STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345280	A. BUILDING _____ B. WING _____	C 06/21/2017

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AUTUMN CARE OF RAEFORD	1206 N FULTON STREET RAEFORD, NC 28376

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F 000	INITIAL COMMENTS A complaint survey was conducted from 6/15/17 through 6/21/17. Immediate Jeopardy was identified at: CFR 483.10 at tag F157 at a scope and severity J CFR 483.12 at tag F224 at a scope and severity J CFR 483.25 at tag F309 at a scope and severity J CFR 483.25 at tag F323 at a scope and severity J The tags F224, F 309, and F 323 constituted Substandard Quality of Care. Immediate Jeopardy began on 4/14/17 and was removed on 6/18/17. An extended survey was conducted.	F 000		
F 157 SS=J	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of	F 157		7/17/17

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

Electronically Signed | 07/13/2017

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F 157	Continued From page 1 treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to consult with the physician regarding a change in condition for one (Resident # 1) of two sampled residents who experienced multiple falls. The resident was found to have a subdural hematoma, extensive bruising to multiple body parts, and gastrointestinal bleeding when she was transferred to the hospital. Immediate Jeopardy began 6/9/17 when facility	F 157	Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. Corrective action taken for the residents found to have been affected: 1a. Resident #1 no longer resides at the facility.	

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F 157	Continued From page 2 staff failed to notify the physician that Resident # 1 was acting differently after sustaining falls and a bruise to her head while taking aspirin. On 6/10/17 the resident refused two meals and care before the staff contacted the physician to obtain new orders. Interview with the facility physician revealed the staff had not communicated the extent of bruising the resident had on her body or the change in her condition. The immediate jeopardy was removed on 6/17/17 when the facility provided an acceptable credible allegation of compliance. The findings included: Record review revealed Resident # 1 resided at the facility from 4/18/17 until 6/10/17. According to the medical record the resident had the following diagnoses: advanced Parkinson's disease, frontotemporal dementia with pseudo bulbar affect, chronic atrial fibrillation, iron deficiency anemia, hyperglycemia, hypertension, alopecia totalis (loss of hair), healed fracture of the right humerus, history of falls; chronic kidney disease, scoliosis, and hypothyroidism. Review of physician orders revealed the resident was admitted on 4/18/17 with an order for Aspirin 325 milligrams (mg) daily for Atrial Fibrillation. (Aspirin can be used as an anti-coagulant.) Record review revealed the physician assessed the resident on 4/21/17 and noted that there was no bruising or abnormal bleeding as of the physician's assessment date, and the resident's last hemoglobin was noted by the physician to be 9.8 (Normal range 12-16). Review of the resident's Minimum Data Set (MDS) assessment, dated 4/25/17, revealed the	F 157	1b. Resident #2's MD and Responsible Party were notified on 4/14/17 and a head to toe assessment was completed at that time. Resident #2 was seen by the Nurse Practitioner 4/19/17 and ordered a CT of chest without contrast, Right shoulder X-Ray and a CBC, and each order was completed. The MD was contacted on June 18, 2017 and an order was obtained at that time for Tylenol 325 MG as needed. Corrective action taken for those residents having the potential to have been affected: 2a. An assessment was conducted on 6/17/17/for current residents that had falls since June 1st. 2b. As of June 1st fall incidents have been audited to include head to toe assessments, neurological checks, pain assessment and intervention as warranted RP notification and MD notification. 2c. A review of the 24 hour report and changes in condition will be discussed and reviewed in clinical meeting. Measures that will be put into place or systemic changes made to ensure that the deficient practice will not occur: 3a. Re-education on notification of responsible party and Physician will be completed by July 17th, 2017 to licensed nurses. This will include SBAR/change in condition. 3b. Newly hired nurses will be educated on notification of responsible party and Physician by DON/designee.	

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F 157	Continued From page 3 resident was cognitively impaired; needed extensive assistance from one staff member for bed mobility, transfers, dressing, toileting, hygiene, and bathing; and needed limited assistance for ambulation. This MDS assessment also coded the resident as having no falls or fractures within the last 6 months prior to her facility admission. Review of the resident's care plan, dated 4/18/17, revealed the staff identified Resident # 1 was at risk for falls. The facility's goal for the resident was that she not sustain injury due to a fall. Listed interventions added on 4/18/17 were: ambulation devices as needed; assess cognitive status, evaluate for unsteady gait, instruct on appropriate safety measures; maintain a safe environment, proper nonskid foot wear; therapy to evaluate and treat as ordered. On 4/25/17 "anti rollback wheelchair brakes" was added to the care plan interventions. On 4/26/17 "assess for fatigue and provide rest periods PRN (as needed)" and "assist with transfers and ambulation" was added to the care plan interventions. On 6/9/17 "offer and assist resident to bed between 7 PM to 8 PM" was added to the care plan interventions. Review of the nursing notes revealed Resident # 1 sustained a fall on 4/24/17 at 6:00 AM. Nurse # 2 documented at this time that Resident # 1 slid out of bed while getting into her wheelchair, and landed on her buttocks with her back against the bed. On 4/24/17 at 7:18 AM, Nurse # 2 documented that the resident had a bruise to her right flank but had no complaint of pain or discomfort. The note indicated the physician was made aware of the fall and bruise. Review of the record revealed that following the	F 157	3c. Based on DON/designee review of events, failure of any employee to comply with notification requirements will receive additional education and counseling. Monitoring: 4a. The 24 hour report will be reviewed to identify changes in condition and SBAR review 5x/week in clinical meeting to ensure ongoing compliance with notification policy for 12 weeks. 4b. An audit of changes in condition will be completed in clinical meeting to ensure ongoing compliance of Physician and responsible party notification requirements. 4c. Audits will be reviewed by the QA and A committee monthly for 3 months.	

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fall of 4/24/17, Resident # 1 did not sustain any further falls until the date of 6/6/17. From 6/6/17 through 6/9/17, the resident was documented as falling three times within these four days.

Record review revealed a nursing note on 6/6/17 (Tuesday) at 5:42 PM by Nurse # 3 noting Resident # 1 was observed sitting on the floor on her buttocks next to her bed. The note indicated the physician was made aware of the fall.

On 6/8/17 (Thursday) at 7:55 PM Nurse # 2 documented Resident # 1 sustained another fall. The nurse noted Resident # 1 was "sitting on the edge of her wheelchair and slid out of the chair onto the floor landing on her buttocks." Nurse # 2 noted the resident was cooperative, pleasant, and her skin tone was normal. There was no documentation of bruising or injury. The note indicated the physician was made aware of the fall.

Nurse # 1 was interviewed on 6/15/17 at 2:00 PM and 6/16/17 at 9:46 AM. Nurse # 1 stated the resident had fallen on 6/9/17 (Friday) but the incident had been logged as occurring on 6/10/17. The nurse pointed to an entry in the nursing notes which was dated 6/10/17 (Saturday) at 5:12 PM. Nurse # 1 stated this Saturday entry, which documented a fall, occurred on 6/9/17 (Friday) at 3:43 PM.

The entry read, "Writer called to TV room Resident observed with her right knee on the floor and her right elbow resting on an arm-chair. Resident assessed for injuries; no injuries noted. Resident had old bruising to her arms and the right temporal area. Resident had no complaints of pain. MD in facility, notified of unwitnessed fall.

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Writer attempted to contact RP (name of RP) to inform of unwitnessed fall." The note was signed by Nurse # 1.

Interview with Nurse # 1 on 6/15/17 at 2 PM and 6/16/17 at 9:46 AM revealed she had been the nurse to respond to the fall on 6/9/17 at 3:43 PM. Nurse # 1 stated NA # 4 had been in attendance with Resident # 1 in the TV room, but was caring for another resident at the time and had not seen Resident # 1 fall. Interview with Nurse # 1 revealed she had checked Resident # 1 in the TV room, but did not take her back to her room and look at her entire body at the time of the incident. Nurse # 1 stated the resident had some yellow bruising on her arms and a purple bruise to the right temple area at the time of her assessment. Nurse # 1 stated the resident continuously wore either a wig or bonnet secondary to her hair loss. Nurse # 1 stated at the time of the incident the bruise did not extend under her bonnet, and she did not take the resident's bonnet off to assess her head further. Nurse # 1 stated she felt the Resident would not have let her remove the bonnet. Nurse # 1 stated she did let the physician know the resident had a bruise to her temple, but she had not noted a change in the resident in order to convey a change in condition to him. This interview also revealed the nurse had not questioned the physician about whether the aspirin dosage should be evaluated.

Nurse # 2 was interviewed on 6/16/17 at 9:16 AM. According to facility staffing sheets, Nurse # 2 had been assigned to care for Resident # 1 from 7:00 PM on 6/9/17 (Friday) until 7:00 AM on 6/10/17 (Saturday). The nurse stated it often got hectic on the unit where Resident # 1 resided and things tended to run together. According to

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Nurse # 2 she thought she might have called and told Resident # 1's responsible party that Resident # 1 had hit her head, but she could not recall the reason she might have done so. According to Nurse # 2, she recalled the assistant director of nursing (ADON) talking to her the Friday evening of 6/9/17 about Resident # 1, and they discussed that Resident # 1 was acting differently and were wondering if she might have a urinary tract infection. Nurse # 2 did not recall speaking to the resident's physician regarding this.

Interview with the ADON on 6/16/17 at 3:55 PM revealed she was responsible for following up on falls and accidents. The ADON stated she had checked on Resident # 1 on the morning of 6/9/17 (Friday) because the resident had fallen on 6/8/17 (Thursday). The ADON stated she had not noticed a bruise to Resident # 1's temple on the Friday morning of 6/9/17. The ADON stated on Friday evening of 6/9/17 she went to check on the resident again, and noted she had a bruise to her temple which she had not seen earlier. According to the ADON on Friday evening of 6/9/17 she saw the resident reach one time into the air as if she was reaching for something that was not there, and her pupils seemed to be small. The ADON stated she did not have a pen light in her pocket to do a neurological check, but she had spoken to Nurse # 1 and it was her understanding that Nurse # 1 was going to follow up with the physician. According to the ADON she had not spoken to the physician directly about her observations.

NA # 2 was interviewed on 6/16/17 at 11:10 AM. NA # 2 stated she had cared for Resident # 1 on the Friday of 6/9/17 from 3:00 PM until 7:00 PM.

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NA # 2 stated Resident # 2 reached for things in the air that were not there; as if she were "hallucinating." NA # 2 stated this was different for Resident # 2 and she had told a nurse about it, but was not exactly sure which nurse it was.

There was no documentation in the nursing notes noting NA # 2's observations or that the physician had been notified.

NA # 3 was interviewed on 6/17/17 at 10:45 AM. NA # 3 stated she arrived to work at 7:00 PM on 6/9/17 (Friday) and stayed in the TV room with residents from 7:00 PM to 9:00 PM. Interview with NA # 3 revealed Resident # 1 was in the TV room when she arrived at work, kept trying to repeatedly stand up, and elbowed NA # 3 when she tried to redirect the resident to sit down. NA # 3 stated the resident would scream, became angry, and did not want to open her mouth for medications from the nurse.

Interview with Nurse # 3 on 6/15/17 at 12:25 PM revealed she had been on duty during the dayshift on 6/10/17 (Saturday). Nurse # 3 stated she had not received anything in report when she reported to duty that Resident # 1 had been bruised or injured. Nurse # 3 stated she did not know the resident had been hurt until two dayshift NAs (NA # 6 and NA # 7) came to her and reported they had found bruises on her while giving her care. Nurse # 3 stated she immediately went to assess the resident and found her to have bruises on her back, legs, hip, and head. The nurse stated the bruises were red in color and she immediately called Nurse # 1, who was her supervisor.

NA # 6 was interviewed on 6/15/17 at 4:35 PM.

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Interview with NA # 6 revealed she had routinely cared for Resident # 1, and the resident was usually very cooperative with care. NA # 6 stated prior to 6/10/17 (Saturday), she had last cared for her on 6/6/17 (Tuesday). NA # 6 stated on Saturday of 6/10/17, Resident # 1 was assigned to NA # 7 and she (NA # 6) had assisted with her. NA # 6 stated Resident # 1 would not eat nor drink for breakfast or lunch, and she refused care by swinging at them. NA # 6 stated after lunch they finally convinced Resident # 1 to let them assist her with care, and when they pulled back her covers and clothing to provide care there were dark purple bruises on her arms, breast, back, thighs, and legs. NA # 6 stated the bruising seemed "like it was everywhere." NA # 6 stated they immediately got the nurse. NA # 6 stated the bruising had not been present when she had last cared for Resident # 1 on 6/6/17 (Tuesday).

NA # 7 was interviewed on 6/16/17 at 12 noon. Interview with NA # 7 revealed she had not received a report when she reported to duty on 6/10/17 that there was anything wrong with Resident # 1. NA # 7 stated Resident # 1 would not eat breakfast nor lunch and refused morning care. NA # 7 stated the nurse also tried to assist her for lunch, and the resident refused. NA # 7 stated after lunch she and NA # 6 went together to provide care, and when they pulled back the sheet there were bruises on both arms, both hips, on her legs, under her arm, on the side of her chest by her breast, and on her right head. Interview with NA # 7 revealed she had not seen the bruise on her head earlier because the resident wore a bonnet and when they were providing care the bonnet tipped backward which revealed the bruising. NA # 7 stated the head bruise was about the size of her hand.

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Review of the record revealed no notation regarding the bruising that was found by NA # 6, NA # 7 and Nurse # 3 on 6/10/17.

According to the record Nurse # 1 noted on 6/10/17 at 5:38 PM "new order noted-CT of hand. Called (responsible party) and left message to return call)." This was the only notation in the nursing notes regarding any communication with the resident's physician since the resident had fallen on 6/9/17 (Friday) at 3:43 PM.

Interview with Nurse # 1 on 6/16/17 at 9:46 AM revealed Nurse # 3 had called her at home on 6/10/17 and told her Resident # 1 had bruises "everywhere." Nurse # 1 stated it was her understanding that the main concern was the bruising and not a change in mental status. Nurse # 1 stated she called the physician and he asked if the resident had been falling. Nurse # 1 stated she told the physician the resident had fallen, and he therefore wanted her sent for a CT scan at the hospital. The nurse clarified the order was for a CT of the head and not of the hand which had been indicated in the notes. The nurse stated it was arranged for Resident # 1 to go to the hospital out-patient department via way of a non-emergency transport service.

Interview with the DON (Director of Nursing) on 6/15/17 at 5:25 PM revealed Nurse # 3 had called her at home and the main concern seemed to be the change in Resident # 1's mental status. The DON stated she had just recently been employed at the facility and therefore Nurse # 1 knew the resident much better than she did. The DON stated Nurse # 1 was planning to go in to work, and therefore she had Nurse # 1 communicate

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with the physician. The DON stated the extent of the bruising was not conveyed to her or she would have gone to the facility when she was called.

A review of the resident's June 2017 medication administration record (MAR) revealed she had received her prescribed dosage of 325 milligrams of Aspirin daily from 6/6/17 through 6/10/17. There was no indication in the record the facility staff had consulted with the physician regarding if the Aspirin should be held when the resident began falling.

Review of 6/10/17 ER medical records revealed the resident's bruising was extensive. The ER physician noted the resident had bruising on the right parietal area of her head; the right flank, the right elbow, the right hip, the right knee, and the left flank. He further noted she had critical anemia with a Hemoglobin level of 5.9 which the physician documented was "likely secondary to a GI (gastrointestinal bleed)." The resident's stool was grossly guaiac positive for blood in the ER. A CT scan of the resident's head on 6/10/17 revealed she had a frontoparietal subdural hematoma measuring 5 mm (millimeters) in thickness.

An interview with the resident's facility physician on 6/17/17 at 7:00 PM revealed the most likely reason for the resident's extensive bruising was her repeated falls. According to the physician the staff had notified him of the bruise to the temple on 6/9/17, but they had not notified him of any other changes in her mental status on Friday (6/9/17), the extent of the bruising, or consulted with him regarding the aspirin dosage. The physician stated he did not usually order aspirin

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at the dosage of 325 milligrams daily for residents, and Resident # 1 had been admitted with the dosage.

Review of the resident's death certificate revealed she passed away on 6/14/17 at 6:30 PM. On the death certificate the physician had listed the cause of death as "subdural hematoma" and "complications of a fall."

On 6/29/17 at 4:52 PM, the administrator was informed of the immediate jeopardy. The facility provided a credible allegation of compliance on 6/18/17. The allegation of compliance indicated:

Credible Allegation of Compliance
Resident # 1 has diagnosis including but not limited to Lewy Body Dementia, Parkinson's disease, Pseudo Bulbar, anemia, and A-fib. Upon admission, she was determined to be a risk for falls. Subsequently, she was care planned for a fall risk as to prevent injuries. Resident #1 sustained three separate falls on 6/6/17, 6/8/17 and 6/9/17 which resulted in bruising to multiple areas of her body. The fall on 6/9/17 was unwitnessed in the dayroom at approximately 3:45 pm. Resident #1 was noted to be on one knee with the other foot flat on the floor. Her right arm was on a chair and her left arm was on her wheelchair. Resident was observed on the floor by the Unit Manager and assisted to a chair in the dayroom and a head to toe assessment was not documented in the clinical record. The ADON observed a bruise to resident's forehead and spoke with the Unit Manager regarding the observation. The Unit Manager observed the area where the bruise was located on resident #1's forehead, but did not complete a head to toe assessment. The bruise to the forehead was not

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completely assessed by the UM and the extent could not be determined due to the UM not removing the cap from resident #1's head. The UM stated to DON that resident #1 didn't let UM remove her night cap. The Unit Manager failed to complete a head to toe assessment immediately following the observation of the bruise to the resident's forehead. UM notified the attending physician regarding the fall and bruise to head. MD was notified of the bruise to resident #1's forehead and ordered neuro checks at that time. Neuro checks were started following the MD order, but did not continue based on the facility's policy. On 6/10/17, resident #1 refused breakfast. She also refused to get out of bed or allow personal care offered by staff. She refused lunch, pushing staff away. Thru encouragement, staff were able to assist resident with ADL care and noted bruises on her body. At this time she was alert but not speaking. The nurse was informed and contacted the DON at 3:25 pm regarding the refusal of meals, refusal of care and multiple bruising. An order was obtained to send resident #1 to hospital for head CT. Resident was transported to hospital via wheelchair at 5:15pm. Resident was later transferred to hospital and admitted with subdural hematoma and GI bleed. Resident later expired at hospital. The nurse failed to complete a thorough head to toe assessment at time of fall per policy. The nurse also failed to contact the MD to report change to Resident #1. Resident #2 sustained a bruise to right armpit that was identified on 4/14/17. The RP and MD were notified on that date, however, the nurses failed to continue to assess the bruise for any changes. In addition, the nurses also failed to advise the MD of changes to resident's #2 area to right armpit. The Nurse Practitioner saw resident #2

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on 4/19/17 and ordered CT without contrast to the chest and X-Ray to right shoulder in which the results later revealed a hematoma with osteopenic bones.

For the resident affected:

All residents who sustained a fall since June 1, 2017 were assessed by the DON/Designee by use of an audit tool to determine completion of head to toe assessments and MD notification regarding changes in resident condition. The assessment audit included a review of the medical record to ensure that all measures were in place to include contacting the MD of any changes to meet the current needs of the affected residents. A review of the medical record was conducted by the DON to review appropriate interventions and assessments subsequent to each fall. Based on findings, staff education was provided by DON.

Plan to identify other residents who are at risk for the deficient practice
Other residents who are at risk for deficient practice will be identified by an assessment audit that will be conducted for all current residents that have had falls since June 1st. Assessments will be reviewed by Director of Nursing or delegated persons for compliance. Based on findings education will be provided. Surveyor identified another resident that had been affected by the failure to conduct assessments according to policy. Resident #2 sustained a bruise on 4/14/17 to the right armpit. The MD and Responsible Party were both notified on that date. No further documentation to include head to toe assessments which would have indicated any change to area was noted until 4/19/17. The

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resident was seen by the Nurse Practitioner. At that time a CT of chest without contrast, Right shoulder X-Ray and a CBC were ordered. The results of the tests revealed an intermuscular hematoma. It was determined from review of the medical record that no head to toe assessment was conducted for the resident. The medical record reflects compound fracture to the lower spine and there have been no follow up X-rays to address the affected area of the spine. The compression fractures were sustained prior to admission to the facility and are noted on admission evaluation by MD. Staff have observed resident #2 calling out in pain during ADL care. MD notified on 6/18/17 to have pain medication ordered for resident #2.

Action Taken to Fix the Problem
Re-education to all nurses and CNAs began on 6/17/17. All Nursing staff to include licensed nurses and CNAs were educated on 6/17/17 either via phone or in person regarding the following: Fall Management, which includes Safe Handling of residents regarding transfers, Head to Toe Assessments, Abuse/Neglect policy and procedure, and Neurological Check Policy and Procedure. All CNAs have received education regarding reporting any change in condition to nurse through the use of a "Stop and Watch Tool." All employees who received education via phone will receive written material upon returning to work.
The Neurological checks education was provided on 6/17/17 to all licensed nurses to specifically address the frequency and duration: It is as follows: Every 15 minutes for 2 hours, then every 30 minutes for 4 hours, then every hour for 4 hours, then every 4 hours for sixteen hours, and every 8 hours for 48 hours. Education was

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F 157	Continued From page 15 provided to all nursing staff on 6/17/17 to include all assessment processes to include assessment for pain. The facility alleged IJ removal on 6/17/17. The credible allegation was verified on 6/21/17 at 6:04 PM. Nurse #1 no longer worked at the facility and could not be reached by phone for interview. A sample of current resident records were reviewed for falls, injury and staff action. The Assistant Director of Nursing was interviewed on 6/21/17 at 5:07 PM. She provided the Fall Management Protocol, Assessment and Neurological Check policy inservice details. On 6/21/17 from 2:02 PM through 5:42 PM, random nursing staff as well as Nursing Assistants involved with Resident #1 following the falls, were able to articulate the steps of the "Stop and Watch Tool" for notification, assessment and reporting. Staff members interviewed were able to describe education received regarding falls, assessment, the policy regarding neurological checks, physician notification, neglect and how to respond to changes in condition. The facility was able to provide evidence that they had completed an audit of the residents and inserviced all staff on 6/17/17. Other residents in the facility were observed and there were no concerns. The immediate jeopardy was removed on 6/17/17.	F 157		
F 224 SS=J	483.12(b)(1)-(3) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN §483.12 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	F 224		7/17/17

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F 224	Continued From page 16 not required to treat the resident's symptoms. 483.12(b) The facility must develop and implement written policies and procedures that: (b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (b)(2) Establish policies and procedures to investigate any such allegations, and (b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews, family interview and physician interview for two (Residents # 1 and Resident # 2) of three residents who had sustained injuries the facility neglected to assess the residents and provide care. The facility failed to assess Resident # 1, communicate clearly to the physician the resident's status, and initiate emergency medical services when the resident was identified to have a head injury and a change in mental status after sustaining three falls within four days. When a decision was made to send the resident out for medical treatment, the facility failed to initiate emergency medical services. The resident was found to have extensive bruising, a subdural hematoma, and critical lab work when transferred to the hospital. The resident expired four days following her facility discharge. The facility failed to assess Resident # 2 following the identification of a painful armpit bruise. The resident was identified to have an intramuscular chest hematoma six days after the armpit bruise was identified for which she had	F 224	Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. Corrective Action taken for the residents found to have been affected: 1a. Residents #1 no resides at the facility. 1b. Resident #2's MD and Responsible Party were notified on 4/14/17 and a head to toe assessment was completed at that time. Resident #2 was seen by the Nurse Practitionaer4/19/17/ and ordered a CT of the chest without contrast, Right shoulder X-Ray and a CBC, each order was completed. The MD was contacted on June 18, 2017 and an order was obtained at that time for Tylenol 325 MG as needed. Corrective action taken for those residents having the potential to have been	

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F 224	Continued From page 17 received nothing for pain. The facility also failed to provide assessment and management of Resident # 2's pain she experienced while receiving transfer assistance from staff. The resident was observed to be in pain during transfers. Immediate jeopardy began on 4/14/17 when Resident # 2, who was cognitively impaired and needed staff's assistance for her care, was identified to have a painful armpit bruise. The facility failed to assess the resident and on 4/19/17 the resident was noted to also have a bruise to her chest. On 4/20/17 a computerized tomography scan revealed the resident had an intramuscular hematoma to her chest muscle for which she had not received anything for pain. Resident # 1 was also neglected at a level of IJ. On 6/9/17 the facility staff identified Resident # 1, who sustained three falls within four days, had a bruise to her head and they failed to assess the resident for further and worsening injury in order that they clearly communicate to the physician the resident's medical status. Following the identification of the head bruise staff were knowledgeable the resident picked at non-existent things in the air, refused fluids, refused meals, and refused care. Nurses did not identify the resident had extensive bruising on multiple areas of her body until the afternoon of 6/10/17. The resident was transported out for medical care by a non- emergent transport. The immediate jeopardy was removed on 6/18/17. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to allow the facility to monitor and fully implement the new procedures to assure residents are assessed and not	F 224	affected: 2a. An assessment audit was conducted on 6/17/17 for current residents that had falls since June 1st. 2b. As of June 21st fall incidents have been audited to include head to toe assessments, neurological checks, pain assessment and intervention as warranted, RP notification and MD notification. 2c. A review of the 24 hour report and changes in condition will be discussed and reviewed in clinical meeting. Measures that will be put into place or systemic changes made to ensure that the deficient practice will not occur: 3a. Re-education on Abuse/Neglect policy and procedure, fall Management (including Safe Handling of residents regarding transfers, Head to Toe assessments,) Neurological Check Policy and Procedure, Pain Management Protocol and Stop and Watch Tool will be completed by DON/designee to licensed nurses and CNAs by 7/17/17. 3b. New employees will be educated on Abuse/Neglect policy and procedure, Fall Management (including Safe handling of residents regarding transfers, Head to Toe Assessments,)Abuse/Neglect policy and procedure, Neurological Check Policy and Procedure, Pain Management Protocol and Stop and Watch Tool by DON/designee. Monitoring: 4a. A review of each incident and the 24 hour report will be discussed and	

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F 224	Continued From page 18 neglected. The findings included: 1.The facility's neurological checks policy, last revised in August 2006, was reviewed. According to the policy neurological checks were to be completed if a resident was suspected of sustaining head trauma. The frequency of the checks were to be done as follows: every 15 minutes for 2 hours; every 30 minutes for four hours; every hour for 4 hours; every 4 hours for 16 hours; and every 8 hours for 48 hours. Record review revealed Resident # 1 resided at the facility from 4/18/17 until 6/10/17. According to the medical record the resident had the following diagnoses: advanced Parkinson's disease, frontotemporal dementia with pseudo bulbar affect, chronic atrial fibrillation, iron deficiency anemia, hyperglycemia, hypertension, alopecia totalis (loss of hair), healed fracture of the right humerus, history of falls; chronic kidney disease, scoliosis, and hypothyroidism. Record review revealed the physician assessed the resident on 4/21/17 and noted that there was no bruising or abnormal bleeding as of his assessment date, and her last hgb (hemoglobin) was noted by the physician to be 9.8. (Normal range 12-16) The physician noted in his 4/21/17 progress note, "Please let me know about any changes in behavior that indicated an exacerbation of today's issues." Review of the resident's MDS (Minimum Data Set) assessment, dated 4/25/17, revealed the resident was cognitively impaired; needed extensive assistance from one staff member for bed mobility, transfers, dressing, toileting,	F 224	reviewed 5x/week in clinical meeting to ensure ongoing compliance with policy for 12 weeks. 4b. A fall audit will be completed by DON/designee for each fall for 12 weeks. 4c. Audits will be reviewed by the QA and A committee monthly for 3 months.	

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hygiene, and bathing; and needed limited assistance for ambulation. This MDS assessment also coded the resident as having no falls or fractures within the last 6 months prior to her facility admission.

From 6/6/17 through 6/9/17, the resident was documented as falling three times within these four days.

Record review revealed a nursing progress note on 6/6/17 (Tuesday) at 5:42 PM by Nurse # 3 noting Resident # 1 was observed sitting on the floor on her buttocks next to her bed. The nurse noted the resident was assessed for injuries and none were noted.

Nurse # 3 was interviewed on 6/15/17 at 12:25 PM. Nurse # 3 stated she had checked Resident # 1 and found no bruising or injury after her fall on 6/6/17.

A nursing progress note dated 6/7/17 (Wednesday) at 4:25 AM by Nurse # 3 contained documentation at this time that the resident was responsive and cooperative, and there was no notation made that the resident had sustained bruises or injuries.

Nurse # 3 was interviewed on 6/15/17 at 12:25 PM. Interview with Nurse # 3 revealed the resident had no bruises on her assessment.

A nursing progress note dated 6/8/17 (Thursday) at 4:25 AM revealed a nurse had completed a head to toe assessment, and the resident was found to be pleasant and cooperative. The note was signed by Nurse #4. There was no documentation within the note the resident had

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bruising or injuries.

Review of a "Bi Weekly Skin Check" dated 6/8/17 at 12:30 PM revealed Resident # 1 had no current skin issues.

Interview with Resident # 1's responsible party (RP) on 6/16/17 at 10:10 AM revealed she had visited Resident # 1 on 6/8/17 during the afternoon and stayed with her until 7 PM. The RP stated she had noted Resident # 1 had bruises on her arm and hand during the visit.

A nursing progress note dated 6/8/17 at 7:55 PM documented Resident # 1 sustained another fall. The nurse noted Resident # 1 was "sitting on the edge of her wheelchair and slid out of the chair onto the floor landing on her buttocks." The resident was cooperative, pleasant, and her skin tone was normal. The note was signed by Nurse #2. There was no documentation of bruising or injury.

Nurse # 2 was interviewed on 6/16/17 at 9:15 AM. Nurse # 2 stated Resident # 1 had been in the TV room when she sustained the fall on 6/8/17 (Thursday) at 7:55 PM. According to the interview with Nurse # 2, she had taken the resident back to her room, lifted her clothes, found no evidence of bruising, and could not recall any injury noted on her shift which ended on 6/9/17 (Friday) at 7 AM.

The next nursing progress note which noted an assessment of Resident # 1's condition was entered on 6/9/17 (Friday) at 3:25 AM by Nurse # 2. Nurse # 2 noted the resident was pleasant and cooperative, and her skin tone was normal. There was no documentation of bruising or injury.

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A nursing progress note was entered by Nurse # 2 on 6/9/17 at 6:56 AM noting the resident had a hematoma to her right elbow. There was no further information in the note.

Nurse # # 2 was interviewed on 6/16/17 at 9:16 AM. Nurse # 2 could not recall any injury she had observed from her assessments of the resident during her shift from 7 PM on 6/8/17 until 7 AM on 6/9/17. She did not recall observing the hematoma on Friday (6/9/17) morning before she left work, but recalled the resident's arm being puffy when she reported to work on Friday (6/9/17) evening for her next shift.

A nursing progress note was entered into the record on 6/9/17 (Friday) at 2:56 PM by Nurse # 1. Nurses # 1 documented at this time that an order was received to x-ray Resident # 1's elbow and that the resident's RP (Responsible Party) was notified. There was no documentation of assessment of the resident's condition or of the hematoma in this note.

Review of the record revealed a mobile x-ray was completed on 6/9/17 of the resident's elbow. The "indication" for the x-ray was noted to be "pain." The X-ray report noted there was "mild soft tissue swelling" but no definite bony abnormalities. The report was electronically signed by the radiologist on 6/9/17 at 9:11 PM.

Nurse # 1 was interviewed on 6/15/17 at 2:00 PM. According to the nurse the resident had a hematoma to her arm on the morning of 6/9/17 and no other injury. The nurse stated this had been communicated to the physician and an x-ray was done.

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Following the nursing progress note of 6/9/17 (Friday) at 2:56 PM there were no other nursing notations in the progress notes for 6/9/17.

It was confirmed with Nurse # 1 on 6/15/17 at 2:00 PM that the following entry was entered in the progress notes for 6/10/17, but was for an incident that occurred on 6/9/17 at 3:43 PM. The entry read, "Writer called to TV room Resident observed with her right knee on the floor and her right elbow resting on an arm-chair. Resident assessed for injuries; no injuries noted. Resident had old bruising to her arms and the right temporal area. Resident had no complaints of pain. MD in facility, notified of unwitnessed fall. Writer attempted to contact RP (name of RP) to inform of unwitnessed fall."

Interview with Nurse # 1 on 6/16/17 at 9:46 AM revealed she had been the nurse to respond to the fall on 6/9/17 at 3:43 PM. Interview with Nurse # 1 revealed she had checked Resident # 1 in the TV room, but did not take her back to her room and look at her entire body at the time of the incident. Nurse # 1 stated the resident had some yellow bruising on her arms and a purple bruise to the right temple area at the time of her assessment. Nurse # 1 stated the resident continuously wore either a wig or bonnet secondary to her hair loss. Nurse # 1 stated at the time of the incident the bruise did not extend under her bonnet, and she did not take the resident's bonnet off to assess her head further. Nurse # 1 stated she felt the Resident would not have let her remove the bonnet. Nurse # 1 stated she did let the physician know the resident had a bruise to her temple. Interview with Nurse # 1 revealed she left the facility around 7:00 PM on

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6/9/17 (Friday), and she stated she had not noted a change in Resident # 1. According to Nurse # 1 she had started a neurological assessment flow sheet for the resident and completed neuro checks up until 6:45 PM. The nurse provided the copy of the neurological assessment flow sheet. The last neuro check documented on the flow record was 6:45 PM. The rest of the flow sheet was blank, and Nurse # 1 could not find any other records to show the neuro checks had been completed per the facility's protocol schedule. Nurse # 1 did not know why the next nurse did not continue the checks per schedule.

NA # 4 was interviewed on 6/16/17 at 3:40 PM. NA # 4 stated she had been present when Resident # 1 fell on 6/9/17. NA # 4 stated she did not recall helping with the Resident for the rest of Friday evening nor any bruises.

On 6/10/17 there was one documented neurological check and assessment of Resident # 1's physical status for the entire day in the nursing progress notes. This was by Nurse # 2 on 6/10/17 at 12:25 AM. Nurse # 2 documented at this time that the resident's neurological checks were normal. There was no mention by Nurse # 2 of any of the bruising that had already been identified earlier by Nurse # 1 or if the bruising was extending.

Nurse # 2 was interviewed on 6/16/17 at 9:16 AM. According to facility staffing sheets, Nurse # 2 had been assigned to care for Resident # 1 from 7 PM on 6/9/17 (Friday) until 7 AM on 6/10/17 (Saturday). Nurse # 2 stated she recalled when she came to work on 6/9/17 (Friday) at 7 PM that Resident # 1's right elbow was puffy and red but she did not recall other bruising. Nurse # 2 stated

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if she had done any neurological checks on the resident, she would have documented them. According to Nurse # 2, she recalled the ADON (assistant director of nursing) talking to her the Friday evening of 6/9/17 about Resident # 1, and they discussed that Resident # 1 was acting differently and wondering if she might have a urinary tract infection. The nurse did not recall exactly how the resident was acting differently.

Interview with the ADON on 6/16/17 at 3:55 PM revealed she was responsible for following up on falls and accidents. The ADON stated she had checked on Resident # 1 on the morning of 6/9/17 (Friday) because the resident had fallen on 6/8/17 (Thursday). The ADON stated she had not noticed a bruise to Resident # 1's temple on the Friday morning of 6/9/17. The ADON stated on Friday evening of 6/9/17 she went to check on the resident again, and noted she had a bruise to her temple which she had not seen earlier. According to the ADON on Friday evening of 6/9/17 she saw the resident reach one time into the air as if she was reaching for something that was not there, and her pupils seemed to be small. The ADON stated she did not have a pen light in her pocket to do a neurological check, but she had spoken to Nurse # 1 and it was her understanding that Nurse # 1 was going to follow up with the physician.

NA # 2 was interviewed on 6/16/17 at 11:10 AM. NA # 2 stated she had cared for Resident # 1 on the Friday of 6/9/17 from 3 PM until 7 PM. NA # 2 stated Resident # 2 reached for things in the air that were not there; as if she was "hallucinating." NA # 2 stated this was different for Resident # 2 and she had told a nurse about it, but was not exactly sure which nurse it was. NA # 2 stated the

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resident always had some bruises on her arms, but she had a cap on her head on the evening of 6/9/17 and she did not recall a bruise on her head.

NA # 3 was interviewed on 6/17/17 at 10:45 AM. NA # 3 stated she arrived to work at 7 PM on 6/9/17 (Friday) and stayed in the TV room with residents from 7 PM to 9 PM. Interview with NA # 3 revealed Resident # 1 was in the TV room when she arrived at work, kept trying to repeatedly stand up, and elbowed NA # 3 when she tried to redirect the resident to sit down. NA # 3 stated the resident would scream, became angry, and did not want to open her mouth for the nurse to give medications. NA # 3 stated she had not assisted her to bed and thought NA # 2 had done so.

NA # 5 was interviewed on 6/15/17 at 11:30 PM. Interview with NA # 5 revealed she recalled Resident # 1 slept Friday night during her shift which began at 11 PM on 6/9/17. NA # 5 stated Resident # 1 normally did everything for herself and therefore she looked in on her, but did not awaken her and was not aware of bruises.

Interview with Nurse # 3 on 6/15/17 at 12:25 PM revealed she had been on duty during the dayshift on 6/10/17 (Saturday). According to Nurse # 3 she had not received a report when she reported to duty that Resident # 1 had been bruised or injured which would have alerted her to do neurological checks. Nurse # 3 stated she did not know the resident had been hurt until two dayshift NAs (NA # 6 and NA # 7) came to her and reported they had found bruises on her while giving her care. Nurse # 3 stated she immediately went to assess the resident and found her to

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have bruises on her back, legs, hip, and head. The nurse stated the bruises were red in color and she immediately called Nurse # 1, who was her supervisor.

NA # 6 was interviewed on 6/15/17 at 4:35 PM. Interview with NA # 6 revealed she had routinely cared for Resident # 1, and the resident was usually very cooperative with care. NA # 6 stated prior to 6/10/17, she had last cared for her on 6/6/17. NA # 6 stated on Saturday of 6/10/17, Resident # 1 was assigned to NA # 7 and she (NA # 6) had assisted with her. NA # 6 stated Resident # 1 would not eat nor drink for breakfast or lunch, and she refused care by swinging at them. NA # 6 stated the nurse also tried to feed the resident lunch and she refused. NA # 6 stated after lunch they finally convinced Resident # 1 to let them assist her with care, and when they pulled back her covers and clothing to provide care there were dark purple bruises on her arms, breast, back, thighs, and legs. NA # 6 stated the bruising seemed "like it was everywhere." NA # 6 stated they immediately got the nurse. NA # 6 stated the bruising had not been present when she had last cared for Resident # 1 on 6/6/17 (Tuesday).

NA # 7 was interviewed on 6/16/17 at 12 noon. Interview with NA # 7 revealed she had not received a report when she reported to duty on 6/10/17 that there was anything wrong with Resident # 1. NA # 7 stated Resident # 1 would not eat breakfast nor lunch and refused morning care. NA # 7 stated the nurse also tried to assist her for lunch, and the resident refused. NA # 7 stated after lunch she and NA # 6 went together to provide care, and when they pulled back the sheet there were bruises on both arms, both hips,

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on her legs, under her arm, on the side of her chest by her breast, and on her right head. Interview with NA # 7 revealed she had not seen the bruise on her head earlier because the resident wore a bonnet and when they were providing care the bonnet tipped backward which revealed the bruising. NA # 7 stated the head bruise was about the size of her hand.

Interview with Nurse # 1 on 6/16/17 at 9:46 AM revealed Nurse # 3 had called her at home on 6/10/17 and told her Resident # 1 had bruises "everywhere." Nurse # 1 stated it was her understanding that the main concern was the bruising and not a change in mental status. Nurse # 1 stated she called the physician and he asked if the resident had been falling. Nurse # 1 stated she told the physician the resident had fallen, and he therefore wanted her sent for a CT (Computerized tomography) scan at the hospital. The nurse stated it was arranged for Resident # 1 to go to the hospital out- patient department via way of a non-emergency transport service. According to Nurse # 1 she had not thought Resident # 1's condition necessitated emergency transport to the emergency room. The nurse also stated it was her understanding the hospital non-emergency out- patient department was open on Saturday afternoons. Therefore Nurse # 1 stated she contacted a non-emergency transport service to take the resident to out-patient. The nurse did not know how the resident ended up in the emergency room.

Interview with the DON (Director of Nursing) on 6/15/17 at 5:25 PM revealed Nurse # 3 had called her at home and the main concern seemed to be the change in Resident # 1's mental status. The DON stated Nurse # 1 knew the resident much

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better than she did. The DON stated Nurse # 1 was planning to go in to work, and therefore she had Nurse # 1 communicate with the physician. The DON stated the extent of the bruising was not conveyed to her or she would have gone to the facility when she was called. According to the DON the resident left the facility around 5:15 PM by non-emergency transport.

A review of the resident's June 2017 MAR (medication administration record) revealed she had received her prescribed dosage of 325 milligrams of Aspirin daily from 6/6/17 through 6/10/17. The MAR was reviewed with the ADON on 6/15/17 at 5:30 PM and it was confirmed with the ADON the MAR showed no documentation the Aspirin was held.

Review of 6/10/17 Emergency Room (ER) medical records revealed the resident's bruising was extensive. The ER physician noted the resident had bruising on the right parietal area of her head; the right flank, the right elbow, the right hip, the right knee, and the left flank. He further noted she had critical anemia with a Hemoglobin level of 5.9 which the physician documented was "likely secondary to a GI (gastrointestinal bleed)." The resident's stool was grossly guaiac positive for blood in the ER. A CT scan of the resident's head on 6/10/17 revealed she had a frontoparietal subdural hematoma measuring 5 mm (millimeters) in thickness.

An interview with the resident's facility physician on 6/16/17 at 3 PM and again on 6/17/17 at 7 PM revealed the most likely reason for the resident's extensive bruising was her repeated falls. According to the physician the staff had notified him of the bruise to the temple on 6/9/17, but they

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had not notified him of any other changes on Friday (6/9/17), the extent of the bruising, or consulted with him regarding the Aspirin dosage. According to the physician any change in mental status in conjunction with a head injury would require an immediate evaluation at the Emergency Room.

Review of the resident's death certificate revealed she passed away on 6/14/17 at 6:30 PM. On the death certificate the physician had listed the cause of death as "subdural hematoma" and "complications of a fall."

2. Resident # 2 was admitted to the facility on 7/11/16 and had diagnoses of failure to thrive, dementia, osteoporosis, anemia, hypertension, gastro-esophageal reflux disease, anxiety, glaucoma, mood disorder, vitamin D deficiency, osteopenia, a history of multilevel compression fractures affecting 12 of the vertebra which ranged in severity from mild to severe; and a history of sternal fracture with deformity. Record review revealed the resident was 97 years of age and her last weight, documented on 6/3/17, was 68.5 pounds.

Review of the resident's quarterly MDS (Minimum Data Set) assessment, dated 2/23/17, revealed the resident had a BIMS (brief interview for mental status) score of "0." This indicated she did not answer any questions correctly on the assessment. The resident was assessed as needing extensive assistance with transfers, dressing, toileting, and hygiene. The resident was totally dependent on staff for her bathing. The resident's annual MDS assessment, dated 5/22/17, coded the resident as unchanged in these areas.

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Review of Resident # 2's current care plan, last updated on 5/26/17, revealed the resident could be resistive to care and combative. The care plan also noted the resident had potential for altered skin integrity. Although not all inclusive some of the listed care plan interventions included: skin assessments quarterly and as needed, and to notify MD of changes in skin as needed. According to the care plan the resident required a "total lift for transfers."

A problem was also on the resident's current care plan which identified the resident had chronic pain. Staff were directed on the care plan to assess the resident for pain.

Review of the record revealed a dayshift nursing progress note by Nurse # 5 on 4/14/17 (Friday) at 8:56 AM noting that the resident had a bruise to her right arm pit which measured 8 X 5 centimeters (cm.) This same nurse noted at 10:48 AM on 4/14/17 the following information: the area was bluish/red and was under her right arm and inner upper arm, the ADON (assistant director of nursing) was notified, a physician communication note was completed, and that the resident complained that the area hurt when it was touched.

Review of Resident # 2's April 2017 MAR revealed no documentation Resident # 2 received any pain medication on the date the nurse documented Resident # 2 complained of pain (4/14/17), or at any time during the month of April, 2017.

Nurse # 5 was not available for interview during the survey per an interview with the ADON on

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6/17/17 at 1:06 PM.

Following the nursing progress note of 4/14/17 (Friday) at 10:48 AM there was no documentation the bruise existed, an assessment of the bruise, or the resident's physical status in the nursing progress notes until 4/19/17 (Wednesday) at 2:30 PM. At this time Nurse # 5 noted the resident was seen by the NP (nurse practitioner) for a hematoma to the right axilla.

Review of the NP's (Nurse Practitioner's) 4/19/17 note revealed the resident had a chest bruise in addition to the right axilla (armpit) bruise. The NP ordered a CT (computerized tomography) of the chest and blood work.

Review of the CT report revealed it was completed on 4/20/17 which corresponded to Thursday after the bruise had been found on Friday 4/14/17. The findings revealed the resident had a "large area of high density within the right pectoralis major muscle measuring 8.5 X 4.1 X 4. 6 cm (centimeter) most likely representing intramuscular hematoma." The CT also showed the extent of the resident's compression fractures. The CT report noted the resident had diffuse osteopenia; prior cement augmentation of two of the compression fractures; three of the compression fractures were documented as mild; five of the compression fractures were documented as moderate; and two of the compression fractures were documented as severe.

On the same day on which the CT was done (4/20/17) showing the hematoma, Nurse # 6 completed a Bi-weekly check of the resident's skin on 4/20/17. Nurse # 6 documented the

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resident had no current skin issues. There was no assessment of the bruising in the nurse progress notes for 4/20/17.

Interview with Nurse # 6 on 6/17/17 at 3:15 PM revealed she had not included bruising on Resident # 2's 4/20/17 skin assessment check because she was assessing for and documenting for areas of pressure sores and not bruises.

Review of Resident # 2's May 2017 MAR revealed the resident received nothing for pain during the month of May.

The ADON (assistant director of nursing) was interviewed on 6/17/17 at 1:06 PM. During the interview the ADON reviewed Resident # 2's record. According to the ADON, on a scheduled basis, the facility's computer system prompts the nurses to complete an assessment after a bruise or injury is entered into a resident's computerized medical record every twenty four hours up until a seventy-two hour period post injury. The ADON stated if there are complications related to the bruise or injury then the assessments would be continued past the 72 hour period. In reviewing the record, the ADON stated Resident # 2's first 24 hour assessment following the identification of the bruise on 4/14/17 had not been completed by a nurse. According to the ADON the other assessments had not been done because the first 24 hour assessment had been missed and the nurses did not receive the prompting. The ADON did not know why the first 24 hour post injury assessment had been missed. Interview with the ADON revealed Resident # 2 had always required a mechanical lift for transfer since her admission. Interview with the ADON and a review of her investigation into the hematoma and

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bruising revealed some of the staff members had not been transferring and repositioning the resident correctly and the facility had concluded this potentially could have led to the resident's injury. Review of in-service materials following the incident revealed staff were to "have her lean forward with her upper body" in order that they "guide her hips back" in the wheelchair."

Resident # 2 was observed on 6/15/17 at 3:55 PM as nursing assistant (NA) # 6 and NA # 9 transferred the resident from her wheelchair to bed using a mechanical lift in order to provide care. The resident was observed to appear extremely thin and frail. Her bones were very prominent. The NAs worked to try to position the mechanical lift sling back beneath the resident in order that they complete the transfer, and it was observed that the resident was not cooperative. The resident was observed to complain of pain as they worked to get the sling beneath her and transfer her into the bed, and she was not cooperative in leaning forward so that they could place the sling beneath her. NA # 6 stated the NA, who had gotten the resident out of bed earlier, should have left the sling beneath her so that they did not have to move the resident as much to get it positioned correctly. Upon completing the care the NAs again transferred the resident back from the bed to the wheelchair, and the resident complained once again she was hurting. According to these evening shift NAs the resident complained of pain anytime they transferred her. The NAs were asked if the nurse knew the resident hurt, and responded that the nurses did because the nurses heard her scream when she was transferred.

Interview with the ADON on 6/17/17 at 3 PM

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revealed the facility used two different pain assessments. One assessment was intended for residents who were cognitively alert and could voice their pain level on a scale of 1-10. The facility also had a pain assessment for the cognitively impaired, which required staff to assess if confused residents expressed pain in other ways such as striking out or pushing away. A review of Resident # 2's pain assessments with the ADON revealed since the hematoma had been identified on 4/20/17 the nurses had not completed a pain assessment using the assessment for a cognitively impaired resident. They had used a numeric evaluation of her pain. According to the ADON the nurses should have been using the pain assessment for cognitively impaired residents. The ADON stated the NAs would need to tell the nurses about how the resident tolerated her care so they could address her pain.

Review of the Resident's June 2017 MAR revealed the resident had not received anything for pain thus far in the month of June 2017. This was confirmed with Nurse # 4 on 6/17/17 at 10:25 AM. The nurse stated the resident did not have anything routinely ordered for pain, but she could have Tylenol if she needed it.

NA # 8 was assigned to care for Resident # 2 on 6/17/17. NA # 8 was interviewed at 10:30 AM on 6/17/17. According to NA # 8, Resident # 2 would say she hurt sometimes, but then would say she was okay and therefore she concluded that the resident was okay and not in pain.

On 6/17/17 at 5:15 PM, the administrator was informed of the immediate jeopardy. The facility provided a credible allegation of compliance on

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6/18/17. The allegation of compliance indicated:
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Credible Allegation of Compliance
Resident # 1 has diagnosis including but not limited to Lewy Body Dementia, Parkinson's disease, Pseudo Bulbar, anemia, and A-fib. Upon admission, she was determined to be a risk for falls. Subsequently, she was care planned for a fall risk as to prevent injuries. Resident #1 sustained three separate falls on 6/6/17, 6/8/17 and 6/9/17 which resulted in bruising to multiple areas of her body. The fall on 6/9/17 was unwitnessed in the dayroom at approximately 3:45 pm. Resident #1 was noted to be on one knee with the other foot flat on the floor. Her right arm was on a chair and her left arm was on her wheelchair. Resident was assessed by the Unit Manager and assisted to a chair in the dayroom. The ADON observed a bruise to resident's forehead and spoke with the Unit Manager regarding the observation. The Unit Manager assessed the area where the bruise was located, but resident didn't let UM remove her night cap. The Unit Manager failed to complete a head to toe assessment immediately following the observation of the bruise to the resident's forehead. UM notified the attending physician regarding the fall and bruise to head. MD ordered neuro checks at that time. Neuro checks were started following the MD order, but did not continue based on the facility's policy. On 6/10/17, resident #1 refused breakfast. She also refused to get out of bed or allow personal care offered by staff. She refused lunch, pushing staff away. Thru encouragement, staff were able to assist resident with ADL care and noted bruises on her body. At this time she was alert but not speaking. The nurse was informed and contacted the DON at 3:25 pm regarding the

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refusal of meals, refusal of care and multiple bruising. An order was obtained to send resident #1 to hospital for head CT. Resident was transported to hospital via wheelchair at 5:15pm. Resident was later transferred to another hospital and admitted with subdural hematoma and GI bleed. Resident later expired at hospital. The nurse failed to complete a thorough head to toe assessment at time of fall per policy and the extent of resident #1's bruising was not assessed by the nurse. The actual bruising to resident #1. The nurse also failed to contact the MD to advice of the changes to resident #1. In addition, the nurses also failed to advise the MD of changes to resident # 2's area to right armpit which was later found to be a hematoma.

For the resident affected:

On 6/17/17 all residents who sustained a fall since June 1, 2017 were assessed from head to toe by the DON and ADON. The assessment audit included a review of the medical record to ensure that all measures were in place to include contacting the MD of any changes to meet the current needs of the affected residents. A review of the medical record was conducted by the DON to review appropriate interventions and assessments subsequent to each fall. Based on findings, staff education was provided by DON.
Plan to identify other residents who are at risk for the deficient practice
Other residents who are at risk for deficient practice will be identified by an assessment audit that will be conducted for all current residents that have had falls since June 1st. Assessments will be reviewed by Director of Nursing or delegated persons for compliance. Based on findings education will be provided. Surveyor identified

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another resident that had been affected by the failure to conduct assessments according to policy. Resident # 2 sustained a bruise on 4/14/17 to the right armpit. The MD and Responsible Party were both notified on that date. No further documentation was noted until 4/19/17 when the resident was seen by the Nurse Practitioner. At that time a CT of chest without contrast, Right shoulder X-Ray and a CBC were ordered. Upon review of the medical record by the surveyor it was determined that no head to toe assessment was conducted for the resident. The nurse failed to assess for any change in resident # 2's condition to include the area on armpit.

Action Taken to Fix the Problem

Re-education to all nurses and CNAs began on 6/17/17. All Nursing staff to include licensed nurses and CNAs were educated on 6/17/17 either via phone or in person regarding the following: Fall Management, which includes Safe Handling of residents regarding transfers, Head to Toe Assessments, Abuse/Neglect policy and procedure, and Neurological Check Policy and Procedure. All nursing staff have been educated that Emergency Medical Services (911) will be contacted for any resident that has been assessed and found to need emergency care. All CNAs have received education regarding reporting any change in condition to nurse through the use of a "Stop and Watch Tool." All employees who received education via phone will receive written material upon returning to work. MD notified on 6/18/17 to have pain medication ordered for resident #2 at which time an order was received for Tylenol 325 MG.

The facility alleged IJ removal on 6/18/17.
The credible allegation was verified on 6/21/17 at

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F 224	Continued From page 38 6:04 PM. Nurse #1 no longer worked at the facility and could not be reached by phone for interview. A sample of current resident records were reviewed for falls, injury and staff action. The Assistant Director of Nursing was interviewed on 6/21/17 at 5:07 PM. She provided the Fall Management Protocol, Assessment and Neurological Check policy inservice details. On 6/21/17 from 2:02 PM through 5:42 PM, random nursing staff as well as Nursing Assistants involved with Resident #1 following the falls, were able to articulate the steps of the "Stop and Watch Tool" for notification, assessment and reporting. Staff members interviewed were able to describe education received regarding falls, assessment, the policy regarding neurological checks, physician notification, neglect and how to respond to changes in condition. The facility was able to provide evidence that they had completed an audit of the residents and inserviced all staff on 6/17/17. Other residents in the facility were observed and there were no concerns. The immediate jeopardy was removed on 6/18/17.	F 224		
F 309 SS=J	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that	F 309		7/17/17

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F 309	Continued From page 39 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews, family interview, and physician interview for two (Residents # 1 and Resident # 2) of three residents who had sustained injuries the facility failed to assess the residents and provide care. The facility failed to assess Resident # 1 and initiate emergency medical services when the resident was identified to have a head injury and a change in mental status after sustaining three falls within four days. The resident was found to have extensive bruising, a subdural hematoma, and critical lab work when transferred to the hospital. The resident expired four days following her facility discharge. The facility failed to assess Resident # 2 following the	F 309	Corrective action taken for the Residents found to have been affected: 1a. Residents #1 no longer resides at the facility. 2a. Resident #2's RP and MD were notified on 4/14/17. The Nurse Practitioner examined resident #2 on 4/19/17. A CT scan without contrast to the chest and X-Ray to right shoulder was completed on 4/19/17 and Physician was notified of results. Address how corrective action will be accomplished for those residents having the potential to be affected by this	

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F 309	Continued From page 40 identification of a painful armpit bruise. The resident was identified to have an intramuscular chest hematoma six days after the armpit bruise was identified for which she received nothing for pain. The facility also failed to provide assessment and management of Resident # 2's pain she experienced while receiving transfer assistance from staff and the resident was observed in pain. Immediate Jeopardy began 4/14/17 when facility staff identified Resident # 2, who was cognitively impaired and needed staff's assistance for care, had a painful bruise to her armpit. The staff failed to assess the resident and on 4/19/17 the resident was identified to have a bruise also on her chest. On 4/20/17 the resident was identified to have an intramuscular chest hematoma for which she had not received anything for pain. For Resident # 1 the facility also failed to provide care and services at the immediate jeopardy level. On 6/9/17 facility staff identified Resident # 1, who sustained three falls within four days, had a bruise to her head and they failed to assess the resident for further and worsening injury. Nurses did not identify the resident had extensive bruising on multiple areas of her body until the afternoon of 6/10/17. The resident was transported out for medical care by a non-emergent transport. The immediate jeopardy was removed on 6/18/17 when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to allow the facility to monitor and fully implement the new procedures to assure residents are assessed and receive care.	F 309	deficient practice will not occur: 3a. Re-education on Fall Management (including Safe handling of residents regarding transfers, head to toe assessments), abuse/neglect policy and procedure, neurological check policy and procedure, stop and watch tool and pain management protocol will be completed by DON/designee to licensed nurses and CNAs by 7/17/17. Nursing staff will be re-educated by DON/designee that emergency medical services (911) will be contacted for any resident that has been assessed and found to need emergency care by 7/17/2017. 3b. New employees will be educated to: Fall Management, which includes safe handling of residents regarding transfers, head to toe assessments, abuse/neglect policy and procedure, neurological check policy and procedure, stop and watch tool and pain management protocol. Nursing staff will be educated that emergency medical services (911) will be contacted for any resident that has been assessed and found to need emergency care. Indicate how the facility plans to monitor its performance to make sure the solutions are sustained: 4a. A fall audit will be completed by DON/designee for any fall for 12 weeks. 4b. Audits will be reviewed by the QA and A committee monthly for 3 months. 4c. Each incident and the 24 hour report will be discussed and reviewed 5x/week in clinical meeting to ensure ongoing	

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F 309	Continued From page 41 The findings included: 1. The facility's neurological checks policy, last revised in August 2006, was reviewed. According to the policy neurological checks were to be completed if a resident was suspected of sustaining head trauma. The frequency of the checks were to be done as follows: every 15 minutes for 2 hours; every 30 minutes for four hours; every hour for 4 hours; every 4 hours for 16 hours; and every 8 hours for 48 hours. Record review revealed Resident # 1 resided at the facility from 4/18/17 until 6/10/17. According to the medical record the resident had the following diagnoses: advanced Parkinson's disease, frontotemporal dementia with pseudo bulbar affect, chronic atrial fibrillation, iron deficiency anemia, hyperglycemia, hypertension, alopecia totalis (loss of hair), healed fracture of the right humerus, history of falls; chronic kidney disease, scoliosis, and hypothyroidism. Record review revealed the physician assessed Resident # 1 on 4/21/17 and noted that there was no bruising or abnormal bleeding as of his assessment date, and her last (hemoglobin) (Hgb) was noted by the physician to be 9.8. (Normal range 12-16) The physician noted in his 4/21/17 progress note, "Please let me know about any changes in behavior that indicated an exacerbation of today's issues. Review of the resident's minimum data set (MDS) assessment, dated 4/25/17, revealed the resident was cognitively impaired; needed extensive assistance from one staff member for bed mobility, transfers, dressing, toileting, hygiene, and bathing; and needed limited assistance for	F 309	compliance with policy for 12 weeks.	

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ambulation. This MDS assessment also coded the resident as having no falls or fractures within the last 6 months prior to her facility admission.

From 6/6/17 through 6/9/17, the resident was documented as falling three times within these four days.

Record review revealed a nursing progress note on 6/6/17 (Tuesday) at 5:42 PM by Nurse # 3 noting Resident # 1 was observed sitting on the floor on her buttocks next to her bed. The nurse noted the resident was assessed for injuries and none were noted.

A nursing progress note dated 6/7/17 (Wednesday) at 4:25 AM by Nurse # 3 documented at this time the resident was responsive and cooperative, and there was no notation made that the resident had sustained bruises or injuries.

Nurse # 3 was interviewed on 6/15/17 at 12:25 PM. Nurse # 3 stated she had checked Resident # 1 after her fall on 6/6/17 and found no bruising or injury. Interview with Nurse # 3 revealed the resident had no bruises on her assessment on 6/7/17.

A nursing progress note dated 6/8/17 (Thursday) at 4:25 AM revealed a nurse had completed a head to toe assessment, and the resident was found to be pleasant and cooperative. The note was signed by Nurse #4. There was no documentation in the note the resident had bruising or injuries.

Review of a "Bi Weekly Skin Check" dated 6/8/17 at 12:30 PM revealed Resident # 1 had no

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current skin issues.

A nursing progress note dated 6/8/17 at 7:55 PM documented Resident # 1 sustained another fall. The nurse noted Resident # 1 was "sitting on the edge of her wheelchair and slid out of the chair onto the floor landing on her buttocks." The resident was cooperative, pleasant, and her skin tone was normal. The note was signed by Nurse #2. There was no documentation of bruising or injury.

Nurse # 2 was interviewed on 6/16/17 at 9:15 AM. Nurse # 2 stated Resident # 1 had been in the TV room when she sustained the fall on 6/8/17 at 7:55 PM. According to the interview with Nurse # 2, she had taken the resident back to her room, lifted her clothes, found no evidence of bruising, and could not recall any injury noted on her shift which ended on 6/9/17 (Friday) at 7:00 AM.

The next nursing progress note which noted an assessment of Resident # 1's condition was entered on 6/9/17 at 3:25 AM by Nurse # 2. Nurse # 2 noted the resident was pleasant and cooperative, and her skin tone was normal. There was no documentation of bruising or injury.

A nursing progress note was entered by Nurse # 2 on 6/9/17 at 6:56 AM noting the resident had a hematoma to her right elbow. There was no further information in the note.

Nurse # 2 was interviewed on 6/16/17 at 9:16 AM. Nurse # 2 could not recall any injury she had observed from her assessments of Resident #1 during her shift from 7:00 PM on 6/8/17 until 7:00 AM on 6/9/17. She did not recall observing the hematoma on Friday (6/9/17) morning before she

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left work, but recalled the resident's arm being puffy when she reported to work on Friday (6/9/17) evening for her next shift.

A nursing progress note was entered into the record on 6/9/17 at 2:56 PM by Nurse # 1. Nurses # 1 documented at this time that an order was received to x-ray Resident # 1's elbow and that the resident's RP (Responsible Party) was notified. There was no documentation of assessment of the resident's condition or of the hematoma in this note.

Review of the record revealed a mobile x-ray was completed on 6/9/17 of the resident's elbow. The "indication" for the x-ray was noted to be "pain." The X-ray report noted there was "mild soft tissue swelling" but no definite bony abnormalities. The report was electronically signed by the radiologist on 6/9/17 at 9:11 PM.

Nurse # 1 was interviewed on 6/15/17 at 2:00 PM. According to the nurse the resident had a hematoma to her arm on the morning of 6/9/17 and no other injury. The nurse stated this had been communicated to the physician and an x-ray was done.

Following the nursing progress note of 6/9/17 at 2:56 PM there were no other nursing notations in the progress notes dated 6/9/17.

It was confirmed with Nurse # 1 on 6/15/17 at 2:00 PM that the following entry was entered in the progress notes for 6/10/17, but was for an incident that occurred on 6/9/17 at 3:43 PM. The entry read, "Writer called to TV room Resident observed with her right knee on the floor and her right elbow resting on an arm-chair. Resident

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assessed for injuries; no injuries noted. Resident had old bruising to her arms and the right temporal area. Resident had no complaints of pain. MD in facility, notified of unwitnessed fall. Writer attempted to contact (responsible party) to inform of unwitnessed fall." The entry was signed by Nurse # 1.

Interview with Nurse # 1 on 6/16/17 at 9:46 AM revealed she had been the nurse to respond to the fall on 6/9/17 at 3:43 PM. Interview with Nurse # 1 revealed she had checked Resident # 1 in the TV room, but did not take her back to her room and assess her entire body at the time of the incident. Nurse # 1 stated the resident had some yellow bruising on her arms and a purple bruise to the right temple area at the time of her assessment. Nurse # 1 stated the resident continuously wore either a wig or bonnet secondary to her hair loss. Nurse # 1 stated at the time of the incident the bruise did not extend under her bonnet, and she did not take the resident's bonnet off to assess her head further. Nurse # 1 stated she felt the resident would not have let her remove the bonnet to assess for injury. Nurse # 1 stated she did let the physician know the resident had a bruise to her temple. Interview with Nurse # 1 revealed she left the facility around 7:00 PM on 6/9/17 (Friday), and she stated she had not noted a change in Resident # 1. According to Nurse # 1 she had started a neurological assessment flow sheet for the resident and completed neuro checks up until 6:45 PM. The nurse provided the copy of the neurological assessment flow sheet. The last neuro check documented on the flow record was 6:45 PM. The rest of the flow sheet was blank, and Nurse # 1 could not find any other records to show the neuro checks had been completed per

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the facility's protocol schedule. Nurse # 1 did not know why the next nurse did not continue the checks per schedule.

Nursing Assistant (NA) # 4 was interviewed on 6/16/17 at 3:40 PM. NA # 4 stated she had been present when Resident # 1 fell on 6/9/17. NA # 4 stated she did not recall helping with the resident for the rest of Friday evening nor any bruises.

On 6/10/17 there was one documented neurological check and assessment of Resident # 1's physical status for the entire day in the nursing progress notes. This was by Nurse # 2 on 6/10/17 at 12:25 AM. Nurse # 2 documented at this time that the resident's neurological checks were normal. There was no mention by Nurse # 2 of any of the bruising that had already been identified earlier by Nurse # 1 or if the bruising was extending.

Nurse # 2 was interviewed on 6/16/17 at 9:16 AM. According to facility staffing sheets, Nurse # 2 had been assigned to care for Resident # 1 from 7:00 PM on 6/9/17 until 7:00 AM on 6/10/17 (Saturday). Nurse # 2 stated she recalled when she came to work on 6/9/17 at 7:00 PM that Resident # 1's right elbow was puffy and red but she did not recall other bruising. Nurse # 2 stated if she had done any neurological checks on the resident, she would have documented them. According to Nurse # 2, she recalled the ADON (assistant director of nursing) talking to her the Friday evening of 6/9/17 about Resident # 1, and they discussed that Resident # 1 was acting differently and wondering if she might have a urinary tract infection. The nurse did not recall exactly how the resident was acting differently.

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Interview with the assistant director of nursing (ADON) on 6/16/17 at 3:55 PM revealed she was responsible for following up on falls and accidents. The ADON stated she had checked on Resident # 1 on the morning of 6/9/17 because the resident had fallen on 6/8/17. The ADON stated she had not noticed a bruise to Resident # 1's temple on the Friday morning of 6/9/17. The ADON stated on Friday evening of 6/9/17 she went to check on the resident again, and noted she had a bruise to her temple which she had not seen earlier. According to the ADON, on Friday evening of 6/9/17 she saw the resident reach one time into the air as if she was reaching for something that was not there, and her pupils seemed to be small. The ADON stated she did not have a pen light in her pocket to do a neurological check, but she had spoken to Nurse # 1 and it was her understanding that Nurse # 1 was going to follow up with the physician.

NA # 2 was interviewed on 6/16/17 at 11:10 AM. NA # 2 stated she had cared for Resident # 1 on the Friday of 6/9/17 from 3:00 PM until 7:00 PM. NA # 2 stated Resident # 2 reached for things in the air that were not there; as if she was "hallucinating." NA # 2 stated this was different for Resident # 2 and she had told a nurse about it, but was not exactly sure which nurse it was. NA # 2 stated the resident always had some bruises on her arms, but she had a cap on her head on the evening of 6/9/17 and she did not recall a bruise on her head.

NA # 3 was interviewed on 6/17/17 at 10:45 AM. NA # 3 stated she arrived to work at 7:00 PM on 6/9/17 and stayed in the TV room with residents from 7:00 PM to 9:00 PM. Interview with NA # 3 revealed Resident # 1 was in the TV room when

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she arrived at work, kept trying to repeatedly stand up, and elbowed NA # 3 when she tried to redirect the resident to sit down. NA # 3 stated the resident would scream, became angry, and did not want to open her mouth for the nurse to give medications. NA # 3 stated she had not assisted her to bed and thought NA # 2 had done so.

NA # 5 was interviewed on 6/15/17 at 11:30 PM. Interview with NA # 5 revealed she recalled Resident # 1 slept Friday night during her shift which began at 11:00 PM on 6/9/17. NA # 5 stated Resident # 1 normally did everything for herself and therefore she looked in on her, but did not awaken her and was not aware of bruises.

Interview with Nurse # 3 on 6/15/17 at 12:25 PM revealed she had been on duty during the dayshift (7:00 AM to 7:00 PM) on 6/10/17. According to Nurse # 3 she had not received a report when she reported to duty that Resident # 1 had been bruised or injured which would have alerted her to do neurological checks. Nurse # 3 stated she did not know the resident had been hurt until two dayshift NAs (NA # 6 and NA # 7) came to her and reported they had found bruises on her while giving her care. Nurse # 3 stated she immediately went to assess the resident and found her to have bruises on her back, legs, hip, and head. The nurse stated the bruises were red in color and she immediately called Nurse # 1, who was her supervisor.

NA # 6 was interviewed on 6/15/17 at 4:35 PM. Interview with NA # 6 revealed she had routinely cared for Resident # 1, and the resident was usually very cooperative with care. NA # 6 stated prior to 6/10/17, she had last cared for her on

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6/6/17. NA # 6 stated on Saturday of 6/10/17, Resident # 1 was assigned to NA # 7 and she (NA # 6) had assisted with her. NA # 6 stated Resident # 1 would not eat nor drink for breakfast or lunch, and she refused care by swinging at them. NA # 6 stated the nurse also tried to feed the resident lunch and she refused. NA # 6 stated after lunch they finally convinced Resident # 1 to let them assist her with care, and when they pulled back her covers and clothing to provide care there were dark purple bruises on her arms, breast, back, thighs, and legs. NA # 6 stated the bruising seemed "like it was everywhere." NA # 6 stated they immediately got the nurse. NA # 6 stated the bruising had not been present when she had last cared for Resident # 1 on 6/6/17.

NA # 7 was interviewed on 6/16/17 at 12:00 noon. Interview with NA # 7 revealed she had not received a report when she reported to duty on 6/10/17 that there was anything wrong with Resident # 1. NA # 7 stated Resident # 1 would not eat breakfast nor lunch and refused morning care. NA # 7 stated the nurse also tried to assist her for lunch, and the resident refused. NA # 7 stated after lunch she and NA # 6 went together to provide care, and when they pulled back the sheet there were bruises on both arms, both hips, on her legs, under her arm, on the side of her chest by her breast, and on her right head. Interview with NA # 7 revealed she had not seen the bruise on her head earlier because the resident wore a bonnet and when they were providing care the bonnet tipped backward which revealed the bruising. NA # 7 stated the head bruise was about the size of her hand.

Interview with Nurse # 1 on 6/16/17 at 9:46 AM revealed Nurse # 3 had called her at home on

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6/10/17 and told her Resident # 1 had bruises "everywhere." Nurse # 1 stated it was her understanding that the main concern was the bruising and not a change in mental status. Nurse # 1 stated she called the physician and he asked if the resident had been falling. Nurse # 1 stated she told the physician the resident had fallen, and he therefore wanted her sent for a CT (Computerized tomography) scan at the hospital. The nurse stated it was arranged for Resident # 1 to go to the hospital out-patient department via way of a non-emergency transport service. According to the interview with the nurse she had not thought Resident # 1's condition necessitated emergency transport to the emergency room. Nurse # 1 also stated it was her understanding the hospital non-emergency out-patient department was open on Saturday afternoons. Therefore Nurse # 1 stated she contacted a non-emergency transport service to take the resident to out-patient. The nurse did not know how the resident ended up in the emergency room.

Interview with the Director of Nursing (DON) on 6/15/17 at 5:25 PM revealed Nurse # 3 had called her at home and the main concern seemed to be the change in Resident # 1's mental status. The DON stated Nurse # 1 knew the resident much better than she did. The DON stated Nurse # 1 was planning to go in to work, and therefore she had Nurse # 1 communicate with the physician. The DON stated the extent of the bruising was not conveyed to her or she would have gone to the facility when she was called. According to the DON the resident left the facility around 5:15 PM on 6/10/17 by non-emergency transport, over 24 hours after Resident #1 fell on 6/9/17 at 3:43 PM.

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Interview with Resident # 1's responsible party (RP) on 6/16/17 at 10:10 AM revealed she had visited Resident # 1 on 6/8/17 and had noted bruises on her arm and hand. The RP stated she stayed with the resident until 7:00 PM, and after leaving she later received a phone call at 10:45 PM that the resident had fallen but was okay. The RP stated she had received another call on 6/9/17 at 2:45 PM from a staff member letting her know Resident # 1 had fallen. The RP stated she was told "it was possible" the resident could have hit her head on another resident's wheelchair.

A review of the resident's June 2017 medication administration record (MAR) revealed she had received her prescribed dosage of 325 milligrams of Aspirin daily from 6/6/17 through 6/10/17. The MAR was reviewed with the ADON on 6/15/17 at 5:30 PM and it was confirmed with the ADON the MAR showed no documentation the Aspirin was held.

Review of 6/10/17 Emergency Room (ER) medical records revealed the resident's bruising was extensive. The ER physician noted the resident had bruising on the right parietal area of her head; the right flank, the right elbow, the right hip, the right knee, and the left flank. He further noted she had critical anemia with a Hemoglobin level of 5.9 which the physician documented was "likely secondary to a GI (gastrointestinal bleed)." The resident's stool was grossly guaiac positive for blood in the ER. A CT scan of the resident's head on 6/10/17 revealed she had a frontoparietal subdural hematoma measuring 5 millimeters (mm) in thickness.

An interview with the resident's facility physician on 6/16/17 at 3:00 PM and again on 6/17/17 at

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7:00 PM revealed the most likely reason for the resident's extensive bruising was her repeated falls. According to the physician the staff had notified him of the bruise to the temple on 6/9/17, but they had not notified him of any other changes on Friday (6/9/17), the extent of the bruising, or consulted with him regarding the Aspirin dosage. According to the physician any change in mental status in conjunction with a head injury would require an immedicate evaluation at the Emergency Room.

Review of the resident's death certificate revealed she passed away on 6/14/17 at 6:30 PM. On the death certificate the physician had listed the cause of death as "subdural hematoma" and "complications of a fall."

2. Resident # 2 was admitted to the facility on 7/11/16 and had diagnoses of failure to thrive, dementia, osteoporosis, anemia, hypertension, gastro-esophageal reflux disease, anxiety, glaucoma, mood disorder, vitamin D deficiency, osteopenia, a history of multilevel compression fractures affecting 12 of the vertebra which ranged in severity from mild to severe; and a history of sternal fracture with deformity. Record review revealed the resident was 97 years of age and her last weight, documented on 6/3/17, was 68.5 pounds.

Review of Resident # 2's quarterly minimum data set (MDS) assessment, dated 2/23/17, revealed the resident was severely cognitively impaired. The resident was assessed as needing extensive assistance with transfers, dressing, toileting, and hygiene. The resident was totally dependent on staff for her bathing. The resident's annual MDS assessment, dated 5/22/17, coded the resident

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as unchanged in these areas.

Review of Resident # 2's current care plan, last updated on 5/26/17, revealed the resident could be resistive to care and combative. The care plan also noted the resident had potential for altered skin integrity. Some of the listed care plan interventions included: skin assessments quarterly and as needed, and to notify MD of changes in skin as needed. According to the care plan the resident required a "total lift for transfers."

A problem was also on the resident's current care plan which identified the resident had chronic pain. Staff were directed on the care plan to assess the resident for pain.

Review of the record revealed a dayshift nursing progress note by Nurse # 5 on 4/14/17 (Friday) at 8:56 AM noting that the resident had a bruise to her right arm pit which measured 8 X 5 centimeters (cm.) This same nurse noted at 10:48 AM on 4/14/17 the following information: the area was bluish/red and was under her right arm and inner upper arm, the ADON (assistant director of nursing) was notified, a physician communication note was completed, and that the resident complained that the area hurt when it was touched.

Review of Resident # 2's April 2017 MAR revealed no documentation Resident # 2 received any pain medication on the date the nurse documented Resident # 2 complained of pain (4/14/17), or at any time during the month of April, 2017.

Following the nursing progress note of 4/14/17

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(Friday) at 10:48 AM there was no documentation the bruise existed, an assessment of the bruise, or the resident's physical status in the nursing progress notes until 4/19/17 (Wednesday) at 2:30 PM. At this time Nurse # 5 noted the resident was seen by the NP (nurse practitioner) for a hematoma to the right axilla.

Review of the nurse practitioner's (NP's) 4/19/17 note revealed the resident had a chest bruise in addition to the right axilla (armpit) bruise. The NP ordered a CT (computerized tomography) of the chest and blood work.
Review of the CT report revealed it was completed on 4/20/17 which corresponded to Thursday after the bruise had been found on Friday 4/14/17. The findings revealed the resident had a "large area of high density within the right pectoralis major muscle measuring 8.5 X 4.1 X 4. 6 cm (centimeter) most likely representing intramuscular hematoma." The CT also showed the extent of the resident's compression fractures. The CT report noted the resident had diffuse osteopenia; prior cement augmentation of two of the compression fractures; three of the compression fractures were documented as mild; five of the compression fractures were documented as moderate; and two of the compression fractures were documented as severe.

On the same day on which the CT was done (4/20/17) showing the hematoma, Nurse # 6 completed a Bi-weekly check of the resident's skin on 4/20/17. Nurse # 6 documented the resident had no current skin issues. There was no assessment of the bruising in the nurse progress notes for 4/20/17.

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Interview with Nurse # 6 on 6/17/17 at 3:15 PM revealed she had not included bruising on Resident # 2's skin assessment check because she was assessing for and documented for areas of pressure sores and not bruises.

Review of Resident # 2's May 2017 MAR revealed the resident received nothing for pain during the month of May.
The assistant director of nursing (ADON) was interviewed on 6/17/17 at 1:06 PM. During the interview the ADON reviewed Resident # 2's record. According to the ADON, on a scheduled basis, the facility's computer system prompts the nurses to complete an assessment after a bruise or injury is entered into a resident's computerized medical record every twenty-four hours up until a seventy-two hour period post injury. The ADON stated if there are complications related to the bruise or injury then the assessments would be continued past the 72 hour period. In reviewing the record, the ADON stated Resident # 2's first 24 hour assessment following the identification of the bruise on 4/14/17 had not been completed by a nurse. According to the ADON the other assessments had not been done because the first 24 hour assessment had been missed and the nurses did not receive the prompting. The ADON did not know why the first 24 hour post injury assessment had been missed. Interview with the ADON revealed Resident # 2 had always required a mechanical lift for transfer since her admission. Interview with the ADON and a review of her investigation into the hematoma and bruising revealed some of the staff members had not been transferring and repositioning the resident correctly and the facility had concluded this potentially could have led to the resident's injury. Review of in-service materials following

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the incident revealed staff were to "have her lean forward with her upper body" in order that they "guide her hips back" in the wheelchair."

Resident # 2 was observed on 6/15/17 at 3:55 PM as nursing assistant (NA) # 6 and NA # 9 transferred the resident from her wheelchair to bed using a mechanical lift in order to provide care. The resident was observed to appear extremely thin and frail. Her bones were very prominent. The NAs worked to try to position the mechanical lift sling back beneath the resident to complete the transfer, and it was observed that the resident was not cooperative. The resident was observed to complain of pain as they worked to get the sling beneath her and transfer her into the bed, and she was not leaning forward so that they could place the sling beneath her. NA # 6 stated the NA who had gotten the resident out of bed earlier should have left the sling beneath her so that they did not have to move the resident as much to get it positioned correctly. Upon completing the care the NAs again transferred the resident back from the bed to the wheelchair, and the resident complained once again she was hurting. According to these evening shift NAs the resident complained of pain anytime they transferred her. The NAs were asked if the nurse knew the resident hurt, and responded that the nurses did because the nurses heard her scream when she was transferred.

Interview with the ADON on 6/17/17 at 3 PM revealed the facility used two different pain assessments. One assessment was intended for residents who were cognitively alert and could voice their pain level on a scale of 1-10. The facility also had a pain assessment for the cognitively impaired, which required staff to

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assess if confused residents expressed pain in other ways such as striking out or pushing away. A review of Resident # 2's pain assessments with the ADON revealed since the hematoma had been identified on 4/20/17 the nurses had not completed a pain assessment using the assessment for a cognitively impaired resident. They had used a numeric evaluation of her pain. According to the ADON the nurses should have been using the pain assessment for cognitively impaired residents. The ADON stated the NAs would need to tell the nurses about how the resident tolerated her care so they could address her pain.

Review of the resident's June 2017 MAR revealed the resident had not received anything for pain thus far in the month of June 2017. This was confirmed with Nurse # 4 on 6/17/17 at 10:25 AM. The nurse stated the resident did not have anything routinely ordered for pain, but she could have Tylenol if she needed it.

NA # 8 was assigned to care for Resident # 2 on 6/17/17 and she was interviewed at 10:30 AM on 6/17/17. According to NA # 8, Resident # 2 would say she hurt sometimes, but then would say she was okay and therefore she concluded that the resident was okay and not in pain.

On 6/17/17 at 5:15 PM, the administrator was informed of the immediate jeopardy. The facility provided a credible allegation of compliance on 6/18/17. The allegation of compliance indicated:

F 309 Assessments of Residents
Credible Allegation of Compliance
Resident # 1 has diagnosis including but not limited to Lewy Body Dementia, Parkinson's

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disease, Pseudo Bulbar, anemia, and A-fib. Upon admission, she was determined to be a risk for falls. Subsequently, she was care planned for a fall risk as to prevent injuries. Resident #1 sustained three separate falls on 6/6/17, 6/8/17 and 6/9/17 which resulted in bruising to multiple areas of her body. The fall on 6/9/17 was unwitnessed in the dayroom at approximately 3:45 pm. Resident #1 was noted to be on one knee with the other foot flat on the floor. Her right arm was on a chair and her left arm was on her wheelchair. Resident was observed on the floor by the Unit Manager and assisted to a chair in the dayroom and a head to toe assessment was no documented in the clinical record. The ADON observed a bruise to resident's forehead and spoke with the Unit Manager regarding the observation. The Unit Manager observed the area where the bruise was located on resident #1's forehead, but did not complete a head to toe assessment. The bruise to the forehead was not completely assessed by the UM and the extent could not be determined due to the UM not removing the cap from resident #1's head. The UM stated to DON that resident #1 didn't let UM remove her night cap. The Unit Manager failed to complete a head to toe assessment immediately following the observation of the bruise to the resident's forehead. UM notified the attending physician regarding the fall and bruise to head. MD was notified of the bruise to resident #1's forehead and ordered neuro checks at that time. Neuro checks were started following the MD order, but did not continue based on the facility's policy. On 6/10/17, resident #1 refused breakfast. She also refused to get out of bed or allow personal care offered by staff. She refused lunch, pushing staff away. Thru encouragement, staff were able to assist resident with ADL care

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and noted bruises on her body. At this time she was alert but not speaking. The nurse was informed and contacted the DON at 3:25 pm regarding the refusal of meals, refusal of care and multiple bruising. An order was obtained to send resident #1 to hospital for head CT. Resident was transported to hospital via wheelchair at 5:15pm. Resident was later transferred to another hospital and admitted with subdural hematoma and GI bleed. Resident later expired at hospital. The nurse failed to complete a thorough head to toe assessment at time of fall per policy. The nurse also failed to contact the MD to report change to Resident #1. Resident #2 sustained a bruise to right armpit that was identified on 4/14/17. The RP and MD were notified on that date, however, the nurses failed to continue to assess the bruise for any changes. In addition, the nurses also failed to advise the MD of changes to resident's #2 area to right armpit. The Nurse Practitioner saw resident #2 on 4/19/17 and ordered CT without contrast to the chest and X-Ray to right shoulder in which the results later revealed a hematoma with osteopenic bones.
For the resident affected:

On 6/17/17 all residents who sustained a fall since June 1, 2017 were assessed by the DON/Designee by use of an audit tool to determine completion of head to toe assessments and MD notification regarding changes in resident condition. The assessment audit included a review of the medical record to ensure that all measures were in place to include contacting the MD of any changes to meet the current needs of the affected residents. A review of the medical record was conducted by the DON to review appropriate interventions and

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assessments subsequent to each fall. Based on findings, staff education was provided by DON.

Plan to identify other residents who are at risk for the deficient practice
Other residents who are at risk for deficient practice will be identified by an assessment audit that will be conducted for all current residents that have had falls since June 1st. Assessments will be reviewed by Director of Nursing or delegated persons for compliance. Based on findings education will be provided. Surveyor identified another resident that had been affected by the failure to conduct assessments according to policy. Resident #2 sustained a bruise on 4/14/17 to the right armpit. The MD and Responsible Party were both notified on that date. No further documentation to include head to toe assessments which would have indicated any change to area was noted until 4/19/17. The resident was seen by the Nurse Practitioner. At that time a CT of chest without contrast, Right shoulder X-Ray and a CBC were ordered. The results of the tests revealed an intermuscular hematoma. It was determined from review of the medical record that no head to toe assessment was conducted for the resident. The medical record reflects compound fracture to the lower spine and there have been no follow up X-rays to address the affected area of the spine. The compression fractures were sustained prior to admission to the facility and are noted on admission evaluation by MD. Staff have observed resident #2 calling out in pain during ADL care. MD notified on 6/18/17 to have pain medication ordered for resident #2 at which time an order was received for Tylenol 325 MG.

Action Taken to Fix the Problem

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Re-education to all nurses and CNAs began on 6/17/17. All Nursing staff to include licensed nurses and CNAs were educated on 6/17/17 either via phone or in person regarding the following: Fall Management, which includes Safe Handling of residents regarding transfers, Head to Toe Assessments, Abuse/Neglect policy and procedure, and Neurological Check Policy and Procedure. All nursing staff have been educated that Emergency Medical Services (911) will be contacted for any resident that has been assessed and found to need emergency care. All CNAs have received education regarding reporting any change in condition to nurse through the use of a "Stop and Watch Tool." All employees who received education via phone will receive written material upon returning to work. The Neurological checks education was provided on 6/17/17 to all licensed nurses to specifically address the frequency and duration: It is as follows: Every 15 minutes for 2 hours, then every 30 minutes for 4 hours, then every hour for 4 hours, then every 4 hours for sixteen hours, and every 8 hours for 48 hours. Education was provided to all nursing staff on 6/17/17 to include all assessment processes to include assessment for pain.

The facility alleged IJ removal on 6/18/17.
The credible allegation was verified on 6/21/17 at 6:04 PM. Nurse #1 no longer worked at the facility and could not be reached by phone for interview. A sample of current resident records were reviewed for falls, injury and staff action. The Assistant Director of Nursing was interviewed on 6/21/17 at 5:07 PM. She provided the Fall Management Protocol, Assessment and Neurological Check policy inservice details. On

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F 309	Continued From page 62 6/21/17 from 2:02 PM through 5:42 PM, random nursing staff as well as Nursing Assistants involved with Resident #1 following the falls, were able to articulate the steps of the "Stop and Watch Tool" for notification, assessment and reporting. Staff members interviewed were able to describe education received regarding falls, assessment, the policy regarding neurological checks, physician notification, neglect and how to respond to changes in condition. The facility was able to provide evidence that they had completed an audit of the residents and inserviced all staff on 6/17/17. Other residents in the facility were observed and there were no concerns. The immediate jeopardy was removed on 6/18/17.	F 309		
F 323 SS=J	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with	F 323		7/17/17

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F 323	Continued From page 63 the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews and family interview the facility failed to evaluate the adequacy of supervision for three (Resident # 1, Resident # 2, and Resident # 3) of three sampled residents who had experienced accidents in their secured unit; two (Residents # 1 and # 2) of whom had experienced hematomas. Immediate jeopardy began on 6/9/17 when Resident # 1 experienced her third fall within a four day period and was found to have bruising to her head. On 6/10/17 Resident # 1 was identified in an Emergency Room to have a subdural hematoma and bruising on multiple parts of her body. The resident was also receiving 325 milligrams of aspirin daily without any consultation from the staff to the physician in regards to whether the aspirin could be increasing her chance for injuries. The administrator and the Director of Nursing were not aware of the extent of the bruising until an outside entity (the county Department of Social Services) talked to them three days following the resident's discharge. The direct care staff had failed to document and convey the extent of the resident's injuries in order that administrative staff assess for any corrective measures which would need to be taken in regards to supervision for residents on their secured unit where Resident # 1 had resided. The immediate jeopardy was removed on 6/17/17 when the facility provided an acceptable credible allegation of compliance. The	F 323	Preparation and submission of this POC is required by state and federal law. This POC does not constitute and admission for purposes of general liability, professional malpractice or any other court proceeding. Corrective action taken for the residents found to have been affected: 1a. Resident #1 no longer resides at the facility 1b. Resident #2 the MD and responsible party were both notified on 4/14/17 and a head to toe assessment was completed at that time. Resident was seen by the Nurse Practitioner on 4/19/2017 and was ordered a CT of chest without contrast, right shoulder xray and a CBC. All were completed. The care plan for resident #2 and resident #3 addresses that "safety needs will be met thru staff supervision". Correction action taken for those residents having the potential to have been affected: 2a. An assessment audit was conducted on 6/17/2017 for current residents that had falls since 6/1/2017. 2b. As of 6/1/2017 fall incidents have been audited to include head to toe	

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F 323	Continued From page 64 facility will remain out of compliance at a scope and severity level of D (not actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure monitoring systems put in place are effective. The facility is also out of compliance at the D scope and severity for Resident # 2 and Resident # 3. The findings included: 1. Record review revealed Resident # 1 resided at the facility from 4/18/17 until 6/10/17. According to the medical record the resident had the following diagnoses: advanced Parkinson's disease, dementia, chronic atrial fibrillation, iron deficiency anemia, hyperglycemia, hypertension, alopecia totalis (loss of hair), healed fracture of the right humerus, history of falls; chronic kidney disease, scoliosis, and hypothyroidism. Review of physician progress notes revealed the physician assessed the resident on 4/21/17 and noted that there was no bruising or abnormal bleeding as of his assessment date. Review of Resident # 1's admission Minimum Data Set (MDS) assessment dated 4/25/17 revealed the resident was cognitively impaired, needed extensive assistance from one staff member for bed mobility, transfers, dressing, toileting, hygiene, and bathing, and needed limited assistance for ambulation. This MDS assessment also coded the resident as having no falls or fractures within the last 6 months prior to her facility admission. Review of Resident # 1's care plan, dated 4/18/17, revealed the staff identified Resident # 1 was at risk for falls. The facility's goal for the resident was that she would not sustain injury due	F 323	assessments, RP notification, MD notification, Post fall huddles and DON/designee notification. Measures that will be put into place or systemic changes made to ensure that the deficient practice will not occur: 3a. Re-education on fall management (including safe handling of residents regarding transfers, ensuring that each resident receives adequate supervision and assistance to prevent accidents, review of/and following care plans, head to toe assessments and post fall huddles), abuse/neglect policy and procedure, neurological check policy and procedure and stop and watch tool will be completed by DON/designee to licensed nurses and CNAs by 7/17/2017. 3b. New employees will be educated on fall management(including safe handling of residents regarding transfers, ensuring that each resident receives adequate supervision and assistance to prevent accidents,head to toe assessments and fall huddles), abuse/neglect policy and procedure, neurological check policy and procedure, and stop and watch tool by the don/designee. Monitoring 4a. A review of each incident and the 24 hour report will be discussed and reviewed 5x/week in clinical meeting to ensure ongoing compliance with policy for 12 weeks. 4b. A fall audit will be completed by	

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F 323	Continued From page 65 to a fall. Listed interventions added on 4/18/17 were: ambulation devices as needed; assess cognitive status, evaluate for unsteady gait, instruct on appropriate safety measures; maintain a safe environment, proper nonskid foot wear; therapy to evaluate and treat as ordered. On 4/25/17 "anti rollback wheelchair brakes" was added to the care plan interventions. On 4/26/17 "assess for fatigue and provide rest periods PRN (as needed)" and "assist with transfers and ambulation" was added to the care plan interventions. On 6/9/17 "offer and assist resident to bed between 7 PM to 8 PM" was added to the care plan interventions. Review of nursing notes revealed Resident # 1 was transferred to the secured facility unit on 4/23/17 due to exit seeking behavior and resided there until her discharge on 6/10/17. Review of a nursing note dated 4/24/17 revealed Resident # 1 sustained a fall on 4/24/17 at 6:00 AM. The note indicated that Resident # 1 slid out of bed while getting into her wheelchair, and landed on her buttocks with her back against the bed. An additional nursing note dated 4/24/17 at 7:18 AM, revealed that the resident had a bruise to her right flank but had no complaint of pain or discomfort. Both notes were signed by Nurse #2. Review of the nursing notes revealed that following the fall of 4/24/17, there was no documentation that Resident # 1 sustained further falls until the date of 6/6/17. A nursing note dated 6/6/17 (Tuesday) at 5:42 PM by Nurse # 3 indicated Resident # 1 was observed sitting on the floor on her buttocks next to her bed. The nurse noted the resident was	F 323	DON/designee for each fall for 12 weeks including: head to toe assessments, RP notification, MD notification, DON/designee notification and post fall huddles. Post fall huddles will be completed by the licensed nurse assigned to the resident and include the type of fall, location of fall, Medication review, what interventions were in place, contributing factors, witness statements and patient's account if able to contribute. 4c. Audits will be reviewed by the QA and A committee monthly for 3 months.	

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assessed for injuries and none were noted.

According to a nursing noted dated 6/8/17 (Thursday) at 7:55 PM Resident # 1 sustained another fall. The nurse noted Resident # 1 was "sitting on the edge of her wheelchair and slid out of the chair onto the floor landing on her buttocks." The note was signed by Nurse #2.

A nursing note dated 6/9/17 (Friday) at 6:56 AM by Nurse # 2 documented the resident had a hematoma noted to the right elbow.

According to staffing sheets, Nurse # 2 was assigned to care for Resident # 1 during the shift which began at 7 PM on 6/8/17 (Thursday) until 7 AM on 6/9/17 (Friday). Nurse # 2 was interviewed on 6/16/17 at 9:16 AM. Nurse # 2 stated she recalled Resident # 1 had been in the TV room (activity room) when she sustained the fall on 6/8/17 (Thursday) at 7:55 PM. Nurse # 2 stated a nurse aide had been with the resident, but could not get to her in time to prevent the fall. Nurse # 2 stated she recalled she (Nurse # 2) had been in the hall outside of the TV room when the incident occurred and she did not recall the resident being hurt when she checked her right after the fall. According to Nurse # 2, she thought there had been three NAs on the unit when Resident # 1 had fallen on Thursday 6/8/17 and she could not recall what all was transpiring that evening or if there had been enough staff to supervise the residents. According to Nurse # 2 sometimes several residents could start displaying behaviors at the same time on the secured unit and therefore those residents on the unit would need more staff attention. The nurse stated on days like that it seemed as if they could use five or six staff members. Nurse # 2 stated, "It just depends

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on the day if we have enough staff."

NA # 4 was interviewed on 6/16/17 at 3:40 PM. Interview with NA # 4 revealed she had been present on 6/8/17 (Thursday) when Resident # 1 fell at 7:55 PM. NA # 4 stated she was not able to get to Resident # 1 in time to stop the fall. NA # 4 stated the resident had not appeared to be hurt. Interview with NA # 4 revealed she could not recall exactly what she was doing at the time of the incident and only that she was present and could not get to the resident before the fall.

Resident # 1's responsible party (RP) was interviewed on 6/16/17 at 10:10 AM. According to the RP she had concerns related to the supervision on Resident # 1's unit. The RP stated she had visited Resident # 1 on the evening of 6/8/17 and she had arrived to find the resident in a man's sleeveless t-shirt which did not belong to the resident. The RP stated she noticed the resident had a bruise to her arm and her left hand. The RP stated she was concerned that evening at 5:12 PM when she saw a resident's food tray had been spilled in the TV/activity room and the tray's contents had extended from the activity room into the hall. The RP stated it took the staff an hour to clean it from the floor because it did not appear as if a housekeeper was available. The RP stated she stayed with Resident # 1 until 7 PM on 6/8/17 before leaving, and at 10:45 PM on 6/8/17 she received a phone call from the facility that Resident # 1 had fallen but did not appear to be hurt.

Nurse # 1 was interviewed on 6/15/17 at 2 PM and 6/16/17 at 9:46 AM. Nurse # 1 stated the resident had fallen on 6/9/17 (Friday) at 3:43 PM but the incident had been logged as occurring on

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6/10/17 in the nursing notes. The nurse pointed to an entry in the nursing notes which was dated 6/10/17 (Saturday) at 5:12 PM. This Saturday entry revealed a fall occurred on 6/9/17 (Friday) at 3:43 PM.

The entry read, "Writer called to TV room Resident observed with her right knee on the floor and her right elbow resting on an arm-chair. Resident assessed for injuries; no injuries noted. Resident had old bruising to her arms and the right temporal area. Resident had no complaints of pain. MD in facility, notified of unwitnessed fall. Writer attempted to contact RP [Name of RP] to inform of unwitnessed fall." The note was signed by Nurse #1.

Interview with Nurse # 1 on 6/15/17 at 2:00 PM and 6/16/17 at 9:46 AM revealed she had been the nurse to respond to the fall on 6/9/17 at 3:43 PM. Nurse # 1 stated NA # 4 had been in attendance with Resident # 1 in the TV room, but was caring for another resident at the time and had not seen Resident # 1 fall. Interview with Nurse # 1 revealed she had checked Resident # 1 in the TV room, but did not take her back to her room and look at her entire body at the time of the incident. Nurse # 1 stated the resident had some yellow bruising on her arms and a purple bruise to the right temple area at the time of her assessment.

NA # 4 was interviewed on 6/16/17 at 3:40 PM. According to NA # 4 she had been present in the TV room when Resident # 1 had fallen on Thursday of 6/9/17 at 3:43 PM. According to NA # 4 she had her back turned while attending to another resident who needed her attention, and when she turned back around she saw Resident

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1 was on her knee on the floor. NA # 4 stated she did not recall helping with the resident for the rest of Friday evening nor did she see any bruises.

According to staffing sheets Nurse # 2 was assigned to care for Resident # 1 for the shift which began at 7 PM on 6/9/17 and ended at 7 AM on 6/10/17. According to an interview with Nurse # 2 on 6/16/17 at 9:16 AM, she recalled the ADON (assistant director of nursing) talking to her the Friday evening of 6/9/17 about Resident # 1, and they discussed that Resident # 1 was acting differently and were wondering if she might have a urinary tract infection. According to Nurse # 2 it was difficult to remember how the resident was exactly acting differently and the details of any falls she had been experiencing because sometimes things "got hectic" on the unit where Resident # 1 resided. The nurse said sometimes "things run together." According to Nurse # 2 she thought she recalled calling Resident # 1's responsible party and telling her the resident may have hit the side of her face but she did not remember the day on which she did this or the reason why she told her this.

Review of the nursing notes revealed no entry by Nurse # 2 documenting an incident where the resident may have hit her head or that she called the responsible party and informed her of this.

Interview with the ADON on 6/16/17 at 3:55 PM revealed she was responsible for following up on falls and accidents. The ADON stated she had checked on Resident # 1 on the morning of 6/9/17 (Friday) because the resident had fallen on 6/8/17 (Thursday). The ADON stated she had not noticed a bruise to Resident # 1's temple on the

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Friday morning of 6/9/17. The ADON stated on Friday evening of 6/9/17 she went to check on the resident again, and noted she had a bruise to her temple which she had not seen earlier. According to the ADON on Friday evening of 6/9/17 she saw the resident reach one time into the air as if she was reaching for something that was not there, and her pupils seemed to be small. According to the ADON she had spoken to Nurse # 1 about this and it was her understanding Nurse # 1 was going to follow up with the physician. According to the ADON she had gone on her scheduled vacation following Friday 6/9/17.

On 6/15/17 administrative staff provided a copy of the facility schedule and had highlighted the NAs who had been assigned to care for Resident # 1 on 6/9/17 and 6/10/17. According to this schedule, NA # 2's name was highlighted as the NA who had been assigned to care for Resident # 1 on the 3 PM to 11 PM shift on 6/9/17.
NA # 2 was interviewed on 6/16/17 at 11:10 AM. Interview with NA # 2 revealed she recalled only being assigned to Resident # 1 from 3 PM to 7 PM. NA # 2 stated she recalled only two NAs on the unit during that time and she had three residents who were at risk for falls trying to stand up, and Resident # 1 was one of them. According to NA # 2 she also noticed that Resident # 1 was picking at things in the air that were not there as if she was "hallucinating" and she had spoken to a nurse about it. She did not recall the exact nurse with whom she had spoken. NA # 2 stated she had not assisted Resident # 1 to bed since she was not assigned to her after 7 PM, and she thought NA # 3 had done so and she did not know what time Resident # 2 had gone to bed.

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NA # 3 was interviewed on 6/17/17 at 10:45 AM. NA # 3 stated she arrived to work at 7 PM on 6/9/17 (Friday) and stayed in the TV/activity room with residents from 7 PM to 9 PM. Interview with NA # 3 revealed Resident # 1 was in the TV room when she arrived at work, kept trying to repeatedly stand up, and elbowed NA # 3 when she tried to redirect the resident to sit down. NA # 3 stated the resident screamed and became angry. NA # 3 stated she had not assisted her to bed and thought NA # 2 had done so. NA # 3 did not know what time Resident # 1 had been assisted to bed.

Resident # 1's RP was interviewed on 6/16/17 at 10:10 AM. The RP stated she had received two phone calls on 6/9/17 from staff letting her know that Resident # 1 had fallen. The RP stated her phone kept a log of when the phone calls were received and they were on 6/9/17 at 2:45 PM and 6/9/17 at 8:45 PM. The RP stated when she was called at 2:45 PM the staff member told her that Resident # 1 had fallen from her chair and had "possibly hit her head on another person's wheelchair." The RP stated she was called again on 6/9/17 at 8:45 PM and was told Resident # 1 was found in front of her roommate's chair on the floor. The RP stated she asked if the resident was okay and was told she was just sitting there and they put her back to bed.

There was no documentation in the nursing notes that the resident had sustained a fall on 6/9/17 at 8:45 PM. According to the staffing sheets provided by the facility, NA # 2 would have been assigned for her care at this time, but the interview on 6/16/17 at 11:10 AM with NA # 2 revealed she did not think Resident # 1 had been assigned to her after 7 PM.

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NA # 5 was interviewed on 6/15/17 at 11:30 PM. Interview with NA # 5 revealed she recalled Resident # 1 slept Friday night during her shift which began at 11:00 PM on 6/9/17. NA # 5 stated Resident # 1 normally did everything for herself and therefore she looked in on her, but did not awaken her and was not aware of bruises.

Interview with Nurse # 3 on 6/15/17 at 12:25 PM revealed she had been on duty during the dayshift on 6/10/17 (Saturday). Nurse # 3 stated she had not received a report that Resident #1 had been bruised or injured when she reported to duty at 7:00 AM on 6/10/17. Nurse # 3 stated she did not know the resident had been hurt until two dayshift NAs (NA # 6 and NA # 7) came to her and reported they had found bruises on her while giving her care. Nurse # 3 stated she immediately went to assess the resident and found her to have bruises on her back, legs, hip, and head. The nurse stated the bruises were red in color and she immediately called Nurse # 1, who was her supervisor.

NA # 6 was interviewed on 6/15/17 at 4:35 PM. Interview with NA # 6 revealed she had routinely cared for Resident # 1, and the resident was usually very cooperative with care. NA # 6 stated prior to 6/10/17 (Saturday), she had last cared for her on 6/6/17 (Tuesday). NA # 6 stated on Saturday of 6/10/17, she had assisted NA #7 with Resident #1. NA # 6 stated Resident # 1 would not eat nor drink for breakfast or lunch, and she refused care by swinging at them. NA # 6 stated after lunch they finally convinced Resident # 1 to let them assist her with care, and when they pulled back her covers and clothing to provide care there were dark purple bruises on her arms,

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breast, back, thighs, and legs. NA # 6 stated the bruising seemed "like it was everywhere." NA # 6 stated they immediately got the nurse. NA # 6 stated the bruising had not been present when she had last cared for Resident # 1 on 6/6/17 (Tuesday). Interview with NA # 6 revealed no administrative staff member had spoken to her as of 6/15/17 regarding the bruises she had found and the events of the resident's day.

NA # 7 was interviewed on 6/16/17 at 12 noon. Interview with NA # 7 revealed she had not received a report when she reported to duty on 6/10/17 that there was anything wrong with Resident # 1. NA # 7 stated Resident # 1 would not eat breakfast or lunch and refused morning care. NA # 7 stated the nurse also tried to assist her for lunch, and the resident refused. NA # 7 stated after lunch she and NA # 6 went together to provide care, and when they pulled back the sheet there were bruises on both arms, both hips, on her legs, under her arm, on the side of her chest by her breast, and on her right head. Interview with NA # 7 revealed she had not seen the bruise on her head earlier because the resident wore a bonnet and when they were providing care the bonnet tipped backward which revealed the bruising. NA # 7 stated the head bruise was about the size of her hand.

Review of the 6/10/17 nursing notes revealed no documentation regarding the bruising that was found by NA # 6; NA # 7 and Nurse # 3 on 6/10/17.

Interview with Nurse # 1 on 6/16/17 at 9:46 AM revealed Nurse # 3 had called her at home on 6/10/17 and told her Resident # 1 had bruises "everywhere." Nurse # 1 stated it was her

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understanding that the main concern was the bruising and not a change in mental status. Nurse # 1 stated she (Nurse # 1) called the physician and he asked if the resident had been falling. Nurse # 1 stated she told the physician the resident had fallen, and he therefore wanted her sent for a CT scan at the hospital. The nurse stated it was arranged for Resident # 1 to go to the hospital out- patient department via way of a non-emergency transport service.

There was no notation in the nursing notes when the resident was transported out of the facility. The DON provided documentation that she was called on 6/10/17 by the non-emergency transport service at 5:15 PM in order to let her know they were in the facility and needed verification of Resident # 1's room number to pick her up for transport.

Interview with the RP on 6/16/17 at 10:10 AM revealed she had received a voice mail on 6/10/17 at 4:50 PM from the facility asking that she call. The RP stated she returned the phone call at 6 PM and was told they were sending the resident to the hospital because she had slept all day and would not eat. According to the RP, when she arrived at the hospital she found the resident disoriented and with extensive bruising. According to the RP the resident was diagnosed with a subdural hematoma and expired on 6/14/17.

A review of the resident's June 2017 MAR (medication administration record) revealed she had received her prescribed dosage of 325 milligrams of Aspirin daily from 6/6/17 through 6/10/17. There was no indication in the nursing notes the nurses had consulted with the physician

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regarding if the Aspirin should be held when the resident began falling in order to avoid further injuries from her falls. The MAR was reviewed with the ADON on 6/15/17 at 5:30 PM and it was confirmed with the ADON the MAR showed no documentation the Aspirin was held.

Review of 6/10/17 Emergency Room (ER) medical records revealed the resident's bruising was extensive. The ER physician noted the resident had bruising on the right parietal area of her head; the right flank, the right elbow, the right hip, the right knee, and the left flank. He further noted she had critical anemia with a Hemoglobin level of 5.9 which the physician documented was "likely secondary to a GI (gastrointestinal bleed)." The resident's stool was grossly guaiac positive for blood in the ER. A CT scan of the resident's head on 6/10/17 revealed she had a frontoparietal subdural hematoma measuring 5 mm (millimeters) in thickness.

An interview with the resident's facility physician on 6/17/17 at 7:00 PM revealed the most likely reason for the resident's extensive bruising was her repeated falls. According to the physician the staff had notified him of the bruise to the temple on 6/9/17, but they had not notified him of any other changes on Friday (6/9/17), the extent of the bruising, or consulted with him regarding the Aspirin dosage.

Interview with the DON (Director of Nursing) on 6/15/17 at 5:25 PM and again on 6/16/17 at 11:40 AM revealed Nurse # 3 had called her at home on 6/10/17 (Saturday) and the main concern seemed to be the change in Resident # 1's mental status. The DON stated Nurse # 1 was planning to go in to work, and therefore she had Nurse # 1

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communicate with the physician. According to the DON the staff had not conveyed to her the extent of the bruising or she would have gone to the facility on Saturday when she was called to look at the resident. According to the DON she had not been made aware there were concerns related to the resident being injured to the extent she was until an outside entity (the County Department of Social Services) spoke to her on Tuesday (6/13/17) about concerns. According to the DON that was the first date she started to get statements from her staff to determine what had happened regarding the resident's care and falls. The DON was not aware of any report that the resident had fallen a second time on 6/9/17 at 8:45 PM.

Interview with the administrator on 6/16/17 at 1:00 PM revealed he relied on his clinical staff to alert him to clinical problems, and the ADON routinely did follow up to falls and injuries. Interview with the administrator revealed the ADON had been on vacation during the current week which began on 6/11/17. According to the administrator the staff had not alerted him to the extent of the bruising which was found on Resident # 1 before she left the facility on 6/10/17 in order that he follow up regarding the supervision she had received.

According to an interview with the ADON on 6/17/17 at 3 PM, a staff member is required to stay within the secured unit's TV room/activity room anytime there is a resident within the room so that there can be supervision. According to the ADON there is a schedule for the NAs that is based upon their assigned room numbers. According to the ADON each NA is assigned an hour in the TV room/Activity room. The assigned

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hour corresponds to the NA room assignments. The ADON stated there are generally three NA room assignments: the back of the 600 hall; the "split," and the back of the 700 hall. The ADON provided an example of the dayroom "Activity Room Schedule" for first shift. According to the schedule, a NA who is assigned to care for residents on the "back of 600" is assigned to be in the TV/Activity room from 9:00 AM to 10:00 AM and from 12 noon to 1:00 PM. According to the schedule the NA assigned to care for residents on the "split" assignment was assigned to be in the TV/Activity room from 10:00 AM to 11:00 AM and again from 1:00 PM to 2:00 PM, and the NA who was assigned to care for the residents on the "back of 700" was assigned to be in the TV/Activity room from 11:00 AM to 12 noon and again from 2:00 PM to 3:00 PM.

There was no documentation in the facility's investigation of Resident # 1's falls showing they had reviewed the responsibilities of the NAs who were assigned for supervision to Resident # 1 when she was experiencing the falls.

On 6/17/17 at 5:15 PM, the administrator was informed of the immediate jeopardy. The facility provided a credible allegation of compliance on 6/18/17. The allegation of compliance indicated:

Resident # 1 has diagnosis including but not limited to Lewy Body Dementia, Parkinson's disease, Pseudo Bulbar, anemia, and A-fib. Upon admission, she was determined to be a risk for falls. Subsequently, she was care planned for a fall risk as to prevent injuries. Resident #1 sustained three separate falls on 6/6/17, 6/8/17 and 6/9/17 which resulted in bruising to multiple areas of her body. The fall on 6/9/17 was

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unwitnessed in the dayroom at approximately 3:45 pm. Resident #1 was noted to be on one knee with the other foot flat on the floor. Her right arm was on a chair and her left arm was on her wheelchair. Resident was observed on the floor by the Unit Manager and assisted to a chair in the dayroom and a head to toe assessment was not documented in the clinical record. The ADON observed a bruise to resident's forehead and spoke with the Unit Manager regarding the observation. The Unit Manager observed the area where the bruise was located on the forehead, but did not complete a head to toe assessment. UM stated to DON that resident didn't let UM remove her night cap. UM notified the attending physician regarding the fall and bruise to head. MD was notified of the bruise to the forehead and ordered neuro checks at that time. On 6/10/17, resident #1 refused breakfast. She also refused to get out of bed or allow personal care offered by staff. She refused lunch, pushing staff away. Thru encouragement, staff were able to assist resident with ADL care and noted bruises on her body. At this time she was alert but not speaking. The nurse was informed and contacted the DON at 3:25 pm regarding the refusal of meals, refusal of care and multiple bruising. An order was obtained to send resident #1 to hospital for head CT. Resident was transported to (hospital) via wheelchair at 5:15pm. Resident was later transferred to (hospital) and admitted with subdural hematoma and GI bleed. Resident later expired at hospital. The nurse failed to complete a thorough head to toe assessment at time of fall per policy.

For the resident affected:

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All residents who sustained a fall since June 1, 2017 were assessed by DON/Designee for a head to toe assessment and appropriate MD notification by use of an audit tool. The assessment audit included a review of the medical record to ensure that all measures were in place to meet the current needs of the affected residents. A review of the medical record was conducted by the DON to review appropriate interventions and assessments subsequent to each fall. Based on findings, staff education was provided by DON.

Plan to identify other residents who are at risk for the deficient practice

Other residents who are at risk for deficient practice will be identified by an assessment audit that will be conducted on 6/17/17 for all current residents that have had falls since June 1st. The audit revealed that there 17 total falls that were comprised of 12 residents with three of those residents having repeated falls. Assessment audits will be reviewed by Director of Nursing or delegated persons for compliance. Education will be provided on 6/17/17. Surveyor identified another resident that had been affected by the failure to conduct assessments according to policy. Resident (L.S.) sustained a bruise on 4/14/17 to the right armpit. The MD and Responsible Party were both notified on that date and a head to toe assessment was completed at that time. There was no further assessment to determine a change in identified area until 4/19/17. No further documentation was noted until 4/19/17 when the resident was seen by the Nurse Practitioner. At that time a CT of chest without contrast, Right shoulder X-Ray and a CBC were ordered in which results revealed an intermuscular hematoma. It was determined that no head to toe assessment was conducted for

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the resident.

Action Taken to Fix the Problem
Re-education to all nurses and CNAs began on 6/17/17. All Nursing staff to include licensed nurses and CNAs were educated on 6/17/17 either via phone or in person regarding the following: Fall Management, which includes Safe Handling of residents regarding transfers, Head to Toe Assessments, Abuse/Neglect policy and procedure, and Neurological Check Policy and Procedure. All CNAs have received education regarding reporting any change in condition to nurse through the use of a "Stop and Watch Tool." All employees who received education via phone will receive written material upon returning to work.

The facility alleged IJ removal on 6/17/17.
The credible allegation was verified on 6/21/17 at 6:04 PM. Nurse #1 no longer worked at the facility and could not be reached by phone for interview. A sample of current resident records were reviewed for falls, injury and staff action. The Assistant Director of Nursing was interviewed on 6/21/17 at 5:07 PM. She provided the Fall Management Protocol, Assessment and Neurological Check policy inservice details. On 6/21/17 from 2:02 PM through 5:42 PM, random nursing staff as well as Nursing Assistants involved with Resident #1 following the falls, were able to articulate the steps of the "Stop and Watch Tool" for notification, assessment and reporting. Staff members interviewed were able to describe education received regarding falls, assessment, the policy regarding neurological checks, physician notification, neglect and how to respond to changes in condition. The facility was able to provide evidence that they had completed

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an audit of the residents and inserviced all staff on 6/17/17. Other residents in the facility were observed and there were no concerns. The immediate jeopardy was removed on 6/17/17.

2. Record review revealed Resident # 2 was admitted to the facility on 7/11/16. Record review revealed the resident had diagnoses of failure to thrive, dementia, osteoporosis, anemia, hypertension, gastro-esophageal reflux disease, anxiety, glaucoma, mood disorder, vitamin D deficiency, osteopenia, a history of multilevel compression fractures affecting 12 of the vertebra which ranged in severity from mild to severe; and a history of sternal fracture with deformity.

Review of the resident's annual Minimum Data Set (MDS) assessment, dated 5/22/17, revealed the resident had a BIMS (brief interview for mental status) score of "0" which indicated she did not answer any questions correctly on her cognitive ability assessment. The resident was assessed as needing extensive assistance with transfers, dressing, toileting, and hygiene. The resident was totally dependent on staff for her bathing.

Review of the resident's care plan revealed the resident could be resistive to care. A problem was also listed on the resident's care plan dated 7/12/16 which noted she had the potential for altered skin integrity. Some of the listed care plan interventions included: skin assessments quarterly and as needed; assist resident to wear bilateral geri-legs at all times; and notify MD of changes in skin as needed. According to the care plan the resident required a "total lift for transfers."

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Review of a nursing note by Nurse # 5 on 4/14/17 (Friday) at 8:56 AM revealed the resident had a bruise to her right arm pit which measured 8 X 5 centimeters (cm). Another nurse's note dated 4/14/17 at 10:48 AM revealed the area was bluish/red and was under her right arm and inner upper arm; the ADON (assistant director of nursing) was notified; a physician communication note was completed; and that the resident complained that the area hurt when it was touched. The note was signed by Nurse #5.

Following the nursing entry of 4/14/17 (Friday) at 10:48 AM there was no documentation the bruise existed, an assessment of the bruise, or the resident's physical status in the nursing notes until 4/19/17 (Wednesday) at 2:30 PM.
A nurse's note dated 4/19/17 at 2:30 PM revealed the resident was seen by the (nurse practitioner) NP for a hematoma to the right axilla. According to the note the NP ordered a CT of the chest, x-ray of the shoulder, and a Complete Blood Count for Resident #2. The note was signed by Nurse #5.

A NP's (nurse practitioner's) note on 4/19/17 revealed staff had reported the resident had a bruise and swelling to the resident's right arm pit for three days and it was worsening. The NP also noted the resident had a chest bruise.

Review of the CT report revealed it was completed on 4/20/17. The findings revealed the resident had an intramuscular hematoma to her right pectoralis major muscle (chest muscle) which measured 8.5 X 4.1 X 4. 6 cm.

The ADON (assistant director of nursing) was interviewed on 6/17/17 at 1:06 PM. Interview with

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the ADON revealed Resident # 2 had always required a mechanical lift for transfer since her admission. The ADON stated following the identification of the armpit bruise she had obtained information from the NAs who had recently cared for Resident # 2 in regards to how they transferred her and repositioned her in the chair. According to the ADON and her investigation papers she had found some of the NAs had not been transferring the resident per her plan of care. She had identified that one of the NAs had not been using a mechanical lift but had been picking the resident up "like a baby." The ADON's investigation had revealed one of the NAs had been "lifting and pivoting" the resident. The ADON was not able to explain how the NA had been doing this. According to the ADON the staff had also not been repositioning the resident correctly in the chair, and they at times would reach under her armpits and pull her up in the chair rather than repositioning her hips. According to the ADON she was unable to determine with certainty how the hematoma had occurred but had concluded it could have been attributed to repositioning techniques from staff.

The ADON provided inservice records related to the incident. The inservices were conducted on 4/17/17 after the bruise was found on 4/14/17. According to the inservice sign in sheets there were eight NAs who attended. During the interview with the ADON it was confirmed there were other NAs who worked on Resident # 2's unit but who had not attended the inservice training. Review of the material covered revealed the NAs were directed to "have her lean forward with her upper body" and "then guide her hips back." Review of the ADON's inservice records revealed they addressed positioning for the

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resident, and the only notation about transfers for the resident in the inservice material was "we are a lift free facility."

Resident # 2 was observed on 6/15/17 at 3:55 PM as NA # 6 and NA # 9 transferred the resident from a chair to the bed with a mechanical lift in order to provide care. The NAs worked to try to position the mechanical lift sling back beneath the resident in order that they complete the transfer, and it was observed that the resident was not cooperative. The resident would not lean forward for them in order that they position the sling beneath her. NA # 6 stated the NA, who had gotten the resident out of bed earlier, should have left the sling beneath her so that they did not have to move the resident as much to get it positioned correctly. The resident was observed to complain of pain as they worked to get the sling beneath her and transfer her into the bed. Upon completing the care the NAs again transferred the resident back from the bed to the wheelchair with the mechanical lift, and the resident complained once again she was hurting and was not cooperative in the sling placement. According to these evening shift NAs the resident complained of pain anytime they transferred her with the mechanical lift. The NAs were asked if the nurse knew the resident hurt, and responded that the nurses did because the nurses heard her scream when she was transferred.

During the care, the resident was also observed to have bruising to her right posterior leg and a scabbed area on her left posterior leg. The scabbed area was not observed over a typical pressure point. The elastic in the resident's socks was observed to be compressing into her fragile skin around the "scabbed area" and it was

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reddened around it. The resident was observed not to have geri-legs (a thin protective covering) in place as per her plan of care. She had one skin tube (a thicker protective covering) to one leg, and it was not entirely covering the lower leg it was on but had become displaced.

The resident was again observed on 6/17/17 at 9:50 AM in her wheel chair as Nurse # 1 was present. The resident was observed not to have any geri-legs in place per her plan of care. Nurse # 1 did not know why the geri-legs were not in place.

Interview with NA # 8 revealed she was assigned to care for her on 6/17/17 and she had sent the resident's geri-legs to the laundry the previous day because they had blood on them from an arm skin tear. The NA stated the resident slept in a fetal position and the resident, who currently had a skin tear to her arm, had gotten them soiled.

The ADON was interviewed on 6/17/17 at 3 PM. During the interview the ADON could not verify from her follow up records where the "scabbed area" to the resident's left lower leg originated. Interview with the ADON revealed the skin tubes are thicker than geri-legs but easier for the resident to remove, and verified that that the resident should have the geri-legs in place at all times.

On 6/17/17 a review of the resident's April 2017, May 2017, and June 2017 MARs revealed the resident had not received any pain medication. There was no documentation within the ADON's investigation following the 4/20/17 hematoma and identification that staff were not transferring the resident per her plan of care that they evaluated if

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the resident's pain was impacting her ability to cooperate with positioning and placement of the sling for mechanical lift transfers.

3. Record review revealed Resident # 3 was admitted to the facility on 9/8/16. The resident's diagnoses included but were not limited to the following: vascular dementia with behavioral disturbance, generalized weakness, glaucoma, history of cerebral infarction, osteoarthritis, major depressive disorder, anxiety disorder, and affective mood disorder
.
Review of the resident's readmission MDS (Minimum Data Set) assessment, dated 5/4/17, revealed the resident was cognitively impaired and needed extensive to total assistance from staff with his transfers, toileting, hygiene, and bathing needs.

Review of the resident's current care plan revealed the staff had identified on 9/8/16 the resident had sustained a fall and was at risk for future falls. One of the interventions was to encourage the resident to remain in high traffic areas while out of bed.

Review of nursing notes revealed Resident # 3 was ambulatory with supervision up until 4/12/17, when he experienced a fall and sustained a left hip fracture. Per the nursing notes, the resident was transferred to the hospital where he had an open reduction internal fixation and returned to the facility on 4/20/17 under a non-weight bearing status.

Review of the nursing notes revealed the resident continued to try to get up unassisted following his surgery. Review of the facility's documentation of

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accidents and nursing notes revealed the resident sustained five unwitnessed falls since his return from the hospital. These were 5/3/17, 5/27/17, 6/3/17; 6/9/17, and 6/11/17.

A nursing note on 5/3/17 at 4:50 PM noted the resident had been found sitting in his doorway. There was no documentation the resident was hurt. The note was signed by Nurse # 5.

There was no nursing entry in the record noting the fall of 5/27/17. The facility's documentation of the accident revealed on 5/27/17 at 5:09 AM Resident # 3 was found on the floor in his room and he told the staff he was going to get his boat.

On 5/7/17 the resident's care plan was updated to include a new intervention of "every fifteen minute visual checks."
A nursing note entry on 6/3/17 at 11:30 PM noted the resident was observed sitting beside his roommate's bed on his buttocks and was found to not have injuries. The note was signed by Nurse # 2.

A nursing note entry on 6/9/17 at 10:55 AM noted the resident had been found lying on his left side with his head resting in his left hand in the TV room. There was no documentation of injury. The note was signed by Nurse # 1
.
A nursing note entry on 6/11/17 at 1:28 PM noted the resident had been sitting in the dining room in his wheel chair, had gotten up unassisted and was observed laying on the floor on his left side in the dining room. There was no documentation of injury. The note was signed by Nurse # 3.
The facility's documentation of the incident noted the 6/11/17 fall had been "unwitnessed."

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On 6/17/17 at 3 PM the resident's falls were reviewed with the ADON (Assistant Director of Nursing) who had investigated the circumstances which led to the falls According to the ADON, Resident # 3 worked both as a farmer and in a job prior to residing at the facility and was accustomed to being busy all the time and arising early and he also had poor safety awareness following his surgery. According to the ADON a staff member is required to stay within the secured unit's TV room/activity room anytime there is a resident within the room so that there can be supervision. According to the ADON there is a schedule for the NAs that is based upon their assigned room numbers. According to the ADON each NA is assigned an hour in the TV room/Activity room. The assigned hour corresponds to the NA room assignments. The ADON stated there are generally three NA room assignments: the back of the 600 hall; the "split," and the back of the 700 hall. The ADON provided an example of the dayroom "Activity Room Schedule" for first shift. According to the schedule, a NA who is assigned to care for residents on the "back of 600" is assigned to be in the TV/Activity room from 9:00 AM to 10:00 AM and from 12 noon to 1:00 PM. According to the schedule the NA assigned to care for residents on the "split" assignment was assigned to be in the TV/Activity room from 10:00 AM to 11:00 AM and again from 1:00 PM to 2:00 PM, and the NA who was assigned to care for the residents on the "back of 700" was assigned to be in the TV/Activity room from 11:00 AM to 12 noon and again from 2:00 PM to 3:00 PM. The ADON stated NA # 8 had been assigned to be in the activity room during the time that Resident # 3 fell on 6/9/17. The ADON stated NA # 8 had thought

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F 323	Continued From page 89 the activity room schedule had been changed on 6/8/17, and therefore she had not been in the activity room to monitor the resident when he fell. According to the ADON she had been on vacation and she had not yet identified the circumstances which had let to Resident # 3 being found on the dining room floor on 6/11/17 at 8:30 AM. There was no documentation in the facility's investigation of Resident # 3's falls showing they had reviewed the responsibilities of the NAs who were assigned for supervision to Resident # 3 when he was experiencing the falls to assure the staff members were being able to check on him every fifteen minutes per his plan of care.	F 323		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in	F 329		7/17/17

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F 329	Continued From page 90 paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to consult with the physician to determine the necessity of a resident's Aspirin dosage for one (Resident # 1) of two sampled residents who sustained multiple falls which resulted in a subdural hematoma and extensive bruising. The findings included. Resident # 1 resided at the facility from 4/18/17 until 6/10/17. Review of physician orders revealed the resident was admitted on 4/18/17 with an order for Aspirin 325 mg (milligrams daily) for Atrial Fibrillation. (Aspirin can be used as an anti-coagulant.) According to the physician's progress note, dated 4/21/17, the resident had the following diagnoses: advanced Parkinson's disease, frontotemporal	F 329	Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. Corrective action taken for the residents found to have been affected: 1a. Resident #1 no longer resides in the facility. Corrective action taken for those residents having the potential to have been affected: 2a. Subsequent to each fall a review of medications will be completed by the nurse to determine if the resident is	

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dementia with pseudo bulbar affect, chronic atrial fibrillation, iron deficiency anemia, hyperglycemia, hypertension, alopecia, history of a healed fracture, and history of falls. The physician indicated in this note that Resident #1 had no bruising or abnormal bleeding as of his assessment date, and her last hgb (hemoglobin) was 9.8. The physician also noted, "Please let me know about any changes in behavior that indicate an exacerbation of today's issues."

A nursing note on 4/24/17 at 7:18 AM indicated Resident # 1 had slid to the floor and sustained bruising to her right flank.

Review of the resident's MDS (Minimum Data Set) assessment, dated 4/25/17, revealed the resident was cognitively impaired.

A pharmacy review note dated 5/30/17 at 4:12 PM contained no recommendations or notations related to the resident's Aspirin dosage.

Review of the nursing notes and facility documentation of accidents revealed that Resident # 1 sustained three falls on 6/6/17, 6/8/17, and 6/9/17.

A nurse's note dated 6/10/17 at 5:38 PM revealed, "Writer called to TV room Resident observed with her right knee on the floor and her right elbow resting on an arm-chair. Resident assessed for injuries; no injuries noted. Resident had old bruising to her arms and the right temporal area. Resident had no complaints of pain. MD in facility, notified of unwitnessed fall." The note was signed by Nurse #1.

Nurse # 1 was interviewed on 6/15/17 at 2:00 PM

receiving anticoagulants.
2b. For each resident that has a fall, the MD will be notified if a resident is receiving an anticoagulant.
2c. An audit tool has been put in place to include head to toe assessments, RZP and MD notifications, and medication review for each fall.

Measures that will be put into place or systemic changes made to ensure that the deficient practice will not occur:

3a. Re-education will be provided to licensed nurses regarding Anticoagulants including: identification, side effects and contraindications by 7/17/2017.
3b. Re-education will be provided to licensed nurses regarding protocol of medication review and MD notification by 7/17/2017.
3c. Education for newly hired nurses will be provided regarding Anticoagulants, protocol for medication review and MD notification.

Monitoring:

4a. The fall audit will be completed by DON/designee for each fall for 12 weeks.
4b. Audits will be reviewed by the QAPI committee monthly for 3 months.
4c. Each fall will be discussed and reviewed in clinical meeting 5x/week to ensure ongoing compliance with protocol for 12 weeks.

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and clarified the entry which noted the resident had a bruise to her head, was a documentation of the fall that occurred on 6/9/17 at 3:43 PM.

A review of the resident's June 2017 MAR (medication administration record) revealed she had received her prescribed dosage of 325 milligrams of Aspirin daily from 6/6/17 through 6/10/17.

Review of 6/10/17 hospital records revealed the resident was evaluated in the emergency room and found to have extensive bruising. The ER physician noted the resident had bruising on the right parietal area of her head; the right flank, the right elbow, the right hip, the right knee, and the left flank. He further noted she had critical anemia with a Hemoglobin level of 5.9 which the physician documented was "likely secondary to a GI (gastrointestinal bleed)." The resident's stool was grossly guaiac positive for blood in the ER. A computerized tomography (CT) scan of the resident's head on 6/10/17 revealed she had a frontoparietal subdural hematoma measuring 5 mm (millimeters) in thickness.

Interview with Nurse # 1 on 6/15/17 at 2:00 PM and 6/16/17 at 9:46 AM revealed she had been the nurse to respond to the fall on 6/9/17 at 3:43 PM. Nurse # 1 stated the resident had some yellow bruising on her arms and a purple bruise to the right temple area at the time of her assessment, and she did not take her back to her room to check her entire body.

Nurse # 2 was interviewed on 6/16/17 at 9:16 AM. According to facility staffing sheets, Nurse # 2 had been assigned to care for Resident # 1 from 7 PM on 6/9/17 (Friday) until 7 AM on 6/10/17

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(Saturday). According to Nurse # 2, she recalled the ADON (assistant director of nursing) talking to her the Friday evening of 6/9/17 about Resident # 1, and they discussed that Resident # 1 was acting differently and wondering if she might have a urinary tract infection.

Interview with the ADON on 6/16/17 at 3:55 PM Resident # 1 had a bruise to her temple which she had not seen earlier. According to the ADON on Friday evening of 6/9/17 she saw the resident reach one time into the air as if she was reaching for something that was not there, and her pupils seemed to be small. The ADON stated she had spoken to Nurse # 1 and it was her understanding that Nurse # 1 was going to follow up with the physician.

Interview with Nurse # 3 on 6/15/17 at 12:25 PM revealed she had been on duty during the dayshift on 6/10/17 (Saturday). Nurse # 3 stated she had not received a report that Resident # 1 had been bruised or injured. Nurse # 3 stated she did not know the resident had been hurt until two dayshift NAs (NA # 6 and NA # 7) came to her and reported they had found bruises on her while giving her care. Nurse # 3 stated she immediately went to assess the resident and found her to have bruises on her back, legs, hip, and head. The nurse stated the bruises were red in color and she immediately called Nurse # 1, who was her supervisor.

NA # 7 was interviewed on 6/16/17 at 12 noon. Interview with NA # 7 revealed she had been assigned to care for Resident # 1 on 6/10/17. NA # 7 stated the resident had refused care until after lunch, and when they pulled back the sheet after lunch to provide care for Resident # 1 there were

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bruises on both arms, both hips, on her legs, under her arm, on the side of her chest by her breast, and on her right head. Interview with NA # 7 revealed she had not seen the bruise on her head earlier because the resident wore a bonnet and when they were providing care the bonnet tipped backward which revealed the bruising. NA # 7 stated the head bruise was about the size of her hand.

Interview with Nurse # 1 on 6/16/17 at 9:46 AM revealed Nurse # 3 had called her at home on 6/10/17 and told her Resident # 1 had bruises "everywhere." Nurse # 1 stated she called the physician and he wanted her sent for a CT scan at the hospital. The nurse stated it was arranged for Resident # 1 to go to the hospital out- patient department via way of a non-emergency transport service.

The MAR was reviewed with the ADON on 6/15/17 at 5:30 PM and it was confirmed with the ADON the MAR showed no documentation the Aspirin was held. There was no indication in the nursing notes the facility staff had consulted with the physician regarding the resident's Aspirin dosage when the resident began falling or when they had observed the head bruise on 6/9/17.

An interview with the resident's facility physician on 6/17/17 at 7 PM revealed the most likely reason for the resident's extensive bruising was her repeated falls. According to the physician the staff had not consulted with him regarding the resident's Aspirin dosage when she had a bruise on her head and the three falls within four days. The physician stated he did not usually order Aspirin at that dosage for residents, and Resident # 1 had been admitted with the dosage.

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(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) COMPLETION DATE
F 514 SS=E	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure the medical records were	F 514	Preparation and submission of this POC is required by state and federal law. This	7/17/17

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	345280	A. BUILDING _____ B. WING _____	C 06/21/2017

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F 514	Continued From page 96 accurate and complete for three (Resident # 1, Resident # 2, and Resident # 3) of three sampled residents who had sustained accidents or injuries. The findings included. 1. Record review revealed Resident # 1 resided at the facility from 4/18/17 until 6/10/17. According to the medical record the resident had the following diagnoses: advanced Parkinson's disease, frontotemporal dementia with pseudo bulbar affect, chronic atrial fibrillation, iron deficiency anemia, hyperglycemia, hypertension, alopecia totalis (loss of hair), healed fracture of the right humerus, history of falls; chronic kidney disease, scoliosis, and hypothyroidism. a. Review of the nursing notes revealed an entry with an "effective date" of 6/10/17 at 5:12 PM which read, "Writer called to TV room Resident observed with her right knee on the floor and her right elbow resting on an arm-chair. Resident assessed for injuries; no injuries noted. Resident had old bruising to her arms and the right temporal area. Resident had no complaints of pain. MD in facility, notified of unwitnessed fall. Writer attempted to contact RP [Name of RP] to inform of unwitnessed fall." The note was signed by Nurse #1. Nurse # 1 was interviewed on 6/15/17 at 2 PM and clarified the entry was documentation of an incident that occurred on 6/9/17 at 3:43 PM and had not occurred on 6/10/17 at 5:12 PM as the record reflected. b. Interview with Nurse # 3 on 6/15/17 at 12:25 PM revealed she had been on duty during the dayshift on 6/10/17 (Saturday). Nurse # 3 stated she had not received a report that Resident #1	F 514	POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. Corrective action taken for the residents found to have been affected: 1a. Resident #1 no longer resides in the facility. 1b. A review of resident #2's medical record was conducted by the DON to validate the most recent assessments are reflective of the resident's current condition. 1c. A review of resident #3's medical record was conducted by the DON to validate the most recent assessments are reflective of the resident's current condition. Corrective action taken for those residents having the potential to have been affected: 2a. An assessment audit was conducted on 5/17/2017 for current residents that had falls since 6/1/2017. The audit tool included head to tote assessments, RP notifications and MD notification. 2b. The DON/designee will review the medical records for changes in condition to ensure that assessments and medical record are accurate. Measures that will be put into place or systemic changes made to ensure that the deficient practice will not occur. 3a. Re-education on fall management	

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F 514	Continued From page 97 had been bruised or injured when she reported to duty at 7:00 AM on 6/10/17. Nurse # 3 stated she found Resident # 1 had bruising on multiple body parts when two dayshift NAs (nurse aides) came to her and reported they had found bruises on the resident while giving her care. Nurse # 3 stated she immediately went to assess the resident and found her to have bruises on her back, legs, hip, and head. Review of the medical record revealed no documentation by Nurse # 3 of the bruises she had found and the time she went to assess the resident on 6/10/17. Interview with the DON on 6/17/17 at 5:30 PM revealed it was her expectation that the nursing staff document any bruising or abnormal skin areas accurately in the record until it was resolved. 2. Record review revealed Resident # 2 was admitted to the facility on 7/11/16. Record review revealed Resident # 2 had diagnoses of failure to thrive, dementia, osteoporosis, anemia, hypertension, gastro-esophageal reflux disease, anxiety, glaucoma, mood disorder, vitamin D deficiency, osteopenia, a history of multilevel compression fractures affecting 12 of the vertebra which ranged in severity from mild to severe; and a history of sternal fracture with deformity. Review of the record revealed a dayshift nursing entry by Nurse # 5 on 4/14/17 at 8:56 AM noting that the resident had a bruise to her right arm pit which measured 8 X 5 centimeters (cm.) A nurse's note dated 4/19/17 at 2:30 PM revealed the resident was seen by the (nurse practitioner)	F 514	(including safe handling of residents regarding transfers and head to toe assessment completion), documentation accuracy including dates and times, abuse/neglect policy and procedures, neurological check policy and procedure, stop and watch tool and pain management protocol will be completed by DON/designee to licensed nurses and CNAs by 7/17/2017. 3b. New employees will be educated to: fall management, which includes safe handling of residents regarding transfers, head to toe assessment completion, documentation accuracy, abuse/neglect policy and procedure, neurological check policy and procedure, stop and watch tool and pain management protocol. Monitoring 4a. The 24 hour report will be reviewed to identify changes in condition 5x/week in clinical meeting to ensure ongoing compliance with notification policy for 12 weeks. 4b. An audit of changes in condition to include: type of change, DON/designee notification, MD notification, RP notification and documentation accuracy, will be completed in clinical meeting to ensure ongoing compliance. 4c. Audit results will be reviewed by the QA and A committee monthly for 3 months.	

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F 514	Continued From page 98	F 514		

NP for a hematoma to the right axilla. According to the note the NP ordered a CT (computerized tomography) of the chest.

The NP's note on 4/19/17 revealed the resident also had a chest bruise.

Review of the CT report revealed it was completed on 4/20/17. The findings revealed the resident had an intramuscular hematoma to her right pectoralis major muscle (chest muscle) which measured 8.5 X 4.1 X 4. 6 cm.

On the same day when the CT was done (4/20/17) showing the hematoma, Nurse # 6 completed a Bi-weekly check of the resident's skin on 4/20/17. Nurse # 6 documented the resident had no current skin issues. There was no documentation on 4/20/17 of the bruise in the nursing notes on 4/20/17.

Review of a Bi-Weekly skin check dated 4/23/17 revealed Resident # 2 had bruising and hematoma to the right arm pit. The Bi-Weekly Skin Check was signed by Nurse #5.

A Bi-Weekly skin check dated 4/26/17 revealed that Resident # 2 had no current skin issues. The skin check was signed by Nurse #6. There was no documentation on 4/26/17 of the bruise in the nursing notes on 4/26/17.

On 4/29/17 Nurse # 7 documented on a Bi-weekly skin check that Resident # 2 had a bruise under her right arm.

Interview with the DON on 6/17/17 at 5:30 PM revealed it was her expectation that the nursing staff document any bruising or abnormal skin

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F 514	Continued From page 99 areas accurately in the record until it was resolved. 3. Record review revealed Resident # 3 was admitted to the facility on 9/8/16. The resident's diagnoses included but were not limited to the following: vascular dementia with behavioral disturbance, generalized weakness, glaucoma, history of cerebral infarction, osteoarthritis, major depressive disorder, anxiety disorder, and affective mood disorder. On 6/17/17 at 3 PM the ADON (Assistant Director of Nursing) was interviewed regarding falls the resident had sustained. This interview and review of the resident's medical record revealed Resident # 3 had sustained a fall on 5/27/17 at 5:09 AM and the incident had not been documented in the resident's medical record. The ADON stated the nurses should have entered the fall into the nursing notes.	F 514		