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F 000	INITIAL COMMENTS The survey team entered the facility on 02/20/19 to conduct a complaint survey and exited on 02/23/19. Additional information were obtained on 02/27/19 and 03/01/19. Therefore, the exit date was changed to 03/01/19. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tags F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 01/09/19 and was removed on 02/23/19. An extended survey was conducted.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, hospital records and medical examiner review, the facility failed to provide constant supervision during toileting for a cognitively impaired resident who was at risk for falls and fell during toileting while unsupervised. The fall resulted in right subdural hematoma (a pool of blood between the brain and its outmost covering) and fracture of the first	F 689	Grantsbrook Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents.	3/21/19

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

Electronically Signed | 03/19/2019

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F 689	Continued From page 1 thoracic vertebra (T1). (Resident #1). Immediate jeopardy began on 01/09/19 when Resident #1 had been left unattended in the bathroom and subsequently fell which caused her to sustain a right subdural hematoma and T1 fracture. The Immediate Jeopardy was removed on 02/23/19 when the facility provided an acceptable credible allegation of immediate jeopardy removal. 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 for on-going in-servicing and monitoring to be accomplished. The findings included: Resident #1 was admitted to the facility on 12/22/18. Resident #1's diagnoses included congestive heart failure, atrial fibrillation, atrial flutter, cardiac pacemaker, chronic obstructive pulmonary disease, cognitive communication deficit, difficulty in walking, muscle weakness, need for assistance with personal care, dementia without behavioral disturbance, age-related osteoporosis without current pathological fracture, lower back pain, compressed vertebra, history of falls and unspecified fracture of thoracic (T) 11-12 vertebra sequelae. A review of Resident #1's Fall Risk Evaluation, dated 12/22/18, revealed a score of 16. Instructions on the form indicated a total score of 10 or higher revealed the resident is at risk for falls. A review of Resident #1's Care Plan, last updated on 12/25/18, revealed the following:	F 689	The Plan of Correction is submitted as a written allegation of compliance. Grantsbrook Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Grantsbrook Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. On 1/9/19 at 2:32 am the assigned 11-7 shift nursing assistant put resident's shoes on and walked resident to the bathroom with assistance of a walker. Once in the bathroom, the Nursing assistant assisted resident with lifting gown, removing the brief, and sitting on the toilet. Nursing assistant left resident in the bathroom to provide privacy while standing at the door. Resident needed more time to have a bowel movement so nursing assistant went to the bed to pull resident's covers back. While pulling the bed covers back, nursing assistant heard a noise in the bathroom. Nursing assistant checked the bathroom and found resident on knees on the floor. Neurological check was completed by assigned hall nurse with no abnormal findings and no injury to resident. On 1/9/19 at approximately 7:30 am, the resident representative and physician was notified of resident #1 fall	

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F 689	Continued From page 2 1. Activities of Daily Living (ADL)/Personal Care with a goal ADLs/Personal Care will be completed with staff support as appropriate to maintain or achieve highest practical level of functioning through the next review. Interventions included, in part, transfers - stand-by assist, provide supervision, cueing, encouragement; toileting - one-person constant supervision and physical assistance for safety to adjust clothing, wash hands and peri-care. 2. Progressive decline in intellectual functioning characterized by deficit in memory, judgment, decision making and thought processes related to dementia with a goal resident's safety awareness will improve from marked impairment to mild impairment by next review. Interventions included speech therapy. 3. Risk for falls characterized by history of falls/actual falls, multiple risk factors related to weakness, impaired cognition and resident's attempts to transfer and ambulate without assistance with a goal resident will not sustain serious injury through next review. Interventions included, in part, reminder sign in room to encourage resident to call and wait for assistance with transfers and ambulation, keep call light within reach and answer timely, observe and intervene for factors causing falls and resident to wear proper and non-slip footwear. A review of Resident #1's Resident Care Guide (a communication tool used by staff for direction in the care needs of the resident), last updated 12/25/18, indicated Resident #1 had been placed on falls precautions, had required the use of non-skid footwear and had transferred with stand-by assist. The Resident Care Guide indicated Resident #1 had required one-person constant supervision and physical assistance for	F 689	with no injury. On 1/9/19 at 9:50am -10:31am resident #1 completed physical therapy with no complaints of pain initially but later complained of lower back pain. At 10:30 am, the assigned hall nurse was notified of resident's pain and reassessed the resident with pain medication administered. On 1/9/19 at 1:10pm-1:40pm resident attended physical therapy with complaint of pain. The hall nurse was notified, reassessed the resident, administered pain medication, and notified the physician of resident's pain. The Physician gave order to obtain lumbar spine x-ray. On 1/9/19 at 6:30pm resident #1 was unable to complete in-house x-ray due to complaints of pain and was sent to the emergency room via emergency medical services for further evaluation. Daughter of resident #1 was at bedside. Resident #1 never returned to the facility. 100% of all residents' care guides and care plans were audited on 2/22/19 by the Director of Nursing (DON) and Minimum Data Set (MDS) nurse to ensure the care guide and care plan accurately addresses the residents need for supervision related to toileting and at risk for falls. The care plans and care guides were updated for interventions to include required supervision related to toileting and at risk for falls during the audits for any identified area of concern. 100% audit of all current residents falls x 30 days was initiated on 2/21/19 and completed on 2/22/19 by the Registered Nurse (RN) Facility Consultant to ensure all incidents were investigated	

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F 689	Continued From page 3 safety to adjust clothing, wash hands and peri-care during toileting. A review of Resident #1's admission Minimum Data Set (MDS), dated 12/29/18, revealed Resident #1 had been severely cognitively impaired and required extensive assistance with a 1-person physical assist for toileting. The MDS indicated Resident #1 had not been steady and had only been able to stabilize with staff assistance during transitions and walking. The MDS indicated Resident #1 required the use of a walker or a wheelchair as a mobility device. A review of Resident #1's Care Area Assessment (CAA), dated 12/29/18, revealed Resident #1 had not been steady when moving on and off the toilet and had only been able to stabilize with staff assistance. The Analysis of Findings indicated the problem/need had been actual and stated the nature of the problem/condition as follows: Resident #1 "was admitted to this facility from home on 12/22/18 ... Her diagnoses included ... weakness, atrial flutter, dementia, recent T11-12 fracture and acute on chronic congestive heart failure (CHF) ... She is dependent on staff for assistance with all Activities of Daily Living (ADLs) ... She has exhibited continence since admission, despite need for assistance with toileting. Resident attempts to perform transfers and ambulation without assistance due to her inability to recognize limitations and she has had falls since admission." The CAA indicated Resident #1's underlying problems that may affect function included changing cognitive status, mood decline and fall. The CAA indicated Resident #1's physical limitations such as weakness, limited range of motion, poor coordination, poor balance, visual impairment or pain resulted in her need for	F 689	for root cause with appropriate interventions initiated based on the root cause, resident was assessed following incident, physician /Resident Representative (RR) notified, and care plan/care guide updated. All areas of concern were immediately addressed by the Director of Nursing (DON) by 2/22/19 to include assessment of resident, investigating incident to determine root cause, initiating appropriate interventions based on root cause, notification of Physician/RR and updating care plan/care guide with any new interventions. 100% observation of all nursing assistants and nurses was initiated on 2/22/19 and completed on 2/27/19 by the Director of Nursing (DON), Minimum Data Set (MDS) nurse and Admission nurse to ensure the care guides and care plans are being read in the mobile ipads and followed for required supervision during toileting to prevent accidents. There were no other identified areas of concern during the audit. 100% in-service of nursing assistants and nurses was initiated by the Admission nurse on 2/22/19 and completed on 3/6/19 in regards to (1) reading and following the resident care guide and care plan located in the mobile ipad for required supervision and at high risk for falls during toileting to prevent accidents. (2) Definition of constant supervision to include within arm's reach and eyes view of the resident at all times. All newly hired nursing assistants and nurses will be in-serviced by the Staff Facilitator during	

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F 689	Continued From page 4 assistance with any of the ADLs. A review of the Incident/Accident reports revealed Resident #1 had three falls from her admission on 12/22/18 to her discharge on 01/09/19. Resident #1 had an unwitnessed fall without injury in her room on 12/23/18. Nurse #1 completed the Incident Report which included the following description: "At 5:05 a.m., resident was observed lying on floor on her back trying to lift her torso in an attempt to get up from the floor. Resident's head was near left side of bed and feet were facing window. Resident alert and oriented to self. Denied hitting her head. Active range of motion (AROM) times four. Denied any pain. Resident's socks were removed and grip slippers applied. Assisted to standing position by two staff. Able to bear full weight without pain or difficulty. Assisted to bathroom by one staff with use of walker ... Assisted back to bed ... Call bell in reach. Bed maintained in low position." During an interview with Nurse #1 on 02/21/19 at 3:33 p.m., Nurse #1 stated she had been the nurse assigned to care for Resident #1 on 12/23/18. Nurse #1 stated Resident #1 had been in her bed prior to the fall and the fall had been unwitnessed. Nurse #1 stated she did not recall how she had been made aware of Resident #1's fall. Nurse #1 stated she went to Resident #1's room and the resident was not lying flat on the floor, her torso was halfway up. Nurse #1 stated she had completed a head-to-toe assessment on the resident which had been negative for injuries. Nurse #1 had asked the resident if she was okay and stated the resident had denied pain. Nurse #1 stated she had also observed the resident for non-verbal signs of pain and there had been	F 689	orientation. Nurses and nursing assistant are required to read the resident care guide located in the mobile ipads for updates of care to include interventions for residents that require supervision during toileting and are at risk for falls. 25% of nurses and nursing assistants will be observed during toileting and residents at risk for falls by the Admission nurse, treatment nurse and MDS nurse utilizing the Resident Care Toileting Audit Tool weekly x 8 weeks then monthly x 1 month. This audit is to ensure nurses and nursing assistants are reading and following care guide and care plan located in the mobile ipads in regards to providing supervision with toileting to prevent accidents. All areas of concern will be immediately addressed by the Admission nurse, MDS nurse and treatment nurse to include re-training of staff during the audit. The DON will review and initial the Resident Care Toileting Audit Tool weekly x 8 weeks then monthly x 1 month to ensure all areas of concern were addressed. The DON will forward the Resident Care Toileting Audit Tool to the Executive QA Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months and review the Resident Care Toileting Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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none. Nurse #1 stated she had thought Resident #1 had been on her way to the bathroom and she had noticed the resident did not have on non-skid socks which she removed and replaced with non-skid socks and then assisted her to the bathroom and then back to bed. Nurse #1 stated Resident #1 had a history of always wanting to do things on her own and had never known a time when Resident #1 had called for assistance.

Resident #1 had an unwitnessed fall which resulted in a skin tear over her left eye on 12/28/18 at 3:11 p.m. Nurse #2 completed the Incident Report which included the following description: "Code green (resident fall) called to room 218. Resident found on bathroom floor. Injury noted skin tear over left eye. Medical Doctor (MD) and daughter notified. Area cleansed with normal saline solution (NSS), skin prep applied. Area measures 2 centimeters (cm), well approximated, steri-strips (wound closure strips) applied. No dressing, left open to air. Non-skid footwear in use. Intervention, when awake, will be at nurses' station or with staff as resident allows. No other injury noted. Assisted to wheelchair and brought to nurses' station."

During an interview with Nurse #2 on 02/21/19 at 4:11 p.m., Nurse #2 stated she had been working on 12/28/19 as the Quality Improvement nurse. Nurse #2 stated whenever a Code Green is announced, all available staff respond. Nurse #2 stated she had helped out the nurse assigned to Resident #1 after the resident had fallen. Nurse #2 stated Resident #1 had sustained a skin tear over one of her eyes as a result of the fall but could not recall whether it had been over the left or right eye. Nurse #2 stated she had cleansed the skin tear and approximated the wound edges

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with steri-strips. Nurse #2 stated she had wanted to ice the wound however Resident #1 would not allow it. Nurse #2 stated notifications had been made to the MD and the responsible party and neurological (neuro) checks had been performed on the resident. Nurse #2 stated Resident #1 had been at her baseline confusion after the fall.

Resident #1 had an unwitnessed fall on 01/09/19 at 2:32 a.m. Nurse #3 completed the Incident Report which included the following description: "called by Nursing Assistant (NA) to resident bathroom. Resident observed sitting on floor with walker in front of her. Stated she fell attempting to ambulate from bathroom. Resident assisted up and ambulated with walker with stand-by assist back to bed. Denies complaints of injury. Resident assessed and no apparent injury noted. Neuro checks unchanged. Resident reoriented to calling for assistance, even has signs in room."

During an interview with Nurse #3 on 02/21/19 at 3:35 p.m., Nurse #3 stated she had been the nurse assigned to care for Resident #1 on 01/09/19. Nurse #3 stated she did not witness Resident #1's fall. Nurse #3 stated the NA had told her she had turned her back on the resident for a second to get the walker to bring it to the bathroom and when she returned, the resident was on the floor, against the wall in an "L" shape, close to the toilet paper holder. When asked if the NA had left the bathroom, Nurse #3 stated she did not know. When asked if she investigated the cause of the fall, Nurse #3 stated she just knew what the NA had told her. Nurse #3 stated she had performed a head-to-toe assessment of the resident and it had been negative for injury. Nurse #3 stated neuro checks performed on the resident had been negative.

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Nurse #3 stated she and the NA stood the resident and she asked the resident if she was hurting and the resident stated no. Nurse #3 stated Resident #1 had been known for not waiting for assistance and her balance had been off. Nurse #3 stated Resident #1 had been able to walk but had always been very unsteady on her feet and the resident would often jump right up without using her walker. When asked about her intervention of re-orienting a cognitively impaired resident to call for assistance, Nurse #3 stated she had been taught by the board of nursing to always educate a patient even if the patient was not able to retain the information.

During interviews with NA #1 on 02/22/19 at 10:10 a.m. and 02/23/19 at 5:28 a.m. , NA #1 stated she had been an NA for 45 years and had worked at the facility for 5 years. NA #1 stated she had been the NA assigned to care for Resident #1 from 11:00 p.m. on 01/08/19 until 7:00 a.m. on 01/09/19. NA #1 stated she had been making her rounds when she noticed Resident #1 sitting up on the side of her bed. NA #1 stated she entered the resident's room and asked her if she needed something. NA #1 stated the resident told her she had to use the bathroom. NA #1 stated she had raised the bed, put shoes on the resident and got the resident's walker. When asked how she knew the resident's transfer needs, NA #1 stated she asked the resident if she could walk and stated the resident told her she could. NA #1 stated she took Resident #1 to the bathroom and the resident sat on the toilet. NA #1 stated she gave Resident #1 about 10 minutes and then asked her if she was ready to get up and stated the resident told her no because she had needed to have a bowel movement. NA #1 stated she then

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told the resident, "don't move, sit here, I'm going to straighten the bed up, let me know when you're ready." NA #1 stated at that time she did not know whether or not Resident #1 had Alzheimer's but she had been able to answer her questions. NA #1 stated she had been at the resident's bed straightening it up when she heard a "bump" noise in the bathroom and stated she returned to the bathroom and found the resident on her knees. NA #1 stated she had asked Resident #1 if she had been hurt and stated the resident had said no. NA #1 stated she told the resident to "sit there a while," put the walker near her, and called for Nurse #3 to come to the bathroom. NA #1 stated Nurse #3 entered the bathroom and had asked the resident if she was hurt and the resident stated no. NA #1 stated Nurse #3 checked the resident's body for bruises and none were noticed. NA #1 stated she and Nurse #3 stood the resident and took her back to her bed. When asked how residents' care needs are communicated to her, NA #1 indicated she would get a verbal report from the off-going NA or read the resident Point of Care (POC) in the electronic health record. NA #1 stated this had been the first time she had cared for Resident #1 and stated she had not been aware of the resident's history of falls or cognitive status. NA #1 stated she had not received verbal report from the off-going NA nor read Resident #1's POC prior to beginning her shift on 01/08/19. NA #1 stated she had planned on talking with Resident #1's nurse prior to beginning of her shift on 01/08/19 but could not find her at the time and began her duties.

A review of therapy notes, dated 01/09/19, revealed the following:
1. 9:50 a.m. - "patient participated in transfer

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training to increase level of independence. Patient performed supine to sit with moderate assistance. Patient reports pain in low back. Patient transferred from bed to wheelchair with moderate assist secondary to low back ... Notified nurse of patient reports of low back pain."
2. 1:10 pm - "patient performed 6 reciprocal steps with lumbar, thoracic and cervical region flexion along with shuffling gait pattern during gait training with rolling walker, minimal assist and wheelchair follow when patient reported increased pain in lumbar back and required a prolonged seated rest break and reported pain 6/10 after rest break."
3. 2:47 p.m. - "patient complained of back pain and discomfort, her nurse was already aware."

A review of nurse progress notes revealed the following:
1. 01/09/19 at 1:19 p.m. - "obtained order from doctor ... via telephone order for lumbar spine x-ray with complaint of lower back pain."
2. 01/09/19 at 3:24 p.m. - "complaint of lower back pain; PRN (as needed) pain medication given without any relief. Lumbar spine x-ray ordered."
3. 01/09/19 at 6:36 p.m. - "observed resident is in excruciating pain during diagnostic procedure, was not able to tolerate. Order to send to emergency department (ED) for further evaluation and treatment. Responsible Representative (RR) is present. Rescue was called."
4. 01/10/19 at 6:59 a.m. - "this nurse called (local hospital) to follow up on resident and was informed that she was being sent to (trauma center) for fractured back ..."
5. 01/10/19 at 2:40 p.m. - "01/09/19 as day progressed mid-morning to afternoon, resident

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began to complain of low back pain. MD re-called and order for mobile x-ray obtained. X-ray attempted, resident in pain and daughter asked if resident to go to the ED. New order obtained to transport to ED for evaluation ..."

A review of Resident #1's Medication Administration Record for January 2019 revealed the resident had been administered acetaminophen 500 milligrams (mg) for pain on 01/09/19 at 10:13 a.m.

A review of the "Nursing Home to Hospital Transfer Form, dated 01/09/19, listed the reason for Resident #1's transfer to the hospital as "pain (uncontrolled)."

A review of the hospital records indicated Resident #1 had been transferred to a local hospital and then transferred to a trauma center at another hospital.

A review of the local hospital ED notes, dated 01/09/19, revealed the following:
1. History of Presenting Illness - " ... presents to the Emergency Department (ED) after having several falls over the past few weeks, most recently this morning when she was getting up from the toilet ... the patient's daughter is at bedside and reports that the patient as had approximately 5 falls in the past few weeks. She reports that she hit her head during some of those falls but the daughter is unsure if she hit her head this morning. Upon Emergency Medical Services (EMS) arrival, the patient was complaining of lumbar back pain and EMS administered 75 mcg of Fentanyl (an opiate pain medication) prior to arrival ... Patient denies any complaints at this time."

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F 689	Continued From page 11 2. Computed tomography (CT) spine cervical without contrast - "T1 moderate acute compression fracture." 3. CT head or brain without contrast - "interval development of mild temporoparietal subdural hemorrhage. This appears to be subacute in nature." 4. Review of Systems: "musculoskeletal - no back pain, neck pain, joint pain, muscle pain, normal range of motion and strength x 4, no tenderness or swelling; neurologic - no headaches, focal weakness, numbness, speech problems, steady gait; general - alert and oriented x 2, no focal deficits, grasps strong and equal bilaterally; eyes - patient's left pupil is irregularly shaped and 4 millimeters (mm) in diameter. Her right pupil is 2 mm." 5. Medical Decision Making: " ...patient denies any complaints at this time. Upon assessment the patient is oriented to self which the daughter reports is her baseline. She is awake and alert. Her grasps are strong and equal bilaterally. She moves all 4 extremities independently and to command. She has no focal weaknesses appreciated. The patient's pupils, however, are unequal. Her left pupil is irregularly shaped and approximately 4 mm in size. Her right pupil is 2mm and round. The patient's daughter denies any known history of irregularly shaped or unequal pupils. She denies any neck pain or back pain at this time. She does not grimace upon rotation of her hips or movement of her knees, elbows, shoulders. Denis any neck pain ... The patient does have a healing laceration to the left portion of her forehead, approximately 3 centimeters (cm) in length ... The patient's head CT did reveal a right temporoparietal subdural hemorrhage that appears to be subacute in nature."	F 689		

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6. Clinical Impression: "1) right subdural hemorrhage; 2) T1 compression fracture; 3) fall; 4) dementia; 5) atrial fibrillation"
A review of Resident #1's trauma center's discharge summary, dated 01/17/19 revealed " ...does not respond verbally much. Grunting slowly. Not in any acute serious distress. Admitted initially after fall at nursing home. Found to have acute on chronic subdural hematoma. Was admitted under trauma service. Family decided for palliative care and comfort measures. She was transferred to palliative care unit overnight. All non-comfort medications were stopped. Discussed with doctor ... about plan of care. She requested patient to be transferred to inpatient hospice services."

A review of Resident #1's Certificate of Death, dated 01/19/19, indicated the immediate cause of the resident's death to be "complications of blunt force injury of head and back." The Medical Examiner indicated the injury occurred as "fell, struck head and back" and listed the location of the fall as the address of the nursing facility.

During an interview with the Medical Examiner on 03/01/19 at 2:05 p.m., the Medical Examiner stated Resident #1's fall of 01/09/19 played a significant role in her death. The Medical Examiner stated Resident #1's death was brought about from complications of the fall.

During an interview with the Director of Nursing (DON) on 02/23/19 at 9:34 a.m., the DON stated it was her expectation nursing staff follow the care guide they have set up for them to use when caring for a resident.

During an interview with the Administrator on

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02/23/19 at 9:52 a.m., the Administrator stated it was his expectation staff provide residents the care they need as set up in their individualized plan of care.

The Administrator was notified of the Immediate Jeopardy on 02/22/19 at 4:30 p.m. On 02/23/19, the facility provided the following credible allegation of Immediate Jeopardy removal:

The process that lead to deficiency
Resident # 1 is alert and oriented to self. Resident diagnosis includes cognitive communication deficit, difficulty walking, muscle weakness generalized, dementia, and unspecified fracture of T11-12 vertebra, osteoporosis, congestive heart failure, major depressive disorder and gastrointestinal hemorrhage. On 1/9/19 at 2:32 am the assigned 11-7 shift nursing assistant put resident's shoes on and walked resident to the bathroom with assistance of a walker. Once in the bathroom, the Nursing assistant assisted resident with lifting gown, removing the brief, and sitting on the toilet. Nursing assistant left resident in the bathroom to provide privacy while standing at the door. Resident needed more time to have a bowel movement so nursing assistant went to the bed to pull resident's covers back. While pulling the bed covers back, nursing assistant heard a noise in the bathroom. Nursing assistant checked the bathroom and found resident on knees on the floor. Neurological check was completed by assigned hall nurse with no abnormal findings and no injury to resident. On 1/9/19 at approximately 7:30 am, the resident representative and physician was notified of resident #1 fall with no injury. The 11-7 assigned nursing assistant was trained on safe handling

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and movement which includes reading the resident care guides prior to resident care during orientation on 6/6/14 by the Director of Nursing. The nursing assistant's most recent training on reading the resident's care guide prior to providing care was on 10/5/18 by the Director of Nursing. On 1/9/19 at 9:50am -10:31am resident #1 completed physical therapy with no complaints of pain initially but later complained of lower back pain. At 10:30 am, the assigned hall nurse was notified of resident's pain and reassessed the resident with pain medication administered. On 1/9/19 at 1:10pm-1:40pm resident attended physical therapy with complaint of pain. The hall nurse was notified, reassessed the resident, administered pain medication, and notified the physician of resident's pain. The Physician gave order to obtain lumbar spine x-ray. On 1/9/19 at 6:30pm resident #1 was unable to complete in-house x-ray due to complaints of pain and was sent to the emergency room via emergency medical services for further evaluation. Daughter of resident #1 was at bedside. Resident #1 never returned to the facility.

--The procedure to implement a plan of Immediate Jeopardy removal for specific deficiency

100% of all residents' care guides and care plans will be audited on 2/22/19 by the DON and MDS nurse to ensure the care guide and care plan accurately address the residents need for supervision related to toileting and at risk for falls. The care plan and care guide will be updated for interventions to include required supervision related to toileting and at risk for falls during the audits for any identified area of concern. The audit will be completed by 2/22/19. 100% audit of

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all falls x 30 days was initiated on 2/21/19 by the Facility Consultant to ensure all incidents were investigated for root cause with appropriate interventions initiated based on the root cause, resident was assessed following incident, physician /Resident Representative (RR) notified, and care plan/care guide updated. All areas of concern will be immediately addressed by the Director of Nursing (DON) to include assessment of resident, investigating incident to determine root cause, initiating appropriate interventions based on root cause, notification of Physician/RR and updating care plan/care guide with any new interventions. The audit will be completed by 2/22/19.

100% observation of all nursing assistants and nurses was initiated on 2/22/19 by the Director of Nursing (DON), Minimum Data Set (MDS) nurse and Admission nurse to ensure the care guides and care plans are being read in the mobile iPads and followed for required supervision during toileting to prevent accidents. All areas of concern will be addressed during the audit by the DON, MDS nurse and Admission nurse to include re-training of the nursing assistant and/or nurse. The audit will be completed by 2/22/19. After 2/22/19 any nursing assistant or nurse that has not worked will be audited on the next scheduled shift.

100% in-service of nursing assistants and nurses was initiated by the Admission nurse on 2/22/19 in regards to (1) reading and following the resident care guide and care plan located in the mobile iPad for required supervision and at high risk for falls during toileting to prevent accidents. (2) Definition of constant supervision to include within arm's reach and eyes view of the resident at all times. In-services will be completed by 2/22/19. After 2/22/19, the Medical Records

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F 689	Continued From page 16 Director will mail the in-services via certified mail to any nursing assistant or nurse who has not received the in-service with instructions to review, sign the in-service, and return to the DON or Admission Nurse prior to next scheduled work shift. All newly hired nursing assistants and nurses will be in-serviced by the Staff Facilitator during orientation. --The procedure for monitoring the plan of Immediate Jeopardy removal The decision to monitor required supervision during toileting was made by the Administrator on 2/22/19. Nurses and nursing assistant are required to read the resident care guide located in the mobile iPads for updates of care to include interventions for residents that require supervision during toileting and are at risk for falls. 25% of nurses and nursing assistants will be observed during toileting and residents at risk for falls by the Admission nurse, treatment nurse and MDS nurse utilizing the Resident Care Toileting Audit Tool weekly x 8 weeks then monthly x 1 month. This audit is to ensure nurses and nursing assistants are reading and following care guide and care plan located in the mobile iPads in regards to providing supervision with toileting to prevent accidents. All areas of concern will be immediately addressed by the Admission nurse, MDS nurse and treatment nurse to include re-training of staff during the audit. The DON will review and initial the Resident Care Toileting Audit Tool weekly x 8 weeks then monthly x 1 month to ensure all areas of concern were addressed. The initial Quality Assurance (QA) meeting to review the plan of Immediate Jeopardy removal was held on 2/22/2019.	F 689		

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The DON will forward the Resident Care Toileting Audit Tool to the Executive QA Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months and review the Resident Care Toileting Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.

--The title of person responsible for implementing the plan of Immediate Jeopardy removal

The Administrator and DON are responsible for the implementation of corrective actions to include all 100% audits, in-service and monitoring related to the plan of Immediate Jeopardy removal.

--Date corrective action completion

Final Immediate Jeopardy removal date was 2/22/19.

The Credible Allegation for Immediate Jeopardy removal was validated on 02/23/19 which removed the Immediate Jeopardy on 02/22/19. Interviews were conducted with nursing staff present in the facility on 02/23/19. The staff confirmed the recent in-services and trainings related to following the plan of care as described in the residents' Care Guides and the definition of "constant supervision." Reviews of the in-service records, audit tools, audits performed and facility assessments were made.