STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 11/01/2019

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PEAK RESOURCES - BROOKSHIRE, INC	**300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278**

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F 000	INITIAL COMMENTS The survey team entered the facility on 10/1/19 to conduct a complaint investigation survey and exited on 10/5/19. Immediate Jeopardy was identified at CFR 483.25 at tag F689 at a scope and severity (J) for example 1. The tag F689 constituted Substandard Quality of Care. An extended survey was conducted. Additional information were obtained on 10/10/19 for example #2. Per management review, example 2 of tag F689 was determined to be at the immediate jeopardy level also. The facility was notified and a credible allegation of removal for example #2 was accepted on 10/25/19. Validation of the credible allegation of removal for example #2 occurred on 11/1/19. Therefore, the exit date was changed to 11/1/19. Immediate Jeopardy for example #1 began on 9/22/19 and was removed as of 10/5/19. Immediate Jeopardy for example #2 began on 4/3/19 and was removed as of 4/4/19 . Event ID# N8UW11. 3 of the 14 complaint allegations were substantiated resulting in deficiencies.	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	F 689		11/15/19

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

Electronically Signed | 11/12/2019

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F 689	Continued From page 1 §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 observation, staff, Physical Therapist, nurse practitioner, radiologist, and physician interviews and facility and hospital record reviews, the facility failed to provide supervision in accordance with Resident #1's 9/20/19 care plan when the resident who was assessed to be at a high risk for falls experienced 3 falls within a one-hour period of time. The third fall resulted in a transfer to the hospital where the resident was diagnosed with a large subdural hematoma. He expired at the hospital within 5 hours of the third fall. The facility also failed to transfer Resident #7 using 2 staff members and a mechanical lift according to her care plan which resulted in an incident where the resident received a left transverse, mildly comminuted fracture of the proximal tibia and fibula. This occurred for two of three sampled residents reviewed for accidents. Immediate Jeopardy for Resident #1 began on 9/22/19 when Resident #1 experienced two unwitnessed falls and then a third fall within a one hour period without increased supervision with intensity as identified on the care plan. The last fall resulted in increased weakness and a significant change in his mental status. Resident #1 was transferred to the hospital and diagnosed with a large subdural hematoma; he expired on 9/23/19 at 12:35 AM. Immediate Jeopardy for Resident #1 was removed as of 10/5/19 when the facility implemented an acceptable allegation of Immediate Jeopardy removal.	F 689	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. It is solely created to demonstrate our good faith attempt to continue to provide a quality of life for all our residents. I. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident#1 Audit that was completed on 09/24/2019 indicated that only one resident was affected by the alleged noncompliance. The affected resident was transported to the hospital on 9/22/2019 and did not return to the facility. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Resident #1 The clinical team reviewed all falls, new admissions, and changes in condition from 9/24/19 through 10/4/2019. No additional residents were identified	

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F 689	Continued From page 2 Immediate Jeopardy for Resident #7 began on 4/3/19 when a nursing assistant (NA #2) transferred Resident #7 by a mechanical lift without the assistance of a second person. NA #2 did not notify the facility, and initially told the facility that she had the help of another staff in the transfer. NA#2 also asked NA#1 to tell the facility that she helped NA#2 with transfering Resident #2. The resident sustained a comminuted fracture of the proximal tibia and fibula. Immediate Jeopardy for Resident #7 was removed as of 4/4/19 when the facility implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "D" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to complete staff education and ensure monitoring systems put into place are effective. The findings included: 1. Resident #1 was admitted to the facility on 8/23/19 from the hospital for rehabilitation. His cumulative diagnoses upon admission to the facility included a history of multiple falls, hydropneumothorax (the presence of both air and fluid within the space between the lungs and chest cavity) and multiple rib fractures. A review of the resident ' s medical record included a baseline care plan dated 8/23/19. The care plan noted Resident #1 was assessed to have a high fall risk score of 21 from his admission assessment. A fall risk score of greater than 13 was indicative of a high risk.	F 689	3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Resident #1 Going forward, all residents will be reviewed in morning clinical meeting regarding falls experience, falls risk and falls interventions. All Residents will be assessed for fall risk on Admission, quarterly, and with any fall occurrence. Nurses will be educated to implement interventions on all residents that are identified as high risk. This education was initiated on 9/24/19 and completed on 10/04/2019. The supervision protocol described in step 3 below was initiated on 10/04/19 by the DON for all employees currently in the building. Staffing will be assigned as needed to accommodate the supervision protocol. On 10/04/2019 the supervision protocol described below was initiated by the DON for all employees currently in the building. Staffing will be assigned as needed to accommodate the supervision protocol. The SDC educated 100% of licensed nursing staff on the facility fall policy, to include the importance of documentation of falls; intervention implementation at time of incident; the need to place new interventions with every fall; and revising care plan. The education included levels	

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F 689	Continued From page 3 A review of Resident #1 ' s medical record included the following Interdisciplinary Team (IDT) progress notes, in part: --8/23/19 at 7:31 PM: "Resident OOB (out of bed) walking unassisted through BR (bathroom) into next room - bed alarm sounding. Resident assisted back to room and to bed by nursing staff. Alarm in place and functioning." --8/30/19 at 12:47 AM: "Resident was in his own bed at start of shift, appeared to be resting comfortably. During HS (hour of sleep or bedtime) med pass, resident was noted to be standing in (another resident ' s room), with only shirt and socks on ... Around 0030 (12:30 AM), nurse heard a bed alarm sounding, and it was coming from his room. Resident had gotten out of Bed A and was sitting on Bed B. Resident was attempting to put the fitted sheet back on the bed." The nurse assisted him back to Bed A (his bed). --9/1/19 at 11:55 PM: "This writer was notified that residents bed alarm was sounding, and that he was standing in his room, holding onto his bedside table. When this writer approached resident he was happy to say he had found his car. Resident had no physical evidence of pain or distress. He was placed in his wheelchair, and brought out to common area for closer supervision ..." Review of an Event/Incident report dated 9/4/19 at 1:15 PM revealed Nursing Assistant (NA). found Resident #1 in a doorway sitting on the floor in front of his wheelchair. The resident was reported to have been attempting to stand/transfer unassisted. The notes indicated the wheelchair ' s brakes were not locked and, "Resident was not strong enough to hold his weight and ended up falling straight down to floor	F 689	of appropriate supervision titled Supervision protocol. Supervision Protocol Definitions: In Eyesight- indicates a resident must always be in sight of staff. Arms Length-indicate that a resident must always be in reach of staff One on One - indicates that staff must always be with resident Repeat fallers must be placed on a higher level of supervision after each fall and, for such residents, the SDC will educate staff regarding the need for heightened supervision prior to the start of their next shift. Any licensed nurse on vacation or leave of absence was educated prior to returning to their assignment. Any new licensed nurse will be educated by the Staff Development Coordinator/designee upon hire, during orientation. Education for licensed nursing staff will also be completed annually and as needed by the DON/SDC/designee. This education was completed on 10/4/2019. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. For Resident #1: An audit tool was developed to include a list of all residents who have sustained a fall and to determine if appropriate interventions are in place and on the care plan. The audit tool also monitors all new admissions	

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F 689	Continued From page 4 onto his buttocks from standing position." Resident #1 did not complain of pain. A physical assessment was completed and reported he had some blanchable redness (skin becomes lighter with pressure and color returns immediately with release) on his buttocks. Vital signs were stable. No new orders or fall interventions for this event were noted. A notation on the report indicated the resident was being sent out to the hospital on that date. Review of an Event report dated 9/4/19 at 2:42 PM reported Resident #1 was sent out to the hospital for evaluation of right-sided weakness. A review of the resident ' s hospital records revealed he was admitted to the hospital with a chief complaint of altered mental status; his right-sided weakness was noted to be resolved. Hospital records included the resident ' s history of present illness (dated 9/5/19) which reported a computed tomography (CT) scan of his head was negative for acute changes. Resident #1 was treated and discharged back to the facility on 9/13/19 with a principal discharge diagnosis of aspiration pneumonia. A review of the resident ' s medical record included a second baseline care plan (dated 9/13/19) for his readmission to the facility. The care plan noted Resident #1 was assessed to have a high fall risk score of 22 at that time. Safety interventions identified on this baseline care plan included the following, in part: bed alarm; low bed; mats on the floor; and non-skid socks. A review of Resident #1 ' s medical record included the following IDT progress notes, in part: --9/15/19 at 7:08 PM: "Received report from	F 689	who are at high risk for falls to ensure that appropriate interventions are identified on the residents□ care plan. This audit will also determine if a resident with multiple falls requires progressive supervision. Audits were initiated on 9/24/19 and will be done by the DON/RN Supervisor/designee daily Monday through Friday for 60 days, then ongoing weekly by the Interdisciplinary Team at Clinical At Risk Meeting. Audits done on Monday will review all falls/admissions from Friday through Sunday. The results of these audits were brought to the QAPI Committee by the DON on 10/30/2019 for further review and recommendations. Ongoing Audits will be brought by the DON to the next quarterly QAPI meeting for further review and recommendations. II. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #7 A root Cause analysis (RCA) was conducted by the DON on 04/03/2019. It was determined that there was sufficient staff, and each hall had its own functioning set of mechanical lifts that were easily accessible to staff. Plenty of the lift pads were also available. There were three Unit-managers in addition to the floor nurse and the hall NAs that were available to assist. The DON's RCA indicated that Resident #7 Plan of care accurately identified her as a 2-person	

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F 689	Continued From page 5 previous shift nurse that resident is fidgety, anxious, and requires constant supervision throughout shift; upon arrival of tour, resident is noted to be making multiple attempts to exit wheelchair, walk without assistance, states that he needs to go home, or also that he needs to be present somewhere to sign a document; makes offers to staff to pay them money if they will give him a ride to 'home' or another destination on (name of a specific road). After multiple redirection and constant supervision resident is currently sitting quietly in chair. Note in MD (Medical Doctor) book to provide further assessment." --9/17/19 at 3:39 AM: "At start of shift tonight, resident was noted to be in wheelchair by nursing cart on hall. Resident made several attempts to stand up without assistance. While this nurse was passing medications tonight, resident was seated beside med cart as well. Resident continued to stand up and walk whenever this nurse was out of his sight. Resident was seen taking off his PCA alarm (personal alarm) also several times. This nurse stopped med pass on two occasions and allowed resident to walk in the hallway while holding rail beside him. Nurse pulled wheelchair behind him and held his free hand on both occasions. Immediately prior to this note, resident was seen standing in the middle of the hallway, one door up from his room ...Notified MD of residents restless behaviors this shift." --9/17/19 at 1:15 PM: "Resident noted ambulating in hallway unassisted this shift. Alarm sounding, w/c (wheelchair) in room and resident walking up hallway several times. Assisted back to w/c by nursing staff and PSA (personal alarm) alarm replaced." --9/18/19 at 12:37 AM: "At the start of shift, resident was laying comfortably in his bed, he	F 689	transfer using (mechanical) lift. It was identified that (NA#2) had received appropriate training on Mechanical lift usage upon hire and as recent as 03/14/2019. It was determined that the NA used poor judgement and decision-making ability on the date of the incident, as evidenced by failing to follow facility policy requiring the use of 2 persons with a mechanical lift for Resident # 7 and by her attempting to coerce her coworker into lying on her behalf. Resident # 7 was transported to the local hospital for treatment and returned to the facility on 4/6/2019 with an immobilizer since the family did not want surgery for her. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Resident #7 Audit that was completed on 04/03/2019, identified only one resident (resident #7) as being affected by the alleged non-compliance. Initial Audit was completed on all residents that utilized a mechanical lift on 04/03/2019. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Resident #7 The DON/Staff Development Coordinator (SDC) educated 100% of licensed nursing staff and certified nursing assistants on facility policy regarding transfers with	

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F 689	Continued From page 6 appeared to be sleeping. During medication pass, resident was seen sleeping in Bed A (not his bed), in his own room. Resident was resistant to going into his own bed, so nurse advised CNA (Certified Nursing Assistant) to let him remain where he is, and to try again later in the shift." Review of a psychiatric consult revealed the resident was seen by a geriatric neuropsychiatry provider on 9/18/19 for initiation of a treatment plan and ongoing management. The resident was started on 125 milligrams (mg) Depakote (a mood stabilizer) to be given every night at bedtime for three nights, then twice daily. The assessment/plan read, in part: "Very impulsive with poor safety awareness contributing to attempts to get up independently and falls." Resident #1 ' s medical record also included a progress note written on 9/19/19 at 1:29 AM which read, "Resident up out of bed and ambulating room and hallway without assistance multiple times this shift, requires constant supervision and redirection from daytime staff members; after several episodes of exiting bed, setting off bedside alarm and attempting ambulation in room with multiple redirects from staff for safety, resident currently sleeping quietly in bed." Further review of the resident ' s medical record revealed he was seen by a Nurse Practitioner (NP) on 9/19/19 upon request of nursing due to agitation and restlessness. The NP ' s notation indicated nursing reported Resident #1 was confused with poor safety awareness and poor impulse control. He was reported as requiring constant redirection and reorientation. The NP ' s notation indicated measures already being	F 689	mechanical lifts, following the resident plan of care, reporting changes in condition, including injuries, and the zero-tolerance policy for failure to follow facility policies and procedures. This was completed on 4/4/19. Any licensed nurse or CNA on vacation or leave of absence was educated prior to returning to their assignment. Any new licensed nurse or CNA will be educated by the Staff Development Coordinator/designee upon hire, during orientation. Education for licensed nursing staff and CNA□s will also be completed annually and as needed by the DON/SDC/designee. Weekly Audits were completed for 3 months by the SDC nurse and the SDC continues to complete random spot audits monthly for compliance. Incidents/Accidents are reviewed 5 days a week by clinical team and no incidents have been identified as a result of non-compliance with mechanical lifts. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. For Resident #7: A Transfer Order Audit tool was developed. This tool audits residents for transfer orders to ensure that all transfer orders are accurate and reflected on resident care plan. Audits were completed on 3 residents per week for 4 weeks, then 3 residents per month for 2 months. A mechanical lift audit tool was also developed. This tool audits staff to ensure that residents are being	

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F 689	Continued From page 7 implemented by staff to address his behavior and risk for falls included pain assessment/management, frequent redirection, reorientation, toileting and personal alarm as well as adjusting his bed to a low position. It was also noted the resident ' s family had declined aggressive evaluation and treatment and the MD indicated he was going to be transitioned to palliative care. On 9/19/19, a diagnosis of "Impulsiveness" was added to Resident #1 ' s list of diagnoses. A review of the resident ' s most recent Minimum Data Set (MDS) was a 5-day assessment dated 9/20/19. Section C of the MDS assessment revealed the resident had moderately impaired cognitive skills for daily decision making. Section G of the MDS reported the resident required extensive assistance with 2+ person physical assistance for bed mobility and transfers; he required limited assistance with one person physical assistance for toileting and walking in his room; and supervision with 1 person physical assistance for walking in the corridor. Section J of the MDS assessment revealed the resident had experienced two falls with injury (not major) since his last assessment. Section O of the assessment revealed the resident received Physical Therapy (PT) rehabilitation services 4 of the last 7 days with a start date of 9/13/19. Review of an Event/Incident report dated 9/20/19 at 8:08 PM revealed the resident had an unwitnessed fall on 9/20/19 at 4:00 PM. A summary of the investigation reported after a concert in the Dining Room, he was moved by the Activities Director (AD) to the Activity Room to do a puzzle. The AD noted she turned around to retrieve the puzzle from a desk across the hall.	F 689	transferred according to their transfer order and care plan. Audits were completed on 3 residents per week for 4 weeks, then 3 residents per month for 2 months.Random audits will be completed by the SDC, as needed. The results of these audits were brought to the Quality Assurance and Performance Improvement Committee by the DON on July 17, 2019 and again on October 30, 2019 for further review and recommendations. Ongoing Audits will be brought by the DON to the next quarterly QAPI meeting for further review and recommendations. 5. Corrective Action Completion Date for POC is 11/15/2019	

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When she returned 20-30 seconds later with the puzzle, she found Resident #1 on the floor. A narrative note included on the Event/Incident report dated 9/20/19 at 8:08 PM further described the incident. It read, "Resident stood up from his wheel chair and fell in the activities room at approximately 4pm. Resident stated he thought he hit his head on the bookcase. There is a bump on his right forehead and two small cuts over his right eyebrow. Physical assessment done. He MAEB (moved all extremities well), w/o (without) complaint of pain, no bruising noted. Neurochecks started and WNL (within normal limits). MD informed and (family member) informed during visit with resident at 5pm. Oncoming nurse informed. Will continue to monitor." Orders (interventions) for this event included, in part: every 15 minute checks; and, monitoring his status every shift for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to fall.

A review of Resident #1 ' s medical record included an individualized care plan with an area of focus related to the resident ' s risk for falls due to confusion/unsteady gait (created on 9/20/19). The interventions included the following, in part: increased staff supervision with intensity based on resident need (initiated on 9/20/19).

Review of a Neurological Observations Form revealed periodic neurochecks and vital signs were initiated on 9/20/19 at 4:15 PM through 9/22/19 at 1:15 PM with no concerns identified. A Resident Monitoring Sheet initiated after the fall on 9/20/19 revealed the resident ' s location was recorded every 15 minutes from 9/20/19 through 9/22/19 at 8:30 PM.

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Review of an Event/Incident report revealed Resident #1 was found on the floor of his room after experiencing an unwitnessed fall on 9/22/19 at 7:35 PM. A notation from 9/22/19 at 7:47 PM [recorded as a late entry on 9/23/19 at 10:47 AM by Nurse #1] read: "Resident had an unwitnessed fall in his room approximately 1935 (7:35 PM). Nurse went in to assess resident. He was sitting on his bottom with his back and head against the wall. Resident denies pain, and has no physical evidence of such. Full ROM (range of motion) in all 4 extremities without difficulty. Resident had strong hand grips in both hands. Nurse placed her foot in front of resident feet, held both hands, and assisted resident to a standing position, and then walked him 3 steps to his wheelchair. Nurse noted bleeding to left elbow after resident was seated there. Nurse cleansed elbow with NS (normal saline), applied TAO (triamcinalone ointment), covered with dry gauze, and secured it with tegaderm (a transparent film dressing). Resident stated he needed to use the bathroom when nurse finished treatment, so nurse assisted him to bathroom and notified CNA of event. Resident had PCA in place while on the commode. No further concerns at this time." Orders (interventions) for this event were noted on the Event/Incident report to included, in part: Ensure resident is in sight of nursing staff at all times while awake.

Review of a second Event/Incident report from 9/22/19 revealed at approximately 7:50 PM that evening, the resident's alarm sounded and he was found to have experienced an unwitnessed fall in the bathroom. A Nursing notation dated 9/22/19 at 7:50 PM [Recorded as late entry on 9/23/19 at 11:34 AM by Nurse #1] read as follows: "This nurse had brought resident to the bathroom

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after he stated he needed to use the toilet. Nurse attached PCA to resident ' s shirt and grab bar behind him due to high falls risk, then notified CNA of resident ' s location, and asked that she assist him off the commode while nurse contacted MD. Resident ' s alarm was sounding within minutes of being placed on commode. He was found sitting on his buttocks with shoulders resting on wall behind him. Resident denies pain or discomfort, and has no new visible injuries. Resident has full ROM in all 4 extremities and strong hand grasps. Residents LOC (level of consciousness) was at baseline. No slurred speech noted. Resident was assisted to standing with 2 staff members, and placed in wheelchair. Resident had PCA attached to shirt, and was sat in front of nurses station for close supervision. Nurse attempted to contact resident ' s (family member) again, to notify her of skin tear from previous fall, and of second fall. No answer at this time either."

A review of a third Event/Incident report dated 9/22/19 revealed Resident #1 experienced a third fall from his wheelchair while sitting near the nursing station at approximately 8:30 PM on 9/22/19. A Nursing notation made on the report read as follows: [Recorded as Late Entry on 09/23/2019 12:37 PM by Nurse #1] "While resident was sitting in wheelchair at nursing station, he was noted to be reaching for his brakes on several occasions. It also appeared as if resident was trying to stand up, but did not succeed. Nurse verbally redirected resident to stay seated to ensure safety. Approximately 2030 (8:30 PM), resident fell onto floor, landing on his right side. It appeared as if resident was pushing off his chair to stand, and it gave out. Wheelchair did fall onto its side as well, but landed just

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behind resident. This nurse called 911 and resident ' s (family member) again, and again got no answer. (Family member) called back and spoke with this nurse just as 911 call ended. During this conversation, she requested resident be sent to (name of hospital) for evaluation ... A second nurse was at resident ' s side while the phone calls were being made. Resident was log rolled onto his back, keeping neck as straight as possible, for thorough assessment. Resident was noted to have weakness in BUE (bilateral upper extremities) and non-reactive pupils. Resident was moving, as if trying to get up off the floor, but with noted weakness. Resident was attempting to respond verbally as second nurse was speaking with him, but he was unable to form words. Due to the significant changes after this fall, nursing staff allowed resident to stay on the floor until EMS (Emergency Medical Services) arrived to transport him to (name of hospital). Nursing staff was at his side the entire time, providing comfort and support. EMS left with resident around 2045 (8:45 PM). Resident had been on neuro checks at start of shift, which were being done as per order. New neuro checks started after initial fall this shift."

A review of the hospital Emergency Department records from 9/22/19 revealed Resident #1 was not responsive to painful stimuli upon arrival to the hospital. A CT scan indicated he had a large subdural hematoma suggestive of recurrent hemorrhage. There was no indication on the report as to when the resident may have sustained a previous subdural hematoma. The family did not wish to have invasive interventions so comfort care measures were taken. Resident #1 passed away on 9/23/19 at 12:39 AM.

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An initial interview was conducted on 10/2/19 at 12:43 AM with Nurse #1 and follow-up telephone interviews were completed on 10/4/19 at 8:00 AM and 10/4/19 at 10:35 AM. Nurse #1 was the hall nurse who was assigned to care for Resident #1 the evening of 9/22/19 from 7:00 PM to 7:00 AM when he experienced three falls. Upon inquiry, the nurse described the events surrounding the resident ' s falls on 9/22/19. Nurse #1 reported she was in a room directly across the hall from Resident #1 ' s room when she heard his PCA alarm going off at the time of his first fall. When she entered the room, the resident was sitting up with his back against the wall, "almost like he had landed against the wall and slid down." She reported he sustained a skin tear on his elbow with only a small amount of bleeding. Nurse #1 stated she also noticed a bruise on the resident ' s head first after the 1st fall, but it appeared to be an old bruise. The nurse reported the resident did not complain of pain, had full range of motion, and was able to stand up from the floor with assist of one then take two steps with assistance to his wheelchair. Nurse #1 reported the resident ' s strength and cognitive status were at baseline after the fall. The nurse reported she took him in the wheelchair to the treatment cart to get supplies for his skin tear. Resident #1 told her he needed to go to the bathroom, so she took him to his bathroom and helped him get seated on the commode. She connected his PCA alarm (described as an alligator clip that sounds when it is disconnected) to the resident ' s clothing and the grab bar in the bathroom while he was on the commode. The nurse reported she used the PCA alarm for the resident while he was on the commode as a precaution only because he had just had a fall. She stated she was still in the resident ' s room when she told NA (Nursing

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Assistant) #3 to come into the bathroom to supervise the resident. The nurse reported she did not intend to leave him unattended. Nurse #1 then went to the nursing station and called his MD and family about the falls. When asked, the nurse stated she did not know how long NA #3 stayed with him. The nurse reported that just before 8:00 PM, she heard Resident #1 ' s alarm go off while she was on the phone at the nursing station. She recalled staff went to check on the resident (including herself, NA #3, Nurse #3). Nurse #3 assessed the resident after the fall and he did not appear to have any new injuries at that time. Nurse #1 stated NA #3 brought the resident in his wheelchair to the central area near the nursing station after that second fall. The nurse reported as she worked on passing medications on the hall, she would "put my eyes on him and at least look ...I saw him trying to mess with the brakes and appear to start to get up and would remind him to be seated." Around 8:30 PM, Nurse #1 recalled she heard the resident ' s PCA alarm sound again. Although she did not see him actually fall, she stated it appeared he ' d slipped out of the wheelchair and he landed on his right side with the wheelchair tipped over behind him. Nurse #1 reported both she and Nurse #3 went over and simultaneously agreed the resident needed to be sent out to the hospital for evaluation, "because it was obvious he had hit his head this time." The nurse reported although his vital signs were not abnormal, the resident was less responsive and much weaker after this third fall.

A telephone interview was conducted on 10/2/19 at 12:33 PM with NA #3. NA #3 was identified as the nursing assistant assigned to care for Resident #1 the evening of 9/22/19 from 7:00 PM

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to 7:00 AM when he experienced three falls. The NA reported her assignment for that evening included two partial halls plus Resident #1 on a 3rd hallway. When asked, the NA described the events surrounding Resident #1 ' s falls on 9/22/19. NA #3 reported she had last checked on Resident #1 approximately 45-60 minutes prior to his first fall. After Resident #1 ' s first fall, she went to his room to see what had happened and if he was okay. When she entered the room, Nurse #1 and NA #4 had already helped him into his wheelchair. The NA stated she observed "a knot" on the resident ' s head at that time. After the resident fell a second time, she reported Nurse #1 called her to the resident ' s room. When she got to the room, she saw the resident in the bathroom as staff were transitioning him to his wheelchair. Upon further inquiry, NA #3 reported she was not aware Resident #1 was in his bathroom until after he had fallen the second time. She reported the resident did not appear to have any apparent injuries after his second fall. The NA stated she took Resident #1 in his wheelchair to the nursing station and locked the wheelchair brakes. When asked why she brought him there, the NA stated she wanted to place him "where everyone could keep an eye on him." Approximately 10-15 minutes after he was brought to the nursing station, NA #3 stated she turned around a corner and saw him standing up. She told him to sit down and he did. A little while later, the NA reported the resident stood up again and fell down hard as he hit the tile floor.

An interview was conducted on 10/3/19 at 2:26 PM with Nurse #2. A follow-up interview was completed with the nurse on 10/4/19 at 11:35 AM. Nurse #2 was the day shift (7:00 AM - 7:00 PM) hall nurse who was sitting at the nursing station

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the evening of 9/22/19 when Resident #1 experienced three falls. Upon inquiry, the nurse stated she saw Resident #1 being brought to the area by the nursing station while she was finishing up her charting for the day. Nurse #2 reported she was not sure who brought the resident to the nursing station, but did hear Nurse #1 say, "I ' ve got some meds to give." Nurse #2 stated she was aware the resident was a high fall risk and needed to be watched. She did not recall anyone specifically asking her to keep an eye on the resident. Nurse #2 reported she heard Resident #1's chair alarm go off and she saw the resident as he began to stand up unassisted. The nurse reported she immediately told the resident to sit down and before she could get around the desk to him, he had already fallen. Nurse #2 identified the position where she was sitting at the nursing station, as well as where Resident #1 was sitting in his wheelchair.

On 10/4/19 at 11:42 AM, the Maintenance Director was observed as he measured the height of the nursing station desk to be 45 and ½ inches high. On 10/4/19 at 11:55 AM, the Maintenance Director provided results of an additional measurement taken. Based on their reported locations, he determined Nurse #2 would have needed to walk 342 inches (28 and ½ feet) in order to get around the nursing station desk to where Resident #1 ' s wheelchair had been placed.

An observation and a follow-up interview was conducted on 10/4/19 at 1:50 PM with Nurse #2. The observation of the nurse sitting at the nursing station revealed her eyes were approximately at the same level as the top of the desk at the nursing station. During an interview conducted

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with Nurse #2 at that time, the nurse was asked if she had been able to see the resident over the top of the desk when he was placed in the area of the nursing station on the night of 9/22/19. The nurse reported she could see "the top of his head" from where she was sitting because the resident was tall.

An interview was conducted on 10/3/19 at 6:55 AM with NA #4. NA #4 was identified as the NA who was assigned to care for all residents on Resident #1 ' s hall (with the exception of Resident #1) from 7:00 PM - 7:00 AM on the evening of 9/22/19. NA #4 reported Resident #1 ' s hallway was her usual assignment and that she was typically assigned to care for him as well. She recalled Resident #1 was a fall risk and would constantly get up unassisted. She stated the resident ' s alarm, "would go off constantly" and reported she would go in to check on him and "two minutes later the alarm would go off again." During the interview, NA #4 was asked to recall the events involving Resident #1 on the evening of 9/22/19. The NA reported when she went into the resident ' s room after his first fall that night, he was lying down on the floor beside his bed and Nurse #1 was already in the room with him. She stated the resident said he hit his head, but didn ' t say he was hurting anywhere. At that time, she could not see any unusual marks on his head. She assisted Nurse #1 to get him off of the floor, then left. After Resident #1 fell a second time that night, the NA recalled coming down the hallway when she heard his alarm sounding and Nurse #1 calling for NA #3 to help with the resident. The NA reported she saw NA #3 walking into the resident ' s room. When NA #4 got to his room, the resident had already been helped up into his wheelchair after having a

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fall in the bathroom. The NA stated she noticed Resident #1 started to develop a "knot" on his head, but she wasn ' t sure if it was from his first or second fall. "This time he said he hit his head again when he fell." The NA reported the resident was still acting fine (normal) after the second fall. Resident #1 was brought to the nursing station. The next time NA #4 saw the resident was when she was coming down the hall and he was lying on the floor near the nursing station (after the third fall that evening).

An interview was conducted on 10/2/19 at 1:15 AM with Nurse #3. Nurse #3 was identified as a hall nurse (not assigned to Resident #1 ' s hall) who worked the evening of 9/22/19 when the resident experienced three falls. Upon inquiry, Nurse #3 described the events of 9/22/19 surrounding the time of his falls. Nurse #3 reported she was not directly involved with the resident ' s first fall. However, Nurse #3 stated she went down to the resident ' s room after his second fall. When she entered the room, she saw NA #3 and NA #4 in the room with the resident already sitting in his wheelchair. The nurse stated she assessed the resident and checked his range of motion and hand grips. When she asked him what his name was, he spelled it for her. She recalled the NAs brought the resident out to the nursing station to "keep an eye on him." Nurse #3 reported she was passing medications on another hall when she heard a noise that attracted her attention. She looked down the hall and saw Resident #1 lying on the floor on his right side by the nursing station. The nurse went to check him and reported, "I got down on my hands and knees and started asking him questions...but he couldn ' t answer me. He tried to talk but nothing came out." The nurse

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stated she used a flashlight to check his pupils and they were non-reactive. She reported 911 was called within 5 minutes of the fall. Nurse #3 stated she stayed on the floor with the resident (did not move him) until EMS arrived and put him on the gurney.

An interview was conducted on 10/4/19 at 1:55 PM with the Physical Therapist (PT) who was familiar with Resident #1. The PT reported she had completed the resident ' s Evaluation (dated 9/13/19) and Discharge Summary (dated 9/22/19). She reported therapy was working with the resident on strengthening, balance, wheelchair mobility and safety. Upon review of Resident #1 ' s Discharge Summary, the therapist confirmed the resident required minimum assist or upper extremity support to stand without loss of balance; he was unable to weight shift. He required contact guard assist and verbal cues for transfers. During the interview, the PT reported the resident was "a very high fall risk" and stated he needed someone to be with him all the time when he was transferred, walking and standing. Upon further inquiry, the therapist reiterated Resident #1 required someone touching him and cueing him for safety when he stood up and/or walked.

An interview was conducted on 10/2/19 at 11:30 AM with Resident #1 ' s MD, who also served as the facility ' s medical director. During the interview, the MD recalled the resident and reported his confusion and impulsive behavior were likely the cause of his falls. The MD stated she felt the resident was evaluated in regards to the potential causes of his falls and she felt interventions were implemented appropriately by the facility. "I think everything was done that

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could have been." During follow-up interviews conducted on 10/2/19 at 12:08 PM and 10/2/19 at 1:40 PM, the MD noted Resident #1 ' s family declined doing an imaging scan (magnetic resonance imaging or MRI) during his 9/4/19-9/13/19 hospital stay, so it could not be determined if he had a possible subdural hematoma at that time. The MD reported Resident #1 ' s hospital ED records appeared to indicate the cause of his death was a large subdural hematoma. When asked, she stated it may not be possible to determine which fall was the cause of the subdural hematoma. The MD noted the hospital radiology report from 9/22/19 suggested this was a recurring hematoma.

Interviews were conducted with the Director of Nursing (DON) on 10/3/19 at 9:30 AM and 1:30 PM. During the interview, the DON discussed the procedures staff were expected to follow after a resident experienced a fall. She reported the hall nurse was required to do an assessment of the resident and to try and gain an understanding of what transpired so an intervention could be put into place to prevent future falls. After the resident was taken care of, she would expect the nurse to notify the resident ' s physician and family and to initiate appropriate interventions. If the fall was unwitnessed, neurochecks would also need to be initiated so the resident was monitored for any changes. Additionally, she would expect the nurse to document the fall on an Incident Report, an "Investigation Sheet" (a supplemental, hand-written form), and in the resident ' s medical record. The DON reported in-servicing on the topic of falls/accidents was initiated for the nurses on 9/23/19. A review of the list of nurses educated to date was conducted. The DON acknowledged not all nurses had received the

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in-service education as of this date (10/3/19).

The facility ' s Administrator and Director of Nursing were notified of Immediate Jeopardy on 10/4/19 at 2:35 PM. On 10/5/19 at 10:20 AM, the facility provided the following credible allegation of Immediate Jeopardy removal:

#1 Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

Audit that was completed on 09/24/2019 indicated that only one resident was affected by the alleged noncompliance. That resident will be referred to as Resident #1. All residents are reviewed in morning clinical meeting. The clinical team reviewed all falls, new admissions, and changes in condition from 9/24/19 through 10/4/2015. No additional residents were identified.

#2 Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

The alleged non-compliance resulted from failure to initiate interventions to ensure resident safety by nurse #2.

All Residents will be assessed for fall risk on Admission, quarterly, and with any fall occurrence. Nurses will be educated to implement interventions on all residents that are identified as high risk. This education was initiated on 9/24/19 and completed on 10/04/2019. The supervision protocol was initiated on 10/04/19 by the DON for all

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employees currently in the building. Staffing will be assigned as needed to accommodate the supervision protocol.

The education will include levels of appropriate supervision.

Supervision Protocol:
In Eyesight- indicates a resident must always be in sight of staff.
Arms Length-indicate that a resident must always be in reach of staff
One on One - indicates that staff must always be with resident

Education will include repeat fallers must be placed on a higher level of supervision after each fall. SDC will provide the education to all nursing staff prior to the start of their next shift.

Title of the person responsible for implementing the credible allegation for Immediate Jeopardy removal:
The Administrator and the Director of Nursing Services will be ultimately responsible to ensure the implementation of credible allegation to remove this alleged immediate jeopardy.
Immediate Jeopardy Removal Date: 10/5/19

The credible allegation was verified on 10/5/19 at 12:30 PM as evidenced by licensed and non-licensed nursing staff interviews on each of the halls. Nursing staff had been educated on the implementation of appropriate interventions for residents identified as a high risk for falls. Interventions included the facility ' s "Supervision Protocol." Interviews with the licensed and unlicensed staff confirmed they were in-serviced prior to working on the floor. The facility ' s

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credible allegation of immediate jeopardy removal was verified as having been implemented as of 10/5/19.
2. Resident #7 was admitted to the facility on 3/27/18 and diagnoses included osteopenia, displaced intertrochanteric fracture of right femur, osteoporosis with left hip replacement and stroke.

An annual Minimum Data Set (MDS) dated 3/14/19 for Resident #7 revealed she required extensive two-person assistance with bed mobility, transfers, and personal hygiene. Resident #7 cognitive skill was noted as severely impaired on this MDS. She used a mechanical lift for transfers and had a history of falls before admission to the facility. Resident #7 last fall was in January 2019 with no injury noted on care plan.

A care plan dated 3/18/19 for Resident #7 indicated the resident needed 2- person assistance with a mechanical lift for transfers, unless otherwise advised.

A review of the "Investigation Summary" revealed the DON interviewed nursing assistant (NA) #2 who was assigned to Resident #7 on 4/3/19 from 7am to 7pm. NA #2 indicated she transferred Resident #7 from bed with a mechanical lift with the assistance from NA #1. NA #2 stated she showered Resident #7 after getting her out of bed. NA #2 stated no incident occurred during the transfer. NA #2 did indicate Resident #7 complained of leg pain but had complained of leg pain on prior occasions. NA #2 also indicated the previous shift reported the resident complained of leg pain. After interviewing NA #1, it was determined that NA #2 transferred resident without the assistance of another staff member which was in violation of facility policy. NA #2 was

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asked if she would like to revise her statement. NA #2 resigned and did revise her statement. NA#1 told the DON that she did not assist NA #2 with the transfer.

During a telephone interview with NA # 2 on 10/3/19 at 2:00pm, she revealed she was employed at the facility on 4/3/19 and worked with Resident #7. NA #2 indicated she got to Resident #7's room first that morning because Resident #7 had a history of trying to get out of bed. Initially, NA #2 stated she used the mechanical lift with a second person. Later in the interview, NA #2 changed her statement to say she transferred Resident #2 to the shower bed without a second staff member present because they were short of staff. She also indicated that she never hit Resident #7 hip or leg during this process. NA #2 denied any trauma during care and treatment of Resident #7. NA #2 also indicated that she resigned that day because of other issues with the facility.

A review of statement from Nurse #12, assigned to Resident #7 on 4/3/19, indicated that on 4/3/19, around 10:30am she went into Resident #7's room to administer medications and noted Resident #7 in wheelchair leaning over trying to put her shoe on. Her right shoe was on and the left shoe was off. Nurse #12 attempted to put the left shoe on, and the resident complained of pain. Upon assessment, it was noted her left foot was swollen and a blister was noted to the anterior lower extremity inferior to the knee. The blister measured approximately 1 centimeter (cm) by 2 cm with bluish discoloration noted under the knee.

An interview with Nurse #12 on 10/3/19 at

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12:30pm revealed she went to Resident #7's room around 11:00am on 4/3/19 to pass out the residents' medication. Nurse #12 indicated she also administered pain medications because Resident #7 complained of left leg pain during this visit. Nurse #12 indicated she reported Resident #7's condition to the Director of Nursing (DON) and Unit Manager because the resident's left foot was swollen, and blisters were on the anterior lower extremity inferior to her knee.

The Unit Manager was no longer employed by the facility at the time of the survey and several attempts to interview her were unsuccessful.

Review of a Skin Data form (completed by Nurse #12) for Resident #7 dated 4/3/19 revealed "Location of Bruises/Discolored arm right, legs left, and left knee: 11am noted below left knee a blood blister, approximately 1cm x 1.5cm x 5cm and multiple smaller bluish (areas) below the Left knee. Left knee, calf and ankle appear swollen, discolored. Left wrist has dark purple bruise. Right index finger has purple bruise and bruise on the back of the hand. And by 2:00 pm the blood blister under the knee enlarged to 5cm x 3.5cm, x 1.5 cm depth. Wrapped loosely with dry gauze and kerlix."

A review of "Statement from the Facility" revealed (on 4/3/19) at around 12:30pm nursing assistant (NA) #1 went to get Resident #7 from room for restorative dinning. At this time, Resident #7 was in her wheelchair and again needing assistance with sock and shoe to the left foot. NA #1 attempted to place sock and shoe on and Resident #7 stated" my leg is broken." NA #1 took Resident #7 to the nurse for further assessment. The nurse indicated the blister had increased to

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approximately 5cm by 3.5cm and applied dry dressing.

A review of "Statement from the Facility" dated 4/3/19 revealed that on 4/3/19 at approximately 12:40pm, it was brought to the attention of the Unit Manager by NA #1 that Resident #7 complained of left leg pain. Upon assessment, it was noted her left leg was discolored with bluish color bruising, had several blisters and swelling to knee and foot, and noted internal rotation of left lower extremity. The Nurse Practitioner (NP) was in the facility and she completed assessment and new orders were received to get an x-ray stat (immediately). Resident #7 was placed back into bed from the wheelchair via mechanical lift. Three staff members were present to stabilize her left lower extremity during the transfer. Resident #7 received pain medication. Facility continued to monitor Resident #7 to ensure no distress noted. The family was made aware of findings and new orders.

During an interview on 10/2/19 at 11:10 am, NA #1 stated that she was working with Resident #7 on 4/3/19 around 12:30 pm. She reported Resident #7 to the nurse because the resident complained of left foot and leg pain and she was not able to put Resident #7's shoe on her left foot. NA #1 also indicated that NA #2 who was assigned to Resident #7 wanted her to tell the facility she had assisted her with a transfer of the resident using the mechanical lift from the bed to the shower bed on that day. NA#1 stated that she had not helped NA #2 with this transfer.

A progress note from the Nurse Practitioner dated 4/3/19 stated Resident #7 with "diagnoses of Alzheimer's, insomnia and HTN (hypertension)

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was seen today for swollen left leg and knee. Resident seen today per nursing staff concerns of swollen left leg and knee. During today's visit resident was sitting in wheelchair with complaints of left leg and hip pain. Left lower extremity was swollen, tender to touch, no warmth and limited range of motion. Facial grimaces with slight movement. Blister located on anterior tibia. Minimal redness around knee. Resident was unable to verbalize cause of injury. Plan: left leg painful and swollen. Left hip pain with x-ray of left leg and left hip done. Pain management-tramadol prn (as needed), Tylenol."

A phone interview was held with the NP on 10/3/19 at 1:00pm and revealed she was present on the day of the incident with Resident #7. The NP revealed she was called to the resident's room to complete an assessment because of the resident's pain issues and swollen leg and foot. The NP reported she evaluated and noted the resident's left leg was discolored with bluish color bruising, several blisters and both her left knee and foot were swollen. The NP indicated she ordered an x-ray.

During a chart review dated 4/3/19 revealed that at approximately 4:00pm the facility received x-ray results which indicated acute fracture of left proximal tibia and fibula metaphysis. Resident #7's physician was made aware and new order were received to send her to emergency room (ER). Resident #7's (family member) was in the facility during this time and went to the ER with the resident.

Review of the radiology report dated 4/3/19 for Resident #7 revealed results of the left knee showed there was diffused bone

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demineralization. There were new acute impacted fracture deformities involving the proximal tibia and fibula metaphyses, suprapatellar joint effusion and mild degenerative changes. The conclusion was: Acute proximal tibia-fibula fractures.

The hospital record for Resident #7 dated 4/3/19 revealed she presented with chief complaint of left lower leg pain. There was a bruise of the pretibial region with blisters and minimal tenderness to palpation of the area. The resident did not grimace or withdraw to palpation. The resident and the family did not want surgery.

A nurses' note dated 4/6/19 at 11:42am indicated Resident #7 arrived back to the facility via emergency medical services with immobilizer intact to extremity. Immobilizer needed to be worn, with transfers and while sleeping. Also, the resident may wear the immobilizer during the day as tolerated.

An observation of Resident #7 on 10/2/19 at 11:00am revealed she was in her wheelchair out in the hall next to her room. She was observed with a soft lower left foot boot. Resident #7 showed no signs of discomfort during this observation.

During an interview with facility physician on 10/3/19 at 3:00pm revealed he was aware of this incident that the NA did not use a second staff when transferring Resident #7 and he felt the fracture was unavoidable due to the resident's age, history of osteoporosis and osteopenia. The physician indicated that a wrong move in the bed might have caused the injury.

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During an interview on 10/4/19 at 2:00pm, the Administrator and Director of Nurses revealed that the investigation was completed. They concluded they may never know with 100% certainty what happened to Resident #7, but felt that NA#2 was neglectful in violating the facility policy regarding lift usage. NA #2 knowingly and willfully violated the policy and then attempted to have her co-worker lie on her behalf. The Administrator stated it was his expectation all staff follow the policies for mechanical lift transfers for all residents. He added the facility had a zero tolerance for staff not following policy.

An interview via the phone with the Radiologist on 10/10/19 at 10:52am was conducted. The Radiologist stated the fractures of the proximal tibia and fibula were acute and traumatic. It was almost impossible to determine the exact cause of the fracture with the osteopenia/brittle bones. It was not uncommon to sustain these fractures which were sometimes called insufficiency fractures. The bones were not at their normal strength.

The facility ' s Administrator was notified of Immediate Jeopardy on 10/25/19 at 8:00am . On 10/25/19 at 12:55pm, the facility provided the following credible allegation of Immediate Jeopardy removal:

#1 Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:
Audit that was completed on 04/03/2019, identified only one resident (resident #7) as being affected by the alleged non-compliance. Initial Audit was completed on all residents that utilized

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a mechanical lift on 04/03/2019. Weekly Audits were completed for 3 months by the SDC nurse and the SDC continues to complete random spot audits monthly for compliance.
Incidents/Accidents are reviewed 5 days a week by clinical team and no incidents have been identified as a result of non-compliance with mechanical lifts.
#2 Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.
The alleged non-compliance resulted from (NA #2) failure to follow resident care plan, facility policy regarding transfers, and not notifying the facility of the injury. A root Cause analysis (RCA) was conducted by the DON on 04/03/2019. It was determined that there was sufficient staff, each hall had its own functioning set of mechanical lifts that were easily accessible to staff. Plenty of the lift pads were also available. There were three Unit-managers in addition to the floor nurse and the hall NAs that were available to assist. The DON's RCA indicated that Resident #7 Plan of care accurately identified her as a 2-person transfer using (mechanical) lift. It was identified that (NA#2) had received appropriate training on Mechanical lift usage upon hire and as recent as 03/14/2019. It was determined that the NA used poor judgement and decision-making ability on the date of the incident, as evidenced by her attempting to coerce her coworker into lying on her behalf.

In-servicing was initiated immediately on 04/03/2019 with all licensed nursing staff and NAs by the DON and the SDC nurses. All nursing staff was in-serviced by 04/04/2019 and were not allowed to return to their assignment until they

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were in-serviced. Education included abuse policy and reporting, Facility policy regarding transfers with mechanical lifts, following the resident Plan of Care, reporting change in conditions including injuries, and the zero tolerance for failure to follow facility policies and procedures. In service was completed on 04/04/2019. All licensed nursing staff and CNAs were in-serviced prior to returning to their assignments.
All licensed nursing staff and (NAs) will be educated on facility policy regarding transfers with mechanical lifts, following the resident Plan of Care, reporting change in conditions including injuries, and the zero tolerance for failure to follow facility policies and procedures upon hire during orientation, annually, and as needed.

The Administrator and the Director of Nursing Services will be ultimately responsible to ensure the implementation of credible allegation to remove this alleged immediate jeopardy.
The immediate jeopardy was removed on 4/4/19.

The credible allegation was verified on 11/1/19 at 4:30 PM as evidenced by licensed and non-licensed nursing staff interviews on each of the halls. Nursing staff had been educated on the appropriate use of lifts for residents who required the use of mechanical lifts for transfers. Nursing staff was also educated on reporting behaviors, abuse and neglect, and recognizing change in condition. Interventions included lift training, transfer, inspecting lifts and the number of staff required while using the lift. Interviews with the licensed and unlicensed staff confirmed they were in-serviced prior to working on the floor.
The facility ' s credible allegation of immediate jeopardy removal was verified as having been implemented as of 4/4/19.

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