had not been given a report from the nurse that had worked on the 500 hall the previous night and early this morning. Nurse # 3 reported to the nurse manager, DON and administrator that the NP saw Resident # 11 and ordered x- rays, pain medication, ice and an ace wrap for Resident # 11 as she might have sustained a fall. Nurse # 3 revealed that she started to complete an incident report and other documentation as required for an actual or suspected fall or incident. Nurse # 3 stated at that point they were not clear what may have happened and nurse # 4 came to help her carry out the NP orders, a fall risk evaluation, skin check and pain assessment. Nurse # 3 added that when she gave Resident # 11 her morning pills that Resident # 11 did not complain of any pain or report that she had a fall the night before.

A written statement by nurse # 2 dated 10/09/2020 revealed that when she came to work on 10/07/2020 about 6:00 AM she made facility rounds and spoke to the night shift nurses and asked if there were any falls or other incidents. Nurse # 2 reported that the night shift nurses did not report any falls or other incidents.

Nurse #2 (unit manager) was interviewed on 10/21/202 at 3:52 PM and revealed that the morning of 10/07/2020 when she reported to work that she asked nurse #1 if there had been any falls or other incidents that night and nurse # 1 told her there were no falls or other concerns from 7:00 PM on 10/06/2020 through 7:00 AM on 10/07/2020. Nurse # 2 revealed that later that morning about 11:00 AM nurse # 3 called her to come to the 500 hall to examine Resident # 11 and that the NP was already in with the resident. Nurse # 2 confirmed with nurse # 3 that a fall or

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unknown injury packet (green folder) had been initiated by nurse # 3. Nurse # 2 revealed that when she went in to see Resident # 11 in her room that she was in bed and told nurse # 2 that she fell into the sycamore tree last night.

On 10/21/2020 at 11:35 AM an interview was conducted with the Assistant Director of Nurses (ADON) who stated that when she came to work the morning of 10/07/2020 she was informed by nurse #2 that Resident # 11 may have had a fall the previous night and that the nurse staff had initiated a "green folder" incident investigation as soon as Resident # 11 was discovered with pain to the left wrist and left hip. The nurse informed the ADON that the NP had already examined Resident # 11 and ordered x-rays and pain medication. Nurse #2 reported that none of the staff at work the morning of 10/07/2020 were aware of any fall or other incidents and that the DON was trying to contact all staff from the previous evening and night to obtain statements and that it was not until about 11:00 AM that the RP was notified. The ADON explained that any time there was a fall that a code green was called to alert all staff to respond and a green folder initiated to investigate any witnessed or unwitnessed falls or other incidents (skin tears or bruises) and that the DON, MD or NP and RP were to be notified immediately. The ADON revealed that the RP spoke to the NP and had decided not to send Resident # 11 to the emergency room but to only make her an orthopedic appointment. The ADON then spoke to NA #3 and the NA reported that in fact Resident # 11 had fallen around 8: 30 PM on 10/06/2020 that was witnessed by the floor tech. The ADON notified the DON.

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A phone interview was conducted with the NP on 10/22/2020 at 12:03 PM. The NP explained that on the morning of 10/07/2020 at about 11:00 AM the nurse assigned to the 500 hall called and asked if I would examine Resident # 11 for pain and swelling of the left wrist, hand and fingers as well as a potential bruise to the left hip and hip pain. The NP revealed that on initial observation of the left wrist it appeared broken and the left hip when touched caused pain. NP ordered x- rays to be taken as soon as possible and then called the RP and explained what was observed and immediate treatments ordered. The RP told the NP that Resident # 11 had a mimosa tree ages ago and that might be the reference to a tree. The RP understood that the facility would investigate for a fall and in response to further treatment the RP did not want Resident # 11 sent to the hospital for evaluation and it was agreed that pending x-ray results they would discuss further treatment. The NP revealed that after she received the x - ray reports she spoke again to the RP and it was decided that Resident # 11 would not be sent to the hospital and that an orthopedic appointment would be made, and the RP notified of appointment information. The RP explained to the NP that she would attend all appointments and believed a hospital evaluation might cause duplicate services and also increase anxiety for Resident #11.The NP explained that she tried to allow families to make many care decisions especially with residents that had dementia as the goal was to try to minimize overstimulation which could lead to increased confusion, panic or anxiety for the residents.

The medication administration record for Resident # 11 revealed that Resident # 11 did not receive any pain medication until 12:00 PM on

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10/07/2020 for left wrist and hip pain. Resident # 11 was not on any scheduled or as needed pain medication prior to 12:00 PM on 10/07/2020.

Review of an x- ray report dated 10/07/2020 at 3:15 PM revealed that Resident # 11 had an acute fracture of the left distal diametaphysis of the radius and ulna with swelling of overlying soft tissue and there was also an acute nondisplaced left acetabular fracture and Resident # 11 had osteopenia and an orthopedic evaluation was recommended.

An orthopedic consult note dated 10/09/2020 included in part that Resident # 11 had pain and bruising to the left wrist and left hip and she was to be touch down weight bearing of the left leg, non-weight bearing of the left wrist with a cast in place and that resident # 11 was to remain in bed for 2 to 4 more weeks, maintain pain control and return visit in 4 weeks.

A written statement by the DON dated 10/07/2020 at 7:05 PM revealed that she spoke to nurse # 1 via telephone and asked if there were any incidents on 10/06/2020 related to Resident # 11 and nurse # 1 told the DON that there had not been any and when asked if Resident # 11 fell on 10/06/2020 nurse # 1 replied she did not. The DON told nurse #1 to write and sign a statement saying such and to slide the statement under her office door.

The DON was interviewed via telephone on 10/22/2020 at 12:43 PM. The DON stated that on 10/07/2020 she was notified at approximately 11:00 AM that the NP ordered x- rays of the left wrist and left hip of Resident # 11. The DON explained that the nurse supervisor and unit

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nurse had initiated an investigation and used the green folder which nurses use to begin to follow the investigative time line of any fall, skin tear, bruise or other resident incidents or accidents. The DON explained that the green folder included required follow up care and notifications to be made and that each item was to be checked off, dated and timed when the action was completed. The DON revealed that this was a way to track and insure that all required actions after any incident were completed and proper documentation recorded. The DON revealed that she reviewed the medical record for Resident # 11 and there was no documentation of a fall or other incident and that she began to call staff that had been working on the 500 hall on 10/06/2020 and 10/07/2020. The DON stated that she asked staff to meet with her as soon as possible to provide a written statement related to Resident # 11 and any possible injury they might be aware of. The DON also revealed that when she interviewed the floor tech, he described that Resident # 11 had a fall in the small dining room at about 8:00 PM on 10/06/2020 and that the NAs and nurse were aware and that was about all he knew. The DON described that she did contact Nurse #1 the evening of 10/07/2020 and asked him if resident # 11 fell on 10/06/2020 and his response was that no resident had a fall. The DON asked Nurse #1 to leave a hand written statement under her office door that evening and then when she came to work in the morning of 10/08/2020 she could not find a written statement from nurse # 1 and she then called him and was informed that he was not going to write a statement because there had been no fall. The DON explained to Nurse # 1 that witnesses had revealed that Resident # 11 did fall on 10/06/2020 and that the investigation continued and until it

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was completed Nurse # 1 was suspended from his job. The DON explained that when interviewing staff, she developed a time line of events and determined based on witness statements, NP interview and x-ray and other medical record documentation it was determined that Resident # 11 fell and that the fall was known to Nurse # 1 but was not investigated or reported by that nurse as required. The DON and the administrator determined to terminate nurse #1 from employment effective 10/13/2020. The DON and administrator developed a QAPI and held an ad-hoc meeting on 10/13/2020 and began staff reeducation related to falls and other injuries and required notification and follow up. The DON also initiated audit tools to monitor all resident incidents and related documentation. The DON revealed that she expected all licensed nurses to report any significant changes or incidents/ accidents to the MD, RP, administrator and herself as soon as possible and to follow facility policies and procedures without exception and that failure to follow the correct guidelines would result in disciplinary actions.
On 10/20/2020 at 10:04 AM an observation was made of Resident # 11. Resident # 11 was lying in bed and smiled and responded hello to surveyor. When asked if she was in pain or had a recent fall Resident # 11 responded "no". Resident # 11 had her call light in reach and was covered up to her shoulders with bed linen and her left wrist or hip was not observed. There was a mat on the floor at the side of the bed that was not against the wall and the bed was in the lowest position.

An observation of Resident # 11 on 10/21/2020 8:00 AM revealed Resident # 11 awake and in bed. Her left wrist and lower left arm were covered in a black hard cast. Resident # 11 was

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not able to remember why she had that thing on her arm but if anyone touched it her arm would hurt.

The facility provided a plan of correction with a correction date of 10/13/2020. The plan of correction included: F 600.

1.On 10/07/2020 at approximately 11:00 AM the nurse assigned to the 500 hall contacted the NP and DON to report pain and possible fracture of the left wrist and left hip. Resident # 11 had complained of pain to both areas and both areas showed edema and discolored bruise like areas that were not present on 10/06/2020. The NP notified the RP of injuries identified on examination of Resident # 11.

2.All staff that worked the evening and night shift on the 500 hall on 10/06/2020 and 10/07/2020 were interviewed by the DON and signed a written statement. Nurse #1 refused to write a written statement and on 10/08/2020 he was suspended from employment until the investigation was completed. Nurse # 1 was terminated from employment and not eligible for rehire by the DON and administrator on 10/13/20202.

Nursing assessments were completed by the unit nurse and facility Unit manager nurse on 10/07/2020 these included a pain assessment, fall assessment and a skin assessment. Resident # 11 complained of pain when the left wrist and left hip were touched, and she remained in bed until an MD order was received for out of bed activities. Resident # 11 was administered pain medication as directed.

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All licensed nurse staff were reeducated on 10/13/2020 by the DON and SDC (staff development coordinator) for the procedure for notification of change and documentation of incidents by licensed nurses. Educational information also included was to notification to the RP, MD or NP and DON of any falls or other incidents; to fully document all resident incidents as well as any follow up and resident response to any ordered treatments and MD orders. Post fall or other incident the nurse must document the following: an incident report, a skin assessment, pain assessment and a detailed note outlining all notifications, orders received and any other follow up as directed. Nurses not following proper policies and procedures will result in disciplinary action up to and including termination.

On 10/07/2020 nurse # 4 completed a form titled Incident/Accident Report review and acknowledged that all investigation requirements had been initiated or were in process as directed by the DON. Eleven members of the interdisciplinary team reviewed and signed that the review was in process.

A form titled QAPI (Quality Assurance Performance Improvement) Adverse Event Plan completed by the DON included that resident name, date of admission, current diagnoses and a description of events. The form indicated that notification of the event was reported to the MD or NP, DON, RP as soon as identified and that an incident report, witness statements, chart review, timeline of events and monitoring tools had been initiated on 10/07/2020.

An ad-hoc QA/PI meeting was held on 10/13/2020 to discuss the investigation outcome

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for this fall incident. The meeting members discussed implementation of a Performance Improvement Plan for improper notification and documentation. Identification and root cause analysis were reviewed. The system failure was determined to be failure to provide appropriate notification and documentation of an incident that resulted in resident injury. Root cause analysis was that a licensed nurse did not report a fall to anyone and denied the fall occurred. The plan consisted of 5 bullet points that included the nurse is responsible to notify resident RP, MD and DON of all falls and other incidents. The nurse is responsible to document all resident incidents including follow up, resident response to treatment, MD orders. The SDC to provide licensed nurse education related to incident significant change reporting as well as required documentation (incident report, skin assessment, pain assessment and a detailed outline of notification procedures as well as treatment and follow up). Monitoring to be completed by the DON following all resident incidents daily Monday through Friday and weekends (as needed) prn to ensure that proper documentation was completed, all notifications completed to include notification of all appropriate individuals. Facility to monitor on ongoing basis to ensure adherence to this policy and nurse shift supervisors to review incident documentation at the end of each shift to ensure compliance. Resolution date at present 12/31/2020. This meeting was attended to by the DON, administrator and SDC. Audits to be reviewed in scheduled QAPI meetings with interdisciplinary team members.

3. Further investigation revealed that Nurse # 1 began employment at the facility on 01/01/2011. Nurse # 1 received education related to reporting

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incidents/injuries of unknown origin, notification of MD, DON and RP as soon as possible, incident report documentation on 03/12/2019. On 03/14/2019 Nurse #1 received in - service education related to change of resident condition and notification to MD, DON and RP. On 10/08/2019 Nurse #1 attended an in-service related to calling a "code green" when a resident fell and all staff available is to respond to the area. On 11/30/2019 Nurse # 1 was educated related to the use of a Green Folder when a resident fell, skin tears, a new wound or bruise. Each folder contains a check list of steps to be taken for each incident type and notification to MD, DON, administrator and RP with date and time of notification. Witness statements to be obtained, assessments to be completed and copies of all documentation to be maintained in the folder and given to the DON.

4. Audit forms dated from 10/13/2020 through 10/20/2020 were completed by the DON and reviewed with the administrator. Audits will be included in upcoming QAPI meetings to be reviewed to maintain compliance.

Compliance achieved 10/13/2020.

The corrective action plan and compliance date of 10/13/2020 was validated on 10/22/2020.

Validation included interviews with 5 randomly chosen nurse staff on 10/21/2020 and 10/22/2020 which included validation of recent in-service education for reporting and documentation required for resident incidents and accidents.

On 10/13/2020 the facility-initiated audits of resident incidents and accidents and completion

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F 600	Continued From page 19 of required documentation.	F 600		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of	F 732		11/2/20

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F 732	Continued From page 20 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of the facility's required posted Daily Nurse Staffing forms and the facility's Daily Nurse Staffing Schedules the facility failed to post accurate staffing information for the licensed and unlicensed nursing staff for 6 of the 7 days of staffing information reviewed. Findings included: 1. Review of the facility's Daily Posted Nursing Staffing forms and Daily Nursing Schedules for 10/1/2020 to 10/7/2020 revealed the Daily Nursing Staffing forms were not accurate on the following 6 days: a. The Daily Posted Nurse Staffing form for 10/1/2020 was reviewed and it was noted the facility had recorded 4 Licensed Practical Nurses (LPNs) for 32 hours and 10 Nurse's Assistants (NAs) for 75 hours for 1st shift (7:00 am to 3:00 pm). The Daily Nursing Schedule for 10/1/2020 specified there were 5 LPNs and 11 NAs which would be 40 hours of care provided by the LPNs and 82.5 hours of care provided by the NAs for a total of 122.5 schedule hours on the 1st shift. b. The Daily Posted Nursing Staffing form for the 10/1/2020 was reviewed for the 2nd shift (3:00 pm to 11:00 pm). The facility recorded on the Daily Nursing Staffing form there were 3 LPNs with a total of 24 hours and 7 NAs with 52.4 total hours for 2nd shift. The Daily Nursing Schedule for 10/1/2020 specified there were 4 LPNs and 8 NAs which would have been 32 hours of care	F 732	All residents have the potential to be affected by the deficient practice. Staff Development Coordinator (SDC) educated all nurses starting on 10/25/2020 and completed the education on 11/2/2020. Each Nurse Supervisor (whomever is holding the Supervisor keys for the shift) will complete the correct staffing numbers for the shift. All CNAs will be counted, including the Restorative C.N.A. All Licensed Nurses who provide any patient care will be counted (Ex. Supervisors do provide care and should be counted). Account only for staff present during the shift. Do not count staff members who are scheduled but have called out. Post Daily Staffing Sheet on the Bulletin Board near the service hallway. With completion of the staffing sheet, the Three assignment sheets for that date AND the daily staffing sheet will be forwarded to the Director of Nursing (DON) for review. Ensure that the Assignment sheets are easily understood when assignments have been changed. Document call outs using “WNBI” for Will Not Be IN. Document no call no show using “NCNS” The DON will review for accuracy and forward to the Scheduler for filing. DON or	

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F 732	Continued From page 21 provided by the LPNs and a total of 60 hours of care provided by the NAs on 2nd shift. c. The Daily Posted Nursing Staffing form for 10/1/2020 for the 3rd shift (11:00 pm to 7:00 am) were reviewed and showed there were 5 NAs for 37.5 hours. The Daily Nursing Schedule showed there were 7 NAs for a total of 52.5 scheduled hours. d. The Daily Posted Nursing Staffing form for 10/2/2020 was reviewed and the facility had recorded 2 Registered Nurses (one for 8 hours and one for 7 hours) for 1st shift (7:00 am to 3:00 pm) for a total of 15 hours. The Daily Nursing Schedule for 10/2/2020 for the 1st shift specified the facility did not have a Registered Nurses (RN) scheduled. e. The Daily Posted Nursing Staffing form for 10/2/2020 for 2nd shift (3:00 pm to 11:00 pm) revealed the facility had recorded 1 RN for 3:00 pm to 8:00 pm, 1 RN for 3 pm to 11:00 pm and 1 RN for 7:00 pm to 11:00 pm for 17 hours. The Daily Nursing Schedule showed the facility had 1 RN for 8 hours and 1 RN for 4 hours for a total of 12 scheduled hours for the 2nd shift. f. The Daily Posted Nursing Staffing form for 10/3/2020 for 2nd shift (3:00 pm to 11:00 pm) revealed the facility had recorded 1 RN for 8 hours; 3 LPNs for a total of 24 hours; and 7 NAs for 52.4 hours. The Daily Nursing Schedule showed the facility had 1 RN for 4 hours; 8 LPNs for 4 hours each which totaled 32 hours; and 8 NAs for a total of 60 scheduled hours. g. The Daily Posted Nursing Staffing form for 10/3/2020 for 3rd shift (11:00 pm to 7:00 am)	F 732	designee will review staffing sheet daily 30 days, then weekly review x 2 months.	

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showed the facility recorded 7 NAs for 52.5 hours and the Daily Nursing Schedule showed the facility had 8 NAs for a total of 60 scheduled hours.

h. The Daily Posted Nursing Staffing form for 10/5/2020 for 2nd shift (3:00 pm to 11:00 pm) recorded 2 RNs for 16 hours; 2 LPNs for 16 hours; 1 Medication Aide (MA) for 8 hours; and 7 NAs for 52.5 hours. The Daily Nursing Scheduled showed the facility had 3 RNs for 4 hours each for 12 hours; 5 LPNs for 4 hours each which totaled 20 hours; 1 MA for 4 hours; and 8 NAs for 60 total scheduled hours.

i. The Daily Posted Nursing Staffing form for 10/6/2020 for 1st shift (7:00 am to 3:00 pm) revealed the facility recorded 9 NAs for 67.5 hours; and 1 MA for 8 hours for a total of 75.5 total scheduled hours. The Daily Nursing Schedule recorded the facility had 1 MA for 4 hours; and 7 NAs for 52.5 and 1 NA for 6.5 hours for a total of 63 scheduled hours.

j. The Daily Posted Nursing Staffing form for 10/6/2020 for 2nd shift (3:00 pm to 11:00 pm) revealed the facility had 2 LPNs for 16 hours; and 1 MA for 8 hours for a total of 24 scheduled hours. The Daily Nursing Schedule for 10/6/2020 for 2nd shift (3:00 pm to 11:00 pm) stated there 6 LPNs for 4 hours each that totaled 24 hours; and 1 MA for 4 hours for a total of 28 scheduled hours.

k. The Daily Posted Nursing Staffing form for 10/7/2020 for 2nd shift (3:00 pm to 11:00 pm) showed the facility recorded 27 hours of RN care hours, 28 LPN care hours, and 4 MA care hours for a total of 59 hours. The Daily Nursing

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Schedule showed the facility had 12 hours RN care hours; 56 hours of LPN care hours and 8 hours of MA care hours for a total of 76 scheduled hours.

The Staffing Coordinator was interviewed on 10/21/2020 at 4:57 pm. She stated she completed the Daily Nursing Schedule but did not complete the Daily Nursing Schedule and gives it to the Nurse Supervisor on duty to complete. The Staffing Coordinator stated the Nursing Supervisors update the Daily Nursing Schedules with the call outs and completed the Daily Nursing Staffing forms.

An interview with Nursing Supervisor #2 on 10/21/2020 at 5:10 pm revealed the Nursing Supervisors complete the Nursing Staffing Forms which is posted each day and update the Nurse Staffing Schedules with any changes such as call outs or staff leaving early. Nursing Supervisor #2 stated she counted if there were 2 Registered Nurses on a shift and they worked 4 hours each they were counted as 2 Registered Nurses. Nursing Supervisor #2 also stated the Nursing Supervisor were not counted as giving direct patient care although they do give direct patient care.

An interview with the Director of Nursing on 10/21/2020 at 5:25 pm revealed she was aware the Nursing Supervisor were not completing the Daily Posted Nursing Staffing forms correctly. She stated the Nursing Supervisors did not understand the nursing hours should have included all nurses that gave direct patient care and the number of hours should be recorded for the actual number of hours each nurse had worked. She also stated they had not been

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F 732	Continued From page 24 including each nurse's credentials on the Daily Nurse Staffing forms. The Director of Nursing stated all the Nurse Supervisors would be educated and an improvement plan would be put into place to correct the Daily Nurse Staffing. During a phone interview with the Administrator on 10/23/2020 at 10:33 am he stated he was aware the Director of Nursing was working on the issues regarding the nurse staffing hours not being recorded on the Daily Posted Nursing Staffing form and the facility had already initiated a plan to correct the issue.	F 732		