| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 000 | INITIAL COMMENTS<br><br>A complaint investigation and revisit survey was conducted from 11/19/20 through 12/02/20. Event ID #E4E611. 1 of 1 complaint allegation was substantiated resulting in a deficiency.<br><br>Immediate Jeopardy was identified at:<br><br>CFR 483.12 at tag F600 at a scope and severity J.<br><br>The tag F600 constituted Substandard Quality of Care.<br><br>Immediate Jeopardy began on 11/09/20 and was removed on 11/25/20. An extended survey was conducted. | F 000 | | |
| F 600 SS=J | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by: | F 600 | | 12/18/20 |

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

Electronically Signed | 12/19/2020

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| F 600 | Continued From page 1<br>Based on record review and interviews with the Medical Examiner, attending physician, Responsible Party (RP), and staff, the facility neglected to monitor and assess Resident #1 ' s neurological condition and vital signs following a fall in which the resident hit his head on concrete. The facility also neglected to provide accurate information to Resident #1 ' s attending physician and the RP on the details of the fall by reporting that the resident fell onto a grass surface rather than concrete. This failure caused the physician to keep the resident at the facility for monitoring rather than sending the resident out for evaluation at the Emergency Room (ER). Resident #1 fell and hit his head on concrete on 11/9/20 at 9:55 AM and was found unresponsive at 12:48 PM. The Certificate of Death, dated 11/9/20, indicated the cause of death was "blunt force head trauma". Additionally, the facility neglected to complete neurological assessments for Residents #2, #3, #4, and #5 after unwitnessed falls. This was for 5 of 5 residents reviewed for falls.<br><br>Immediate Jeopardy began on 11/9/20 when Dietary Staff #1 witnessed Resident #1 fall backward in his wheelchair hitting his head on a concrete walkway outside of the facility and his assigned nurse, Nurse #1, neglected to obtain information from the witness to the fall (Dietary Staff #1) and subsequently reported inaccurate information to Resident #1 ' s physician stating that he fell and hit his head on a grass surface. Nurse #1 then neglected to follow the physician ' s orders for monitoring Resident #1 and completing neurological assessments (including vital signs) per facility protocol. Nurse #1 neglected to complete 5 of the neurological assessments that were due on 11/9/20 between 10:15 AM and 12:48 PM (10:15 AM, 10:45 AM, | F 600 | F-600<br><br>This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident.<br><br>Root Cause:<br>The Administrator and the Director of Nursing discussed with the interdisciplinary team quality assurance performance improvement plan committee team (Administrator, Director of Nursing, Staff Development Coordinator, Admissions Director, Housekeeping Supervisor, Scheduler, Dietary Manager, Medical Records Coordinator, Business Office Manager, Assistant Business Office Manager, and Maintenance Director) on 12/02/2020 to identify the root cause of this alleged non-compliance. Root cause analysis conducted revealed that the alleged non-compliance resulted from inadequate training/understanding of the staff on how to properly investigate a fall, assess and complete neurological checks on a resident that hit their head and document conversations with both the responsible party and physician. | |

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| F 600 | Continued From page 2<br>11:30 AM, and 12:00 PM) with her last assessment of Resident #1 being completed at 10:30 AM. At 12:48 PM (11/9/20) Resident #1 was found unresponsive in bed in his room. The cause of Resident #1 ' s death on the Death Certificate was "blunt force head trauma". Immediate Jeopardy was removed on 11/25/20 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy Removal. The facility will remain out of compliance at a lower scope and severity level E (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) for Examples #2, #3, #4, and #5 to correct the deficient practice and to ensure that the education and the monitoring systems put in place to remove the Immediate Jeopardy are effective.<br><br>The findings included:<br><br>1. Resident #1 was initially admitted to the facility on 5/27/12 and most recently readmitted to the facility on 10/21/20 with diagnoses that included Gastrointestinal (GI) bleed, respiratory failure, Chronic Obstructive Pulmonary Disease (COPD), heart disease, hypertension (HTN), hyperlipidemia (HLD), personal history of Transient Ischemic Attack (TIA), personal history of cerebral infarction, and speech disorder.<br><br>The hospital discharge summary dated 10/21/20 indicated Resident #1 was hospitalized from 8/30/20 through 10/7/20 for COVID pneumonia (PNA) complicated by acute hypoxic respiratory failure and new onset of atrial fibrillation. He was previously on Plavix (antiplatelet medication) and aspirin for secondary stroke prevention. This was | F 600 | For affected resident(s):<br>Resident #1 no longer resides in the facility. Residents #2, #3, #4, and #5 did not experience any adverse outcomes due to the alleged non-compliance.<br><br>For other residents with the potential to be affected:<br>All residents have the potential to be affected by this alleged non-compliance and as a result, the systemic changes stated below have been put in place to prevent any risk of affecting additional residents.<br><br>Facility plan to prevent re-occurrence:<br>On 11/23/2020 the Administrator, Director of Nursing (DON), and nurse management team-initiated re-education to all staff regarding neglect. An example was given that the failure to obtain neurological checks and ongoing assessment of a resident's status after a fall with head injury could be considered neglect. Education was completed on 11/24/2020.<br><br>On 11/23/2020 the DON initiated re-education to the nursing staff on the importance of completing neuro checks, assessment, notification, and following the physician orders after a fall. The nursing staff was also re-educated to ask the Unit Managers, Staff Development Coordinator, and/or the Director of Nursing should they have any questions or require guidance and assistance with a resident that has had an acute change. | |

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| F 600 | Continued From page 3<br>changed to aspirin and Xarelto (anticoagulant medication) during the 8/30/20 to 10/7/20 hospitalization. On 10/14/20 Resident #1 presented to the hospital with melena (black, tarry stool usually associated with GI bleed) which was confirmed by Emergency Room (ER) rectal exam. He was admitted to the hospital and a colonoscopy was conducted which revealed diverticulitis and 3 small polyps were resected from his transverse colon. Following the procedure there was no active bleeding and gastroenterology felt it was okay to resume his anticoagulant (Xarelto). His hemoglobin was stable, and he was discharged back to the facility on 10/21/20. His discharge medication orders included Xarelto 15 milligrams (mg) once daily.<br><br>The annual Minimum Data Set (MDS) assessment dated 10/21/20 indicated Resident #1 ' s cognition was severely impaired. He required extensive assistance of 1 with bed mobility and transferred only once or twice with the assistance of 2 or more. He was coded for locomotion on/off unit as only happening once or twice with 1 assist. Resident #1 had no functional impairment with range of motion and utilized a wheelchair.<br><br>The Care Area Assessment (CAA) related to cognitive loss for Resident #1 ' s 10/21/20 MDS indicated he had difficulty with completing thoughts or ideas but was able to complete them when prompted and given ample time. He was noted to be incontinent of bowel and bladder, wore an adult brief, and had bowel movements that had blood present since his last hospital stay. He was at risk for falls related to poor balance, poor safety awareness, and impaired cognition. | F 600 | Education was completed on 11/24/2020.<br><br>On 12/18/2020 an audit was completed by the Administrator and the DON to review all falls that have occurred form 11/25/2020 to present to ensure that if indicated, neuro checks were performed, physician and responsible party (RP) notification, and that accurate information was relayed to the physician and RP. Audit revealed all required documentation was present.<br><br>Facility plan to monitor its performance to make sure that solutions are sustained: A monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure that all falls had a neurological assessment completed if warranted, physician and RP were notified, and that accurate information was given to the physician and RP. This monitoring process will take place daily for 3 weeks, weekly for 3 weeks, then monthly for 3 months.<br><br>The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement (QAPI) Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.<br><br>The facility alleges compliance on 12/18/2020. | |

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A nursing note dated 10/26/20 completed by Nurse #9 indicated the Nursing Assistant (NA) reported Resident #1 had a bowel movement which had a significant amount of blood in it. The physician gave order to send resident to the hospital to evaluate and treat.

The Emergency Room (ER) evaluation dated 10/26/20 indicated Resident #1 was on Xarelto and presented for worsening rectal bleed. Resident #1 was noted to refuse a rectal exam stating that this bleeding was no different from when he was hospitalized and requesting to go back to the facility. His vital signs were within normal limits and his hemoglobin was stable compared to prior values. Resident #1 ' s Responsible Party (RP) was spoken with and she agreed with discharge back to the facility. She stated she would discuss the discontinuation of Xarelto with his attending physician.

A physician ' s order dated 10/27/20 indicated Resident #1 ' s Xarelto was discontinued due to bleeding.

Resident #1 ' s care plan, with a review date of 11/6/20, included the focus area of bowel incontinence related to immobility and limited range of motion and being sent to the ER related to bloody stool with clots. The interventions included ER evaluation and removal of colon polyps while hospitalized. This care plan also included the risk for falls related to gait/balance problems and incontinence. The interventions included anticipating and meeting Resident #1 ' s needs.

A nursing note dated 11/9/20 at 10:25 AM

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completed by Nurse #1 indicated that staff witnessed Resident #1 outside on the ground in his wheelchair. The wheelchair had flipped backward onto the ground. The resident remained in wheelchair as it flipped. Resident #1 had not lost consciousness. He was noted with an abrasion on the back of his head the size of a quarter. Resident #1 was taken to his room and transferred back to bed via a mechanical lift with 2 staff assist. Resident #1 had no complaints of pain or discomfort and no open areas. Vital signs were obtained: blood pressure (bp) 135/81, pulse 101, respirations 20, temperature 97.1, Oxygen (O2) 98% room air. Resident #1 ' s RP and physician were notified, and the physician gave a new order to monitor the abrasion to the back of his head for 7 days and to complete neurological checks per facility protocol. The resident was noted to be in bed watching television.

A review of the neurological assessment record in the Electronic Medical Record (EMR) indicated neurological assessments were supposed to be completed as follows:
- every (q) 15 minutes 4 times
- q 30 minutes 2 times
- q 60 minutes 4 times
- q 4 hours 6 times
- q shift 2 times

The neurological assessment record dated 11/9/20 for Resident #1 revealed no assessments had been completed.

A review of the vital signs record in the EMR indicated the vital signs were obtained twice for Resident #1 after his 11/9/20 fall. These vitals indicated the following:

- 11/9/20 at 9:56 AM completed by Nurse #1:

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respirations 20, temperature 97.1, pulse 101

- 11/9/20 at 10:10 AM completed by the Director of Nursing (DON): bp 135/81

- 11/9/20 at 10:30 AM completed by the DON: bp 100/60, respirations 20, temperature 96.4, and pulse 92

A nursing note dated 11/9/20 at 12:50 PM completed by Nurse #1 indicated that NA #1 picked up Resident #1 ' s lunch tray and informed the nurse that the resident was not responding. Nurse #1 observed Resident #1 who had no pulse, respiration, blood pressure, or O2. Resident #1 had a Do Not Resuscitate (DNR) order.

A nursing note dated 11/9/20 at 2:26 PM (noted as a late entry note) indicated Unit Manager (UM) #2 notified the RP of Resident #1 ' s passing that occurred at approximately 12:48 PM.

A Certificate of Death dated 11/9/20 completed by the Medical Examiner identified the immediate cause of Resident #1 ' s death as "blunt force head trauma". The Medical Examiner noted that the injury occurred from Resident #1 falling backward in wheelchair onto concrete. The time of death was 12:50 PM.

A handwritten statement dated 11/10/20 completed by Dietary Staff #1 indicated she was approaching the sidewalk in back of the facility and saw Resident #1 flip his wheelchair on its back causing him to bump his head on the concrete sidewalk. Dietary Staff #1 stated she called his name and the resident opened his eyes

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and moaned a little. She then ran into the building and asked Nurse #2 to provide assistance. Dietary Staff #1 indicated after she got Nurse #2 she returned to the dietary department.

On 11/19/20 at 12:14 PM an interview was conducted with the witness to Resident #1 ' s 11/9/20 fall, Dietary Staff #1. She verified that she was outside on 11/9/20 and observed Resident #1 ' s fall. She explained that she was coming back from her break and she saw Resident #1 seated in his wheelchair on the sidewalk. She indicated that this was a normal activity for the resident as he frequently went outside independently. She reported that it looked like Resident #1 had one of the wheels from his wheelchair stuck in the grass off the edge of the concrete sidewalk and he was making a rocking movement to get it back on the sidewalk. Dietary Staff #1 stated that Resident #1 must have rocked with too much force and the wheelchair tipped all the way back and the resident landed on the concrete with his back on the ground still seated in the wheelchair. She revealed that she saw Resident #1 hit his head on the concrete. She indicated she asked Resident #1 if he was alright and he responded to his name and said he was okay. She stated she then went into the facility to get nursing staff and she saw Nurse #2 at the nurse ' s station and she told him what happened, and he ran outside to assist Resident #1. She reported that this was the extent of her involvement as she then returned to the dietary department. She indicated Nurse #1, Resident #1 ' s assigned nurse, had not asked her any questions about Resident #1 ' s fall. Dietary Staff #1 reported that she wrote a statement about what she observed for facility management.

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A physician ' s note dated 11/12/20 at 7:23 AM indicated she was informed by staff on 11/9/20 that Resident #1 had fallen outside onto grass striking the back of his head. The physician wrote that the staff member (Nurse #1) was asked if Resident #1 fell on concrete or the grass and she confirmed it was the grass. The physician indicated that Nurse #1 reported he was cognizant to his surroundings, had not lost consciousness, and had no raised area on his head. The physician further indicated she decided that neurological checks were to be performed for Resident #1 every 15 minutes in accordance with the facility protocol and any changes in mentation were to be reported to her.

An interview was conducted with the DON on 11/19/20 at 1:30 PM. When asked about the facility ' s protocol for neurological checks she stated that the assigned nurse was to complete the neurological assessment in the EMR at the following frequency: q 15 minutes x 4, q 30 minutes x 2, q 1 hour x 4, q 4 hours x 6, and q shift x 2. She reported the neurological assessment included vital signs. She stated that the assigned NA was able to obtain vital signs for the nurse, but the NAs were not able to complete the remainder of the neurological assessment as it required a nurse ' s clinical assessment. The DON reported that ultimately it was the assigned nurse ' s duty to ensure neurological assessments with vital signs were conducted in accordance with this protocol.

An interview was conducted with Nurse #2 on 11/19/20 at 12:20 PM. He stated that on 11/9/20

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Dietary Staff #1 ran in from outside and asked for help stating that Resident #1 had flipped his wheelchair. He reported that he and NA #1, NA #2, and the Activities Staff/NA #3 immediately ran out to assist the resident. He reported that Resident #1 was observed seated in his wheelchair with his wheelchair ' s back on the concrete ground. He explained that it was almost the position an astronaut would be in during takeoff as his back was on the ground and his feet were supported by the chair in the air and he was looking up towards the sky. Nurse #2 stated that Resident #1 was responsive and was at his baseline cognitive status. He reported that he asked Resident #1 if he hit his head and the resident said no. He stated that the NAs assisted him with putting the resident and his wheelchair upright. He indicated that at that time he noticed an abrasion to the back of Resident #1 ' s head. Nurse #2 reported that by this time Resident #1 ' s assigned nurse, Nurse #1, came outside and assumed responsibility for his care from there. He stated that Nurse #1 had not asked for any information about the fall but instead began yelling to NA #1 and NA #2 telling them to take Resident #1 inside to lay him down, so she could assess him. Nurse #2 added that it was a normal occurrence for Resident #1 to go outside on his own.

A phone interview was conducted with Nurse #1 (an agency nurse) on 11/20/20 at 11:16 AM. She stated that she had not witnessed Resident #1 ' s fall on 11/9/20. She reported that she was in a room with another resident when she heard some commotion. She indicated that she completed what she was doing and ran outside. Nurse #1 indicated that when she got outside she saw Nurse #2 and the NAs (NA #1, NA #2, and NA #3)

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getting Resident #1 ' s wheelchair upright. Nurse #1 indicated that Nurse #2 said Resident #1 just flipped his wheelchair over on the sidewalk, was fine, and that he had a small abrasion to the back of his head. She said she observed an abrasion the size of a quarter to the back of his head. She reported that she thought Resident #1 fell on the grass as the resident had some grass on him. She stated she told NA #1 and NA #2 to take Resident #1 inside and put him in bed, so she could take his vitals. She reported she asked Resident #1 if he wanted to go to the hospital and he said no. She stated that she took his vitals and completed a neurological check around 10:00 AM and these were within normal limits. Nurse #1 was unable to explain why this initial neurological assessment was not in the medical record. She reported that after she completed her assessment she called the physician and told her that Resident #1 fell and hit his head on grass. She stated that she also provided the vitals to the physician. She indicated that the physician ordered neurological checks every 15 minutes per protocol. She reported she then called the RP and told her that Resident #1 had fallen outside and hit his head on grass and was doing fine. Nurse #1 revealed she had not spoken to Dietary Staff #1 who witnessed the fall. When asked why she had not spoken to Dietary Staff #1 she stated that she had not known she witnessed Resident #1 ' s fall. She reiterated that she assumed Resident #1 had fallen on the grass since he had grass on him.

This interview with Nurse #1 continued. Resident #1 ' s medical record that indicated no neurological assessments were completed after Resident #1 ' s 11/9/20 fall was reviewed with Nurse #1. Nurse #1 revealed that she conducted

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only 2 neurological checks for Resident #1 on 11/9/20, the initial check that occurred soon after the fall around 10:00 AM and a subsequent check around 10:30 AM. She indicated that there were no irregularities with these assessments. Nurse #1 was unable to explain why the neurological check she said she conducted at 10:30 AM was also not in the medical record. When asked why she had not completed the neurological assessments that were due on 11/9/20 at 10:15 AM, 10:45 AM, 11:30 AM, and 12:00 PM Nurse #1 explained that she got very busy that morning and she didn ' t have time to complete the rest of the neurological assessments. She stated that she asked NA #1 to complete the vitals per protocol. She acknowledged that she was aware NA #1 was not able to complete the neurological assessments.

During an interview with NA #1 on 11/19/20 at 12:00 PM she reported that on 11/9/20 she heard Dietary Staff #1 report to Nurse #2 that Resident #1 had fallen so she went outside to provide assistance. She confirmed that Resident #1 was seated in his wheelchair with the back of the wheelchair laying on the concrete ground. She stated she observed the abrasion to the back of his head. NA #1 stated that Nurse #1 came outside as she and the other staff (Nurse #2, NA #2, and NA #3) were putting the resident and his wheelchair upright on the concrete. She reported that Nurse #1 had not asked what happened, but rather she told her and NA #2 to take Resident #1 inside, lay him down in bed, and to take his vitals. NA #1 stated that Nurse #1 then instructed her to continue to take Resident #1 ' s vitals every 15 minutes after that. She stated that she had taken Resident #1 ' s vitals twice, around 10:00 AM and 10:30 AM, and she documented them on a hard

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copy sheet of paper at the nurse ' s station. She explained that this was the normal process for NA documentation of vitals as they had no access to the EMR, so they wrote them down and then the nurse was supposed to enter them into the EMR. NA #1 revealed that she had taken no further vitals for Resident #1 after 10:30 AM as she was very busy that morning. She stated that one of the NAs scheduled to work that day had called off, so the nurses were instructed to take the residents ' vitals that day to alleviate some of the NAs ' work. NA #1 reported that Nurse #1 was aware one of the NAs had called off, but she expected her to take the vitals anyway. NA #1 stated that after 10:30 AM she saw Resident #1 in his room a couple of times as she walked up and down the hall and when she delivered his lunch tray and he seemed to be his normal self.

During a phone interview with Resident #1 ' s physician on 11/20/20 at 4:10 PM she stated that the nurse who called her on 11/9/20 (Nurse #1) said Resident #1 fell and hit his head on grass. She reported that she was familiar with the area outside where Resident #1 was at and she knew that the grass and ground were very soft in that area. She indicated she specifically asked the staff (Nurse #1) if he fell on the concrete or on grass and they stated grass. The physician explained that a fall onto concrete was very different and if she knew he had fallen on concrete she would have immediately ordered them to send Resident #1 to the hospital. She further explained that Resident #1 could have suffered internal injuries that were not able to be observed on the initial assessment. She reported that she instructed the staff (Nurse #1) to perform neurological checks according to protocol.

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Resident #1 ' s physician revealed she was unaware the neurological checks had not been completed per protocol. The physician spoke about Resident #1 ' s medical condition stating that he recently had COVID, was hospitalized for a GI bleed, and was recently on Xarelto which had to be discontinued due to bloody stool. She indicated that with these medical issues it was pertinent to maintain close monitoring and complete neurological checks per the facility ' s protocol as she ordered the nurse (Nurse #1) who contacted her on 11/9/20.

A phone interview was conducted with Resident #1 ' s RP on 11/19/20 at 4:50 PM. She stated that the nurse who called her on 11/9/20 (Nurse #1) said Resident #1 fell and hit his head on grass and that he was doing fine. She reported that if the staff had informed her that he fell onto concrete and hit his head she would have asked them to send him to the Emergency Room (ER). She explained that Resident #1 may not have wanted to go to the hospital, but if she had spoken with him herself that he would have agreed to go to the ER to be evaluated. The RP spoke about Resident #1 ' s recent issues with a GI bleed. She stated that she believed this risk factor should have made staff take extra precautions with monitoring Resident #1 ' s status after a fall with head injury.

During an interview with the Medical Examiner she confirmed that she completed the Certificate of Death for Resident #1 and indicated the cause of death was "blunt force head trauma". She reported that no autopsy was done as autopsies were normally only done for suspicious deaths and this death was not deemed suspicious as the resident had a fall in which he hit his head on

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concrete and less than 3 hours later he was deceased. She stated that it was highly unlikely the fall was not the cause of the death and that at a minimum it was part of the causation that led to the death. The Medical Examiner spoke about Resident #1 ' s medical comorbidities that included recent COVID infection and hospitalization due to rectal bleeding. She stated that these multiple medical conditions put Resident #1 at a higher risk for severe complications after a fall with head injury which made it essential to his well-being for staff to monitor him closely by completing neurological checks and vital signs. The Medical Examiner explained that although Resident #1 presented at baseline following the fall, it was necessary to continue to monitor him closely to see if there were any changes to indicate an injury that would not have presented immediately after a fall, such as a subdural brain bleed.
She reported that she spoke with facility staff, unable to recall staff ' s name, and questioned how frequently Resident #1 had been assessed prior to death and they were unable to provide a specific answer to the number of assessments and/or frequency. The Medical Examiner stated that if the neurological checks were not completed as ordered by the physician after Resident #1 ' s fall that this was neglect by the nursing staff.

During an interview with the DON on 11/19/20 at 1:30 PM the vital sign record in the EMR for Resident #1 was reviewed. The DON revealed that after Resident #1 ' s death she began an investigation in accordance with normal facility protocol and realized that there was only one set of vitals (11/9/20 at 9:56 AM respirations 20, temperature 97.1, pulse 101) in the EMR for

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11/9/20 after the fall. She indicated that Nurse #1 entered the first set of vitals after Resident #1 ' s fall in the EMR with a date of 11/9/20 at 9:56 AM. She indicated that she spoke to NA #1 who reported that she took two sets of vitals, one at approximately 10:00 AM and the other at approximately 10:30 AM. The DON stated that she reviewed the vital signs for Resident #1 that NA #1 recorded on a hard copy paper. She reported that the respirations, temperature, and pulse that NA #1 recorded at approximately 10:00 AM for Resident #1 matched Nurse #1 ' s documentation in the EMR dated 11/9/20 at 9:56 AM. The DON explained that she believed the vital signs that were recorded in the EMR by Nurse #1 were transcribed from the vitals NA #1 recorded on the hard copy paper. The DON further explained that Resident #1 ' s blood pressure (135/81) from this set of vitals taken by NA #1 had not been documented in the EMR so she entered this into the EMR with a time of 10:10 AM. She reported that she should have entered the time as 10:00 AM to match the time that NA #1 indicated she obtained these vital signs. The DON stated that since second set of vitals completed by NA #1 (obtained 11/9/20 at approximately 10:30 AM) were not in the EMR she entered them herself. The DON reported that her documentation in the EMR was completed after Resident #1 ' s death. The neurological assessment record in the EMR dated 11/9/20 for Resident #1 that indicated no assessments had been completed after his 11/9/20 fall was reviewed with the DON. The DON revealed she was aware there were no neurological assessments in the EMR for Resident #1 after his 11/9/20 fall. She was unable to explain why the neurological assessments were not completed by his assigned

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Nurse (Nurse #1). The record review and interviews that revealed Resident #1 had fallen and hit his head on concrete, but that the physician and RP were notified by Nurse #1 that he hit his head on grass were reviewed with the DON. She was unable to explain why Nurse #1 had not obtained the details of the fall from the witness (Dietary Staff #1). The DON stated that Nurse #1 no longer worked at the facility.

An interview was conducted with the DON and Administrator on 12/2/20 at 10:35 AM. The DON revealed that neurological checks were essential to monitor a resident for deviations from their baseline. She explained that after a fall with head injury there could be things going on internally that were not able to be seen with a visual observation. She further revealed that it was essential to inform the physician of all details known about a fall in order for the physician to be able to make sound treatment decisions for follow up care/monitoring. The DON and Administrator acknowledged that it was also important to inform a resident ' s RP of all known details of a fall as the RP could influence a resident ' s decision on whether or not to seek evaluation at the hospital. The Administrator stated that he felt this incident should not be classified as neglect as Nurse #1 acted with "poor judgement" and did not willfully intend to provide the physician with an inaccurate accounting of Resident #1 ' s fall and she also had not willfully intended not to complete neurological checks as ordered by the physician. The Administrator explained that it was his understanding that neglect had to be willful and intentional.

The Administrator and DON were notified of the

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| F 600 | Continued From page 17<br>Immediate Jeopardy on 11/23/20 at 11:12 AM.<br><br>On 11/25/20 at 3:39 PM the facility provided the following credible allegation of Immediate Jeopardy removal:<br><br>Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.<br><br>Resident #1 was re-admitted to the facility on 10/21/2020 for long term care services. Resident was evaluated by PT, OT, and ST on 10/22/2020. Resident was noted by staff to be able to self-propel wheelchair and was able to get outside by himself without assistance. Resident frequently went outside and had not had any prior incidents leading to this event. Resident did not have a history of falls. Residents last fall was on 4/1/19. Resident had diagnosis of: respiratory failure, TIA, cerebral infarct, COPD, atrial fibrillation, hypertension, along with a history of GI bleed and COVID-19.<br><br>On 11/9/2020 at approx. 9:55 AM Resident was witnessed to have fallen backwards in wheelchair outside on sidewalk area off patio witnessed by a dietary worker #1 coming in from the parking lot. Witness observed patient ' s left wheel of his wheelchair came off the sidewalk and when he attempted to get the wheel back onto the sidewalk, he tipped backwards in his wheelchair hitting his head on the sidewalk. Witness ran up to resident to make sure he was ok and ran to get help. Licensed nurse #2 ran out to asses resident and noted a small scrape on the back of his head. Patient was coherent and did not exhibit any change in cognitive behavior and stated he did not hit his head. Patient did not complain of | F 600 | | |

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any pain and no other injuries were noted. Resident was assisted back up into wheelchair by the nurse #2 and other staff members. Resident was subsequently taken back to his room for further evaluation for any additional injuries by his primary nurse, nurse #1, along with initiation of neuro checks. No other injuries were noted, and patient remained at his baseline for cognitive behavior and when asked if he would like to go to the hospital to be evaluated stated no. Residents ' Physician was notified by nurse #1 who initially thought that the resident may have hit his head on the grass because she noted grass on the resident. The residents ' representative (RP) was also notified by nurse #1 that resident had fallen outside and hit his head at approximately 10:25 AM. The RP did not ask any further questions. There was no further communication with the RP regarding the fall. Nurse 1 notified the physician at approximately 10:10 AM based on the facts she knew after speaking and assessing the resident at the time and she had not spoken with the dietary aide that was the witness at the time. It was when the Director of nursing started the full investigation immediately after the incident but the facility was not aware that the resident hit his head on the concrete during the initial investigation, and this was determined after the dietary aide was interviewed. The medical director was notified of the results of the investigation and was made aware that the resident hit his head on the concrete. Nurse #1 was not aware that the resident hit his head on the concrete based on her statement. The physician is the attending for this resident and sees this resident almost monthly. The physician recommended to continue to monitor the resident and notify her of any changes which included neuro checks to be done every 15 minutes x4, 30

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minutes x2, 60 minutes x4, four hours x6, shift 1 then shift 2. Statements from nurse #1 did not show that the physician asked if he hit his head on the concrete. Resident #1 also stated that he did not want to go to the hospital as well. Resident also stated that he did not hit his head.

At approx. 12:48 PM the certified nursing assistant (CNA) went in to retrieve his lunch tray and noticed that the resident was unresponsive. CNA ran to get the nurse. Upon arrival to the residents ' room the attending nurse, the Director of Nursing (DON), and unit manager discovered that the resident had a faint pulse. Resident was a Do Not Resuscitate (DNR) and subsequently passed. Primary Physician and RP were notified. The CNAs had been in the residents ' room at approximately every 30 minutes starting at 10 am until 1245pm and vital signs were obtained during two of these observations with the second set being obtained at 10:30 AM which were the last vitals taken. After 10:30 the CNA was under the impression that the vital signs would be included with the neuro-checks by nurse #1. At no time did any observation conclude with a change in condition of the resident prior to 1245 pm. The Certified nursing assistants observed the resident to be able to answer simple questions and did not note any change in the resident ' s normal everyday status. Nurse #1 stated the neurological checks were completed twice at 10:00 AM and 10:30 AM and of which she failed to completely document. Based on the statement of nurse #1 she did intend to complete and document the neurological checks but became busy with several other residents. The number of times due of neurological checks with vitals not complete by nurse #1 as instructed by the physician and in accordance with the facility protocol included

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10:15 AM for the Q (every) 15 minutes check #2, 10:45 AM for the Q 15 minutes check #4, 11:00 AM for the Q 30 minutes check #1, 11:30 AM for the Q 30 minutes check #2, 12:00 PM for the Q 30 minutes #3. Patient remained at his cognitive baseline the entire time according to all non-clinical statements of the NAs working on the floor. There were no clinical assessments by licensed nursing staff after the 10:30 AM neurological assessment completed by Nurse #1. There were no clinical assessments documented by licensed nursing staff after the 10:30 AM neurological assessment completed by Nurse #1. Root cause analysis conducted revealed that the alleged non-compliance resulted from inadequate training/understanding of the staff on how to properly investigate a fall, assess and complete neurological checks on a resident that hit their head and document conversations with both the RP and physician. The facility did not submit a 24 hour and 5 day report for neglect because upon the facilities investigation it was noted that Nurse #1 had poor judgement but did not willfully intend not to obtain all the details prior to calling the physician and RP nor did she intentionally not obtain and document vital signs and neuro checks. She indicated she got very busy taking of other residents.

A 24-hour initial allegation of neglect was sent in on 11/25/2020.

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.

On 11/10/2020 an audit was completed by the Director of Nursing and Regional nurse of the

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previous falls with 24 hours were reviewed to ensure an assessment was completed and neurological checks were completed if indicated. It was noted that Neurological checks were not being completed. Licensed nurses were re-educated by the Director of Nursing on November 11 regarding the completion of neurological checks according to the standard of Q 15 minutes X 4, Q 30 minutes X2, Q 1 hour X4 and Q 4 hours X 6 and Q shift X 2 after a fall along with documentation of the checks in the medical record.

On 11/10/2020 the Administrator, DON, and the nurse management team-initiated re-education to all staff regarding the process on assessing falls and their causes, fall care path, falls quick view, neuro check requirements, and environmental hazards. This re-education includes and addresses the need for neurological checks and vital signs when suspected that a resident hit their head and ensuring that accurate details of the fall are relayed to the physician.

Licensed nurses were re-educated on following physician orders by the Director of Nursing on 11/24/2020.

On 11/23/2020 the Administrator, DON, and nurse management team-initiated re-education to all staff regarding neglect. An example was given that the failure to obtain Neurological checks and ongoing assessment of a resident ' s status after a fall with head injury could be considered neglect. Completed on 11/24/2020.

Nurse #1 was instructed by the DON and the Administrator that she should have completed all of the vital signs and neuro checks along with

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documentation. Nurse #1 no longer worked for the facility after 11/9/2020.

The licensed nurses were re-educated to always ask for assistance with assignment if they have a resident with acute changes and this education was completed on 11/24/2020 by the DON.

The licensed nurses were re-educated on 11/24/2020 by the DON on the importance of completing neuro checks, assessment, notification, and following the physician orders after a fall. The Administrator and the DON will monitor this process daily.

An audit sheet will be done by the Administrator, DON, or designee to monitor and review all falls on a daily basis to ensure that a neurological assessment was completed if warranted and what information was documented that was relayed to the RP and physician.

IJ removal date: 11/25/2020

The facility alleges the removal of Immediate Jeopardy on 11/25/20.

On 12/2/20 the credible allegation of Immediate Jeopardy removal was validated by onsite verification. Record review of all residents that had falls after 11/25/20 verified they had neurological assessments completed as ordered and also had the physician and RP (for residents with RPs) notified of the accurate fall details. A review of the daily monitoring audit completed by the facility confirmed that this audit was being completed each day to ensure neurological assessments were completed when warranted and the physician and RP were provided with

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accurate information. The 24 hour report related to the allegation of neglect for Resident #1, dated 11/25/20, was reviewed and confirmed to be completed and faxed to the state agency. A previous phone interview with Nurse #1 (11/20/20 at 11:16 AM) confirmed she spoke with management at the facility who told her the neurological assessments and vital signs should have been completed as ordered by the physician. She additionally confirmed her last day working at the facility was 11/9/20. A review of inservices and inservice sign in sheets as well as staff interviews with various disciplines (Nurses, NAs, Rehabilitation staff, Activities staff) verified education was provided for the required participants on the following: 1) the completion of neurological checks according to the standard of Q 15 minutes X 4, Q 30 minutes X2, Q 1 hour X4 and Q 4 hours X 6 and Q shift X 2 after a fall along with documentation of the checks in the medical record; 2) the process on assessing falls and their causes, fall care path, falls quick view, neuro check requirements, environmental hazards, the need for neurological checks and vital signs when its suspected that a resident hit their head, and ensuring that accurate details of the fall are relayed to the physician and RP; 3) following physician orders; 4) the neglect policy and the fact that the failure to obtain neurological checks and ongoing assessment of a resident ' s status after a fall with head injury could be considered neglect; and 5) staff were instructed to always ask for assistance with their assignment if they have a resident with acute changes. The facility ' s IJ removal date of 11/25/20 was validated.

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2. Resident #3 was admitted to the facility on 9/4/20 with diagnoses that included Diabetes Mellitus type 2 and unspecified convulsions.

The modified admission Minimum Data Set (MDS) assessment dated 9/12/20 indicated Resident #3 ' s cognition was severely impaired. She had no behaviors and no rejection of care.

The care plan for Resident #3 included the focus area of the risk for falls related to deconditioning and unawareness of safety needs. This area was initiated on 9/12/20 and included, in part, the intervention of following the facility fall protocol.

An interview was conducted with the Director of Nursing (DON) on 11/19/20 at 1:30 PM. When asked about the facility ' s protocol for neurological checks she stated that the assigned nurse was to complete the neurological assessment in the Electronic Medical Record (EMR) at the following frequency: every (q) 15 minutes x 4, q 30 minutes x 2, q 1 hour x 4, q 4 hours x 6, and q shift x 2.

2a. A post fall review note completed by Nurse #8 indicated Resident #3 had an unwitnessed fall on 11/8/20 at 9:00 PM. The resident rolled out of bed and onto the floor. Resident #3 was assessed with no injuries.

A review of Resident #3 ' s neurological assessment record initiated after her 11/8/20 fall at 9:00 PM revealed 5 of the 18 neurological assessments were not completed (q 1 hour #4, q 4 hours #1, q 4 hours #2, q 4 hours #3, and q 4 hours #4). The remaining neurological assessments were completed and were all within

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normal limits.

Based on review of the nursing schedule with assignments and documentation in the medical record the following staff were assigned to Resident #3 when neurological assessments were due, but were not completed:
- Nurse #8 was assigned when q 1 hour check #4 was due.
- Nurse #1 was assigned when q 4 hours check #1 and q 4 hours check #2 were due.
- Nurse #4 was assigned when q 4 hours check #3 and q 4 hours check #4 were due.

A phone interview was attempted with Nurse #8 on 11/23/20 at 5:32 PM. She was unable to be reached.

A phone interview was conducted with Nurse #1 on 11/24/20 at 2:45 PM. Nurse #1 was asked how staff knew a neurological assessment was due. She stated that the nurse who worked with the resident the shift prior informed the oncoming nurse if a neurological assessment needed to be completed during their shift. The q 4 hours check #1 and q 4 hours check #2 that were not completed for Resident #3 ' s fall that occurred on 11/8/20 at 9:00 PM were reviewed with Nurse #1. Nurse #1 stated that she had not completed these neurological assessments for Resident #3 as she had not known the assessments were due. She stated that she recalled Nurse #8 worked before her and had not provided her with a report at change of shift on 11/9/20.

A phone interview was conducted with Nurse #4 on 11/30/20 at 3:25 PM. Nurse #4 reiterated Nurse #1 ' s interview stating that the nurse who

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worked with the resident the shift prior informed the oncoming nurse if a neurological assessment needed to be completed during their shift. She indicated that this required communication between the nurses and if this communication didn ' t occur that the neurological assessment would most likely be missed. The q 4 hours check #3 and q 4 hours check #4 that were not completed for Resident #3 ' s fall that occurred on 11/8/20 fall at 9:00 PM were reviewed with Nurse #4. Nurse #4 was unable to recall why she had not completed these neurological assessments for Resident #3.

A follow up interview was conducted with the DON on 12/2/20 at 10:35 AM. The DON revealed that neurological checks were essential to monitor a resident for deviations from their baseline. She explained that neurological checks were conducted after unwitnessed falls as there was a possibility that the resident may have hit their head. She further explained that if the resident had hit their head during the fall that complications could occur internally that were not able to be seen with a visual observation. The DON stated that she expected all neurological checks to be completed as per the facility protocol.

2b. A facility fall report dated 11/10/20 indicated Resident #3 had an unwitnessed fall at 8:05 PM. She was found lying on the floor on her left side and was unable to state what happened. Resident #3 was assessed with no injuries.

A review of Resident #3 ' s neurological assessment record initiated on 11/10/20 after her

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8:05 PM fall revealed 3 of the 18 neurological assessments were not completed (q 4 hours #4, q 4 hours #5, and q 4 hours #6). The remaining neurological assessments were completed and were all within normal limits.

Based on review of the nursing schedule with assignments and documentation in the medical record the following staff were assigned to Resident #3 when neurological assessments were due, but were not completed:
- Nurse #8 was assigned when q 4 hours check #4 and q 4 hours check #5 were due.
- Nurse #3 was assigned when q 4 hours check #6 was due.

A phone interview was attempted with Nurse #8 on 11/23/20 at 5:32 PM. She was unable to be reached.

A phone interview was conducted with Nurse #3 on 11/23/20 at 5:37 PM. Nurse #3 was asked how staff knew a neurological assessment was due. She stated that the nurse who worked with the resident the shift prior informed the oncoming nurse if a neurological assessment needed to be completed during their shift. She indicated that this required communication between the nurses and she revealed that this communication did not always occur. She added that there were some days that the shift seemed to be non-stop and there were things that could get missed, such as one of the neurological assessments. The q 4 hours check #6 that was not completed for Resident #3 ' s fall that occurred on 11/10/20 at 8:05 PM was reviewed with Nurse #3. Nurse #3 was unable to recall why she had not completed this neurological assessment for Resident #3.

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A follow up interview was conducted with the DON on 12/2/20 at 10:35 AM. The DON revealed that neurological checks were essential to monitor a resident for deviations from their baseline. She explained that neurological checks were conducted after unwitnessed falls as there was a possibility that the resident may have hit their head. She further explained that if the resident had hit their head during the fall that complications could occur internally that were not able to be seen with a visual observation. The DON stated that she expected all neurological checks to be completed as per the facility protocol.

3. Resident #4 was admitted to the facility on 10/28/20 with diagnoses that included vascular dementia with behavioral disturbance, chronic obstructive pulmonary disease, personal history of Transient Ischemic Attack (TIA), and cerebral infarction without residual deficits, and peripheral vascular disease.

The admission Minimum Data Set (MDS) assessment dated 11/4/20 indicated Resident #4 ' s cognition was severely impaired. He had no behaviors and no rejection of care.

The care plan for Resident #4 included the focus area of the risk for falls related to confusion, gait/balance problems, unawareness of safety needs, and history of falls. This area was initiated on 11/2/20 and the interventions included, in part, follow facility fall protocol.

A nursing note dated 11/18/20 completed by Nurse #4 indicated Resident #4 had an unwitnessed fall at 7:30 PM. He was noted on his

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left side of the bed near the wall. Resident #4 stated that he hit his head. He was assessed with no injuries. Neurological checks were initiated. The physician was notified and ordered Resident #4 be sent to the Emergency Room (ER) for evaluation. Emergency Medical Services (EMS) were notified at 7:45 PM, arrived at building at 7:55 PM and left facility with Resident #4 at 8:00 PM.

A nursing note dated 11/18/20 completed by Nurse #4 at 11:07 PM indicated Resident #4 returned to the facility at 10:30 PM with no new orders.

A review of Resident #4 ' s neurological assessment record initiated on 11/18/20 after his fall at 7:30 PM revealed 6 of the 18 neurological assessments were not completed (q 4 hours check #1, #2, #3, #5, and #6; q shift check #2) and 1 of the assessments was completed 3 hours late (q 1 hour check #4) by Nurse #6. There were 4 assessments that were not completed due to Resident #4 being out of the facility at the ER (q 15 minutes check #3 and #4; q 30 minutes check #1 and #2; q 1 hour check #1). The remaining neurological assessments were completed and were within normal limits.

An interview was conducted with the Director of Nursing (DON) on 11/19/20 at 1:30 PM. When asked about the facility ' s protocol for neurological checks she stated that the assigned nurse was to complete the neurological assessment in the Electronic Medical Record (EMR) at the following frequency: q 15 minutes x 4, q 30 minutes x 2, q 1 hour x 4, q 4 hours x 6, and q shift x 2.

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A phone interview was attempted with Nurse #6 on 11/24/20 at 10:41 AM. He was unable to be reached. Nurse #6 completed Resident #4 ' s q 1 hour check #4 3 hours late (11/19/20 at 4:15 AM rather than the 1:15 AM due time).

Based on review of the nursing schedule with assignments and documentation in the medical record the following staff were assigned to Resident #4 when neurological assessments were due, but were not completed:
- 11/19/20 1st shift (7:00 AM - 3:00 PM) Nurse #2
- 11/19/20 2nd shift (3:00 PM - 11:00 PM) Nurse #4
- 11/20/20 1st shift (7:00 AM - 3:00 PM) Nurse #2

A phone interview was attempted with Nurse #2 on 11/24/20 at 3:30 PM. He was unable to be reached.

A phone interview was conducted with Nurse #4 on 11/30/20 at 3:25 PM. Nurse #4 was asked how staff knew a neurological assessment was due. She stated that the nurse who worked with the resident the shift prior informed the oncoming nurse if a neurological assessment needed to be completed during their shift. She indicated that this required communication between the nurses and if this communication didn ' t occur that the neurological assessment would most likely be missed. The neurological assessments that were due for Resident #4 on 11/19/20 during the 2nd shift and were not completed were reviewed with Nurse #4. Nurse #4 was unable to recall why she had not completed these neurological assessments for Resident #4 on 11/19/20.

A follow up interview was conducted with the DON on 12/2/20 at 10:35 AM. The DON revealed

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that neurological checks were essential to monitor a resident for deviations from their baseline. She explained that neurological checks were conducted after unwitnessed falls as there was a possibility that the resident may have hit their head. She further explained that if the resident had hit their head during the fall that complications could occur internally that were not able to be seen with a visual observation. The DON stated that she expected all neurological checks to be completed as per the facility protocol.

4. Resident #2 was admitted to the facility on 2/4/19 with diagnoses that included dementia.

The care plan for Resident #2 included the risk for falls related to confusion and unawareness of safety needs. This area was initiated on 2/4/19 and had been revised after falls on 1/18/20, 2/5/20, and 4/10/20. The interventions included, in part, neurological checks after the falls on 1/18/20, 2/5/20, and 4/10/20.

The quarterly Minimum Data Set (MDS) assessment dated 8/5/20 indicated Resident #2 ' s cognition was severely impaired. He had no behaviors and no rejection of care.

A post fall review note dated 10/8/20 indicated Resident #2 had an unwitnessed fall at 11:55 AM. He was seen on the floor in the bathroom in the fetal position on his right side. Resident #2 was assessed with no injuries.

A review of Resident #2 ' s neurological assessment record initiated on 10/8/20 after his fall at 11:55 AM revealed 2 of the 18 neurological

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assessments were not completed (q shift #1 and q shift #2) and 1 of the assessments was completed 4 hours late by Nurse #3 (q 4 hours check #2). The remaining neurological assessments were completed and were all within normal limits.

An interview was conducted with the Director of Nursing (DON) on 11/19/20 at 1:30 PM. When asked about the facility ' s protocol for neurological checks she stated that the assigned nurse was to complete the neurological assessment in the Electronic Medical Record (EMR) at the following frequency: q 15 minutes x 4, q 30 minutes x 2, q 1 hour x 4, q 4 hours x 6, and q shift x 2.

Based on review of the nursing schedule with assignments and documentation in the medical record the following staff were assigned to Resident #2 when neurological assessments were due, but were not completed:
- Nurse #3 was assigned when q shift #1 check was due.
- Medication Technician (Med Tech) #1 was assigned when q shift #2 check was due.

During email correspondence with the DON on 11/23/20 at 5:17 PM she indicated that during the week the Unit Managers were responsible for completing neurological assessments if a med teach was assigned to the resident and on the weekend, this was the floor nurse ' s responsibility.

Further review of the nursing schedule with assignments indicated the q shift #2 check was due on Saturday, 10/10/20, and Nurse #5 was working on the floor with Med Tech #1 at that

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time.

A phone interview was conducted with Nurse #3 on 11/23/20 at 5:37 PM. Nurse #3 was asked how staff knew a neurological assessment was due. She stated that the nurse who worked with the resident the shift prior informed the oncoming nurse if a neurological assessment needed to be completed during their shift. She indicated that this required communication between the nurses and she revealed that this communication did not always occur. She added that there were some days that the shift seemed to be non-stop and there were things that could get missed, such as one of the neurological assessments. The q shift #1 check that was due, but was not completed for Resident #2 ' s fall that occurred on 10/8/20 at 11:55 AM was reviewed with Nurse #3. Nurse #3 was unable to recall why she had not completed this neurological assessment for Resident #2. The q 4 hours check #2 that was completed 4 hours late was reviewed with Nurse #3. Nurse #3 stated that she had not recalled with certainty why this assessment was completed late, but she assumed it was one of the nights that things were very busy causing the assessment to be completed late.

A phone interview was conducted with Nurse #5 on 11/24/20 at 2:26 PM. Nurse #5 reiterated Nurse #3 ' s interview stating that the nurse who worked with the resident the shift prior informed the oncoming nurse if a neurological assessment needed to be completed during their shift. She reported that she was an agency nurse and worked at the facility for 5 weekends and to her recollection she completed no neurological assessments at the facility. Resident #2 ' s

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10/8/20 fall, the q shift check #2 that was not completed, and the schedule with assignments that indicated Nurse #5 was working on the floor with Med Tech #1 who was assigned to Resident #2 when the q shift check #2 was due were reviewed. Nurse #5 revealed that she believed that was the first time she had worked with Med Tech #1 and she had not known that she was a med tech rather than a nurse until the end of the shift. She further revealed that she had not known a neurological assessment was due for Resident #2.

A follow up interview was conducted with the DON on 12/2/20 at 10:35 AM. The DON revealed that neurological checks were essential to monitor a resident for deviations from their baseline. She explained that neurological checks were conducted after unwitnessed falls as there was a possibility that the resident may have hit their head. She further explained that if the resident had hit their head during the fall that complications could occur internally that were not able to be seen with a visual observation. The DON stated that she expected all neurological checks to be completed as per the facility protocol.

5. Resident #5 was admitted to the facility on 4/23/20 and most recently readmitted on 8/17/20 with diagnoses that included cerebral infarction, heart disease, and dementia.

The quarterly Minimum Data Set (MDS) assessment dated 11/5/20 indicated Resident #5 ' s cognition was severely impaired. He had no behaviors and no rejection of care.

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The care plan for Resident #5 included the focus area of the risk for falls related to confusion, gait/balance problems, and unawareness of safety needs. This area was initiated on 4/29/20 and reviewed on 11/16/20. The interventions included, in part, anticipating and meeting Resident #5 ' s needs.

A post fall review note dated 11/19/20 indicated Resident #5 had an unwitnessed fall at 12:30 AM. Resident #5 was found on the floor beside his bed. He was assessed with no injuries.

A review of Resident #5 ' s neurological assessment record initiated on 11/19/20 after his fall at 12:30 AM revealed 2 of the 18 neurological assessments were not completed (q 4 hours #6 and q shift #2). The remaining neurological assessments were completed and were all within normal limits.

Based on review of the nursing schedule with assignments and documentation in the medical record the following staff were assigned to Resident #5 when neurological assessments were due, but were not completed:
- Nurse #7 was assigned when q 4 hours check #6 was due.
- Nurse #8 was assigned when q shift check #2 was due.

A phone interview was conducted with Nurse #7 on 11/25/20 at 8:52 AM. Nurse #7 was asked how staff knew a neurological assessment was due. She stated that the nurse who worked with the resident the shift prior informed the oncoming nurse if a neurological assessment needed to be completed during their shift. Nurse #7 stated that if this communication didn ' t occur that the

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neurological assessment would be missed. She was asked who was responsible for completing a neurological check that was due at change of shift. She reported that this would normally fall to the oncoming nurse unless the previous nurse had extra time and completed it out of a courtesy. The q 4 hour check #6 that was due on 11/20/20 at 7:00 AM but was not completed was reviewed with Nurse #7. Nurse #7 stated that she remembered the nurse who reported off to her that day told her the q shift #1 check was due during her shift. She was unable to recall who this nurse was. She explained that she noticed that the q 4 hours check #6 was not recorded in the neurological record, but she thought the previous nurse had forgotten to document it. She stated this was why she completed the q shift check #1 on 11/20/20 at 11:00 AM rather than completing the q 4 hour check #6 at 7:00 AM. Further review of the nursing schedule with assignments and the neurological assessment record for Resident #2 related to his 11/19/20 fall indicated Nurse #3 completed the q 4 hour check #5 on 11/20/20 at 3:00 AM prior to the missed q 4 hour check #6.

A phone interview was conducted with Nurse #3 on 11/23/20 at 5:37 PM. The neurological assessment record for Resident #2 related to his 11/19/20 fall that indicated Nurse #3 completed the q 4 hours check #5 at 3:00 AM and that the q 4 hours check #6 was not completed was reviewed with Nurse #3. She was unable to recall if she had conducted the q 4 hours check #6 prior to completing her shift or not.

A phone interview was attempted with Nurse #8 on 11/23/20 at 5:32 PM. She was unable to be reached.

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| F 600 | Continued From page 37<br><br>During an interview with the Director of Nursing (DON) on 11/19/20 at 1:30 PM she stated that the facility ' s protocol for neurological checks was for the assigned nurse to complete the neurological assessment in the Electronic Medical Record (EMR) at the following frequency: q 15 minutes x 4, q 30 minutes x 2, q 1 hour x 4, q 4 hours x 6, and q shift x 2.<br><br>A follow up interview was conducted with the DON on 12/2/20 at 10:35 AM. The DON revealed that neurological checks were essential to monitor a resident for deviations from their baseline. She explained that neurological checks were conducted after unwitnessed falls as there was a possibility that the resident may have hit their head. She further explained that if the resident had hit their head during the fall that complications could occur internally that were not able to be seen with a visual observation. The DON stated that she expected all neurological checks to be completed as per the facility protocol. | F 600 | | |
| F 725 SS=D | Sufficient Nursing Staff<br>CFR(s): 483.35(a)(1)(2)<br><br>§483.35(a) Sufficient Staff.<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required | F 725 | | 12/18/20 |

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| F 725 | Continued From page 38<br>at §483.70(e).<br><br>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to provide sufficient staffing to ensure neurological assessments with vital signs were obtained as ordered by the physician for 1 of 5 residents reviewed for falls (Resident #1).<br><br>The findings included:<br><br>Resident #1 was initially admitted to the facility on 5/27/12 and most recently readmitted to the facility on 10/21/20 with diagnoses that included Gastrointestinal (GI) bleed, respiratory failure, Chronic Obstructive Pulmonary Disease (COPD), heart disease, hypertension (HTN), hyperlipidemia (HLD), personal history of Transient Ischemic Attack (TIA), personal history of cerebral infarction, and speech disorder.<br><br>The annual Minimum Data Set (MDS) assessment dated 10/21/20 indicated Resident #1 ' s cognition was severely impaired. He | F 725 | F-725<br><br>This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident.<br><br>Root Cause:<br>The Administrator and the Director of Nursing discussed with the IDT QAPI committee team on 12/02/2020 to identify the root cause of this alleged | |

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| F 725 | Continued From page 39<br>required extensive assistance of 1 with bed mobility and transferred only once or twice with the assistance of 2 or more.<br><br>Resident #1 ' s care plan, with a review date of 11/6/20, included the focus area of the risk for falls related to gait/balance problems and incontinence. The interventions included anticipating and meeting Resident #1 ' s needs. This care plan also included the focus area of a self-care deficit related to physical impairments. The interventions included the assistance of 2 staff and a mechanical lift for transfers.<br><br>A nursing note dated 11/9/20 at 10:25 AM completed by Nurse #1 indicated that staff witnessed Resident #1 outside on the ground in his wheelchair. The wheelchair had flipped backward onto the ground. The resident remained in wheelchair as it flipped. He was noted with an abrasion on the back of his head the size of a quarter. Resident #1 was taken to his room and transferred back to bed via a mechanical lift with 2 staff assist. Vital signs were obtained: blood pressure (bp) 135/81, pulse 101, respirations 20, temperature 97.1, Oxygen (O2) 98% room air. Resident #1 ' s physician was notified and gave a new order to monitor the abrasion to the back of Resident #1 ' s head for 7 days and to complete neurological checks (including vital signs) per facility protocol. The resident was noted to be in bed watching television.<br><br>A nursing note dated 11/9/20 at 12:50 PM completed by Nurse #1 indicated that NA #1 picked up Resident #1 ' s lunch tray and informed the nurse that the resident was not responding. Nurse #1 observed Resident #1 who had no | F 725 | non-compliance. Root cause analysis conducted revealed that the alleged non-compliance resulted from inadequate training/understanding of the staff regarding sufficient staffing level requirements.<br><br>For affected resident(s):<br>Resident #1 no longer resides in the facility.<br><br>For other residents with the potential to be affected:<br>All residents have the potential to be affected by this alleged non-compliance and as a result, the systemic changes stated below have been put in place to prevent any risk of affecting additional residents.<br><br>Facility plan to prevent re-occurrence:<br>On 11/23/202 the DON initiated re-education to the nursing staff on the importance of completing neuro checks, assessment, notification, and following the physician orders after a fall. The nursing staff was also re-educated to ask the Unit Managers, Staff Development Coordinator, and/or the Director of Nursing should they have any questions or require guidance and assistance with a resident that has had an acute change. Education was completed on 11/24/2020.<br><br>On 12/02/2020 the Administrator initiated re-education to the Director of Nursing, Staff Development Coordinator, and the Scheduler regarding the need to maintain sufficient nursing staffing levels to ensure | |

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| F 725 | Continued From page 40<br>pulse, respiration, blood pressure, or O2. Resident #1 had a Do Not Resuscitate (DNR) order.<br><br>A review of the neurological assessment record in the Electronic Medical Record (EMR) indicated neurological assessments were supposed to be completed as follows:<br>- every (q) 15 minutes 4 times<br>- q 30 minutes 2 times<br>- q 60 minutes 4 times<br>- q 4 hours 6 times<br>- q shift 2 times<br><br>The neurological assessment record dated 11/9/20 for Resident #1 revealed no neurological assessments had been completed.<br><br>A review of the vital signs record in the EMR indicated the vital signs were obtained twice for Resident #1 after his 11/9/20 fall. These vitals indicated the following:<br><br>- 11/9/20 at 9:56 AM completed by Nurse #1: respirations 20, temperature 97.1, pulse 101<br><br>- 11/9/20 at 10:10 AM completed by the Director of Nursing (DON): bp 135/81<br><br>- 11/9/20 at 10:30 AM completed by the DON: bp 100/60, respirations 20, temperature 96.4, and pulse 92<br><br>An interview was conducted with the DON on 11/19/20 at 1:30 PM. When asked about the facility ' s protocol for neurological checks she stated that the assigned nurse was to complete the neurological assessment in the EMR at the following frequency: q 15 minutes x 4, q 30 | F 725 | that staff are able to complete required tasks such as neurological assessments and vital signs in the event of a fall.<br><br>The Administrator, the Director of Nursing, Staff Development Coordinator, and the Scheduler will review the staffing schedule daily to ensure that sufficient staffing levels will be met and will adjust as necessary.<br><br>Facility plan to monitor its performance to make sure that solutions are sustained: A monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure that all shifts have the appropriate staffing levels to perform and complete their necessary tasks. This monitoring process will take place daily for 3 weeks, weekly for 3 weeks, then monthly for 3 months.<br><br>The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.<br><br>The facility alleges compliance on 12/18/2020. | |

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minutes x 2, q 1 hour x 4, q 4 hours x 6, and q shift x 2. She reported the neurological assessment included vital signs. She stated that the assigned NA was able to obtain vital signs for the nurse, but the NAs were not able to complete the remainder of the neurological assessment as it required a nurse ' s clinical assessment.

A phone interview was conducted with Nurse #1 (an agency nurse) on 11/20/20 at 11:16 AM. Nurse #1 stated that she was assigned to Resident #1 at the time of his fall on 11/9/20 at approximately 9:55 AM. She indicated Resident #1 fell outside in his wheelchair and hit the back of his head on the ground and sustained an abrasion the size of a quarter to his head. She stated she instructed NA #1 and NA #2 to take Resident #1 inside and put him in bed, so she could take his vitals. Nurse #1 stated that she took his vitals and completed a neurological check around 10:00 AM and these were within normal limits. She reported that after she completed her assessment she called the physician and informed her the resident had fallen and hit his head. She provided the vitals to the physician and the physician ordered neurological checks every 15 minutes per protocol. Resident #1 ' s medical record that indicated no neurological assessments were completed after Resident #1 ' s 11/9/20 fall was reviewed with Nurse #1. Nurse #1 revealed that she conducted only 2 neurological checks for Resident #1 on 11/9/20, the initial check that occurred soon after the fall around 10:00 AM and a subsequent check around 10:30 AM. She indicated that there were no irregularities with these assessments. Nurse #1 was unable to explain why these neurological checks she said she conducted at 10:00 AM and 10:30 AM were

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not in the medical record. When asked why she had not completed the neurological assessments with vital signs that were due on 11/9/20 at 10:15 AM, 10:45 AM, 11:30 AM, and 12:00 PM Nurse #1 explained that she got very busy that morning and she didn ' t have time to complete the rest of the neurological assessments. She stated that she asked NA #1 to complete the vitals per protocol. She acknowledged that she was aware NA #1 was not able to complete the neurological assessments.

An undated written statement completed by NA #1 indicated after Resident #1 ' s fall on 11/9/20 Nurse #1 said she needed the resident in bed so she could assess him. NA #1 reported that she took Resident #1 ' s vitals at 10:00 AM and another set around 10:30 AM. She indicated that after she completed the vital signs she went back to continue care for other residents. She stated that after lunch time she went to pick up Resident #1 ' s tray and she noticed he was unresponsive, so she called the nurses on duty for assistance (Nurse #1 and Nurse #2).

During an interview with NA #1 on 11/19/20 at 12:00 PM she reported that on 11/9/20 after Resident #1 ' s fall, Nurse #1 told her and NA #2 to take Resident #1 inside, lay him down in bed, and to take his vitals. NA #1 stated that Nurse #1 then instructed her to continue to take Resident #1 ' s vitals every 15 minutes after that. She revealed that she had taken Resident #1 ' s vitals twice, around 10:00 AM and 10:30 AM, and she documented them on a hard copy sheet of paper at the nurse ' s station. She explained that this was the normal process for NA documentation of vitals as they had no access to the EMR, so they wrote them down and then the nurse was

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supposed to enter them into the EMR. NA #1 revealed that she had taken no further vitals for Resident #1 after 10:30 AM as she was very busy that morning. She stated that one of the NAs scheduled to work that day had called off, so the assignment sheet stated that nurses were supposed to take the residents ' vital signs. She indicated that this was to alleviate some of the NAs ' work. NA #1 reported that Nurse #1 was aware one of the NAs had called off, but she expected her to take the vital signs anyway. NA #1 indicated that her assignment was around 25 residents that day (11/9/20) and that her normal assignment was around 15. She reported that a lot of the residents at the facility were dependent on the assist of 2, making it difficult for her and NA #2 to complete their tasks with just the 2 of them. She stated that around 10:00 AM the Activities Staff began assisting them with some of the residents as she was also an NA and she noticed that they were having difficulty completing their tasks with only 2 of them. She explained that the Activities Staff/NA #3 took it upon herself to call her boss and ask if she could help NA #1 and NA #2 on the floor. NA #1 reported that by this time (10:00 AM) she and NA #2 were already behind on their tasks so they were trying to make up time with the assistance of Activities Staff/NA #3. She indicated that they were prioritizing the essential tasks, such as incontinent care, and other things got delayed or were not completed, such as vital signs for Resident #1. She reiterated that she had not obtained any vital signs for Resident #1 after 10:30 AM as she was too busy to obtain the other ones. NA #1 was asked if she had informed the DON or Administrator that she and NA #2 were having difficulty completing their tasks and she stated that she had not verbally reported this to them

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that day as she felt it was obvious they were having difficulty because of the NA call off.

A phone interview was conducted with the Activities Staff/NA #3 on 11/19/20 at 3:57 PM. She stated that on 11/9/20 she noticed that 1 of the NAs had called off and NA #1 and NA #2 were working "short". She indicated that she was familiar with the residents and that many of them required 2 staff for assistance so she felt that NA #1 and NA #2 needed help. She reported that she called her boss and asked her if she could assist NA #1 and NA #2 on the floor and that at around 10:00 AM she was given permission to do so. Activities Staff/NA #3 stated that she had not taken an assignment, but was helping with things like answering call lights, passing ice, and passing trays.

A second interview was conducted with Nurse #1 by phone on 11/24/20 at 2:45 PM. NA #1 ' s interview that indicated the nurses were instructed to complete vital signs for the residents on 11/9/20 due to one of the NAs calling off was reviewed with Nurse #1. Nurse #1 revealed she was aware one of the NAs called off, but she still felt that NA #1 could obtain the vital signs for Resident #1 for her as she had many responsibilities that morning. She explained that she had a resident with a tracheostomy which required additional time to complete the necessary nursing care. She reported she provided care for this resident after Resident #1 ' s fall on 11/9/20 for about a 30 minute period and after that she still had blood sugar levels to obtain for her assigned residents before lunch time.

During an interview with the DON on 11/19/20 at 1:30 PM the vital sign record in the EMR for

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Resident #1 was reviewed. She confirmed Resident #1 ' s vitals were obtained only twice (around 10:00 AM and 10:30 AM) after Resident #1 ' s fall on 11/9/20. The neurological assessment record in the EMR dated 11/9/20 for Resident #1 that had no assessments documented and Nurse #1 ' s interview that indicated she completed neurological assessments only twice (around 10:00 AM and 10:30 AM) after his fall were reviewed with the DON. The DON confirmed that these were the only two neurological assessments completed for Resident #1 after his 11/9/20 fall.

An interview was conducted with the DON and Administrator on 12/2/20 at 10:35 AM. They both acknowledged that staffing had been challenging and they had been having to use agency nurses since the end of August/early September 2020. The Administrator indicated that COVID-19 had restricted their ability to utilize PRN (as needed) staff as part of their infection control policy included not permitting their staff to work at other facilities. The schedule with assignments for 11/9/20 that indicated one of the NAs had called off was reviewed with the Administrator and DON. The Administrator stated that the scheduler was always trying to fill in slots for staff who called off, but that this was not always possible if the call off occurred soon before a shift. Resident #1 ' s fall on 11/9/20 and staff ' s failure to obtain neurological assessments with vitals as ordered by the physician as well as Nurse #1 ' s interview and NA #1 ' s interview that indicated the neurological assessments with vitals were not obtained as ordered because they were busy that morning were then reviewed with the DON and Administrator. The Administrator stated that he felt if the staff had worked together they could

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| F 725 | Continued From page 46<br>have completed their tasks. He further stated that if Nurse #1 and NA #1 couldn ' t complete their tasks that they should have informed him and/or the DON of this information so that they could have found them additional help. | F 725 | | |
| F 732 SS=C | Posted Nurse Staffing Information<br>CFR(s): 483.35(g)(1)-(4)<br><br>§483.35(g) Nurse Staffing Information.<br>§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:<br>(i) Facility name.<br>(ii) The current date.<br>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>(A) Registered nurses.<br>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>(C) Certified nurse aides.<br>(iv) Resident census.<br><br>§483.35(g)(2) Posting requirements.<br>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.<br>(ii) Data must be posted as follows:<br>(A) Clear and readable format.<br>(B) In a prominent place readily accessible to residents and visitors.<br><br>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. | F 732 | | 12/18/20 |

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| F 732 | Continued From page 47<br><br>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.<br>This REQUIREMENT is not met as evidenced by:<br>Based on review of the facility ' s required posted daily Nurse Staffing forms and staff interview, the facility failed to complete the posting requirements on 22 of 22 days reviewed (11/01/20 through 11/22/20).<br><br>The findings included:<br><br>Review of the posted daily Nurse Staffing forms from 11/01/20 through 11/22/20 revealed the following information:<br><br>- 11/01/20: The actual hours worked of licensed and unlicensed staff were blank. The resident census was blank.<br>- 11/02/20: The actual hours worked of licensed and unlicensed staff were blank.<br>- 11/03/20: The actual hours worked of licensed and unlicensed staff were blank.<br>- 11/04/20: The actual hours worked of licensed and unlicensed staff were blank.<br>- 11/05/20: The actual hours worked of licensed and unlicensed staff were blank.<br>- 11/06/20: The actual hours worked of licensed and unlicensed staff were blank.<br>- 11/07/20: The total number and actual hours worked of licensed and unlicensed staff were blank.<br>- 11/08/20: The total number and actual hours worked of licensed and unlicensed staff were blank | F 732 | F-732<br><br>This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident.<br><br>Root Cause:<br>The Administrator and the Director of Nursing discussed with the IDT QAPI committee team on 12/2/2020 to identify the root cause of this alleged non-compliance. Root cause analysis conducted revealed that the alleged non-compliance resulted from inadequate training/understanding of the staff regarding the nurse staffing information requirements and posting.<br><br>For affected resident(s):<br>No residents were directly affected. | |

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| F 732 | Continued From page 48<br>- 11/09/20: The actual hours worked of licensed and unlicensed staff were blank.<br>- 11/10/20: The actual hours worked of licensed and unlicensed staff were blank.<br>- 11/11/20: The actual hours worked of licensed and unlicensed staff were blank.<br>- 11/12/20: The actual hours worked of licensed and unlicensed staff were blank.<br>- 11/13/20: The actual hours worked of licensed and unlicensed staff were blank.<br>- 11/14/20: The total number and actual hours worked of licensed and unlicensed staff were blank.<br>- 11/15/20: The total number and actual hours worked of licensed and unlicensed staff were blank.<br>- 11/16/20: The actual hours worked of licensed and unlicensed staff were blank.<br>- 11/17/20: The actual hours worked of licensed and unlicensed staff were blank.<br>- 11/18/20: The actual hours worked of licensed and unlicensed staff were blank.<br>- 11/19/20: The actual hours worked of licensed and unlicensed staff were blank.<br>- 11/20/20: The actual hours worked of licensed and unlicensed staff were blank.<br>- 11/21/20: The total number and actual hours worked of licensed and unlicensed staff were blank.<br>- 11/22/20: The total number and actual hours worked of licensed and unlicensed staff were blank.<br><br>During email correspondence with the Director of Nursing (DON) on 11/24/20 at 3:08 PM she stated that the posted daily Nurse Staffing forms were completed by the Unit Managers (UMs).<br><br>A phone interview was conducted with UM (Unit | F 732 | For other residents with the potential to be affected:<br>All residents have the potential to be affected by this alleged non-compliance and as a result, the systemic changes stated below have been put in place to prevent any risk of affecting additional residents.<br><br>Facility plan to prevent re-occurrence:<br>On 12/2/2020 the Administrator initiated re-education to the Director of Nursing, Staff Development Coordinator, and the scheduler regarding the daily nurse staffing information requirements and that all required areas must be filled out.<br><br>Facility plan to monitor its performance to make sure that solutions are sustained:<br>A monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure that all of the required daily nurse staffing information is complete and displayed appropriately. This monitoring process will take place daily for 3 weeks, weekly for 3 weeks, then monthly for 3 months.<br><br>The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.<br><br>The facility alleges compliance on 12/18/2020. | |

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| F 732 | Continued From page 49 | F 732 | | |

Manager) #1 on 11/24/20 at 3:15 PM. She stated that she and UM #2 had not been responsible for completing the posted daily Nurse Staffing forms since October of 2019. She indicated that she believed Central Supply staff filled out the form in the morning and the floor nurses were supposed to complete it throughout the day.

A phone interview was conducted with Central Supply staff on 11/24/20 at 3:54 PM. She stated that her work schedule was Monday through Friday 5:30 AM to 1:30 PM. She reported she filled in the scheduled hours for licensed and unlicensed staff on the daily Nurse Staffing form based on the schedule when she came to work each weekday. She indicated that UM #1 and UM #2 used to fill out the actual hours worked for staff throughout the day. She revealed that this had not been happening for months. Central Supply staff stated that each day she worked, she took the previous days posting to the Staff Coordinator and she filled out any blanks in the form as she was able to pull time cards to see the actual hours worked of staff. She indicated she was not sure who was responsible for filling in the form on weekends.

A phone interview was conducted with the Staff Coordinator on 11/24/20 at 4:30 PM. She stated that she presently was not responsible for completing any portion of the posted daily Nurse Staffing form. She reported that up until August 2020 when the facility had a COVID-19 outbreak, Central Supply staff brought her the previous day ' s posting and she filled in the blanks on the form by reviewing the timecards for staff from the previous day. She acknowledged her awareness that the posting was supposed to be updated so the information was current, rather than being

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| F 732 | Continued From page 50 | F 732 | | |

updated on the following day after the posting had already been taken down. The Staff Coordinator explained that when the COVID-19 outbreak occurred, she was given additional responsibilities that included coordinating with staffing agencies to fill in holes in the staff schedule, so she was no longer filling in the blanks on the posted daily Nurse Staffing form when Central Supply staff brought her the previous days posting. She reported that her responsibility at this time was keeping all of these forms in a binder when they were given to her by Central Supply staff. She indicated that she told UM #1, UM #2, and Central Supply staff that the form needed to be completed by them or by floor staff throughout the day as she was no longer filling in the blanks on the form due to additional responsibilities. The Staff Coordinator revealed that this task had not been completed as the forms were consistently incomplete.

A phone interview was conducted with the DON on 11/30/20 at 3:00 PM. The DON revealed that she had not observed the posted daily Nurse Staffing form until they were requested for the purposes of this survey and she was unaware they were consistently incomplete. She explained that the former DON left the facility in September 2020 and she became interim DON and then permanent DON shortly thereafter. She indicated that she had many new responsibilities over the past couple of months causing her not to notice that this form was not being completed in accordance with the regulations.

During an interview with the Administrator on 12/2/20 at 10:35 AM he reported that he had not noticed that the posted daily Nurse Staffing form was incomplete from 11/1/20 through 11/22/20.

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| F 732 | Continued From page 51<br>He stated that there was a miscommunication on responsibilities that would be corrected so that the form was completed in accordance with the regulations. | F 732 | | |
| F 842 SS=D | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and<br>(iv) Systematically organized<br><br>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-<br>(i) To the individual, or their resident representative where permitted by applicable law;<br>(ii) Required by Law;<br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br>(iv) For public health activities, reporting of abuse, | F 842 | | 12/18/20 |

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| F 842 | Continued From page 52<br>neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.<br><br>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.<br><br>§483.70(i)(4) Medical records must be retained for-<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to document neurological assessments in the medical record for a resident who fell and sustained a head injury. This was for 1 of 5 residents reviewed for falls (Resident | F 842 | F-842<br><br>This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of | |

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| F 842 | Continued From page 53<br>#1).<br><br>The findings included:<br><br>Resident #1 was initially admitted to the facility on 5/27/12 and most recently readmitted to the facility on 10/21/20 with diagnoses that included Gastrointestinal (GI) bleed, respiratory failure, Chronic Obstructive Pulmonary Disease (COPD), heart disease, hypertension (HTN), hyperlipidemia (HLD), personal history of Transient Ischemic Attack (TIA), personal history of cerebral infarction, and speech disorder.<br><br>The annual Minimum Data Set (MDS) assessment dated 10/21/20 indicated Resident #1 ' s cognition was severely impaired.<br><br>A nursing note dated 11/9/20 at 10:25 AM completed by Nurse #1 indicated that staff witnessed Resident #1 outside on the ground in his wheelchair. The wheelchair had flipped backward onto the ground. The resident remained in wheelchair as it flipped. He was noted with an abrasion on the back of his head the size of a quarter. Resident #1 was taken to his room and transferred back to bed via a mechanical lift with 2 staff assist. Resident #1 had no complaints of pain or discomfort and no open areas. Vital signs were obtained and were within normal limits. Resident #1 ' s physician was notified and gave a new order to monitor the abrasion to the back of his head for 7 days and to complete neurological checks per facility protocol.<br><br>A review of the neurological assessment record in the Electronic Medical Record (EMR) indicated neurological assessments were supposed to be completed as follows: | F 842 | correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident.<br><br>Root Cause:<br>The Administrator and the Director of Nursing discussed with the IDT QAPI committee team on 12/02/2020 to identify the root cause of this alleged non-compliance. Root cause analysis conducted revealed that the alleged non-compliance resulted from inadequate training/understanding of the staff regarding required documentation necessary following a fall.<br><br>For affected resident(s):<br>Resident #1 no longer resides in the facility.<br><br>For other residents with the potential to be affected:<br>All residents have the potential to be affected by this alleged non-compliance and as a result, the systemic changes stated below have been put in place to prevent any risk of affecting additional residents.<br><br>Facility plan to prevent re-occurrence:<br>On 11/23/2020 the Director of Nursing initiated re-education to the licensed | |

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| F 842 | Continued From page 54<br>- every (q) 15 minutes 4 times<br>- q 30 minutes 2 times<br>- q 60 minutes 4 times<br>- q 4 hours 6 times<br>- q shift 2 times<br>The neurological assessment record dated 11/9/20 for Resident #1 revealed no assessments had been completed.<br><br>A phone interview was conducted with Nurse #1 on 11/20/20 at 11:16 AM. Nurse #1 confirmed she was assigned to Resident #1 at the time of his fall with head injury on 11/9/20. She stated she spoke with the physician by phone and informed her that Resident #1 had fallen and hit his head. She reported the physician ordered monitoring of the resident and neurological assessments per facility protocol. Resident #1 ' s medical record that indicated no neurological assessments were completed after Resident #1 ' s 11/9/20 fall was reviewed with Nurse #1. Nurse #1 revealed that she conducted 2 neurological checks for Resident #1 on 11/9/20, an initial check that occurred soon after the fall around 10:00 AM and a subsequent check around 10:30 AM. She indicated that there were no irregularities with these assessments. Nurse #1 was unable to explain why neither of these neurological checks she said she conducted were not in the medical record.<br><br>On 11/20/20 at 4:10 PM a phone interview was conducted with Resident #1 ' s physician. She stated that she was informed by nursing staff (Nurse #1) on 11/9/20 that Resident #1 fell and hit his head. She indicated that she instructed the nurse to complete neurological assessments in accordance with the facility protocol. The physician reported that she expected the nursing | F 842 | nurses on the importance of completing and documenting neuro checks, assessment, notification, and following the physician orders after a fall. Education was completed on 11/24/2020.<br><br>Facility plan to monitor its performance to make sure that solutions are sustained: A monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure that the required documentation has been completed following a fall. This monitoring process will take place daily for 3 weeks, weekly for 3 weeks, then monthly for 3 months.<br><br>The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.<br><br>The facility alleges compliance on 12/18/2020. | |

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| F 842 | Continued From page 55 | F 842 | | |

staff to document these neurological assessments in the medical record. She explained that this documentation was important as it allowed all staff who worked with the resident to see if there were any changes in the assessment that could be indicative of a neurological injury.

During an interview with the Director of Nursing (DON) on 11/19/20 at 1:30 PM when asked about the facility ' s protocol for neurological checks she stated that the assigned nurse was to complete and document neurological assessments in the EMR at the following frequency: every (q) 15 minutes x 4, q 30 minutes x 2, q 1 hour x 4, q 4 hours x 6, and q shift x 2. The neurological assessment record in the EMR dated 11/9/20 for Resident #1 that indicated no assessments had been completed after his 11/9/20 fall was reviewed with the DON. Nurse #1 ' s interview in which she stated she completed 2 neurological assessments after Resident #1 ' s fall was reviewed with the DON. The DON indicated that Nurse #1 should have documented the neurological assessments in the medical record per facility protocol.

A follow up interview was conducted with the DON on 12/2/20 at 10:35 AM. The DON revealed that neurological checks were essential to monitor a resident for deviations from their baseline. She explained that after a fall with head injury there could be things going on internally that were not able to be seen with a visual observation. She stated that documentation of the neurological assessments allowed all the staff who worked with the resident to be able to monitor the resident for changes that could indicate if a neurological injury was sustained.

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