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F 000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted 03/05/24 to 03/06/24. Event ID# 4I6Z11. The following intake was investigated: NC00213972. One (1) of 3 allegations resulted in a deficiency. Intake NC00213972 resulted in Immediate Jeopardy. Past non-compliance was identified at: CFR 483.10 at tag F580 at a scope and severity J CFR 483.25 at tag F684 at a scope and severity J Tag F684 constituted Substandard Quality of Care. A partial extended survey was conducted.	F 000		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the	F 580		

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

Electronically Signed | 03/19/2024

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F 580	Continued From page 1 resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and Medical Doctor (MD) and staff interviews, the facility failed to notify the MD or on-call provider when Resident #1, who was on anticoagulant medication and had a history of brain bleeds, had an unwitnessed fall with obvious head injury for 1 of 3 residents reviewed for accidents and notification. On 02/13/24 at approximately 1:30 AM Resident #1	F 580	Past noncompliance: no plan of correction required.	

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was found lying on the floor of her room in between the bed and wall with her head next to the nightstand. Upon assessment by Nurse #1, Resident #1 had a laceration to the right eyebrow area, a quarter-sized hematoma to the right forehead, and bruising to the right hand. Resident #1 exhibited no signs of respiratory distress. Neurological checks were initiated (refers to an assessment of motor and sensory responses, such as reflexes, to determine if the nervous system is impaired), vital signs were obtained, and all were noted within normal limits. Resident #1 was assisted back to bed and monitored throughout the remainder of the shift with continued neurological checks and vital signs that were noted within normal limits. Between 7:30 AM and 7:40 AM Resident #1 was observed having trouble breathing and Emergency Medical Services (EMS) were called to transport her to a local hospital. Resident #1 was diagnosed with a subdural hematoma (buildup of blood on the surface of the brain) with shift (displacement of brain tissue along the center of the brain) and left-sided pneumothorax (when air leaks into the space between the lung and chest causing the lung to collapse). Resident #1 was intubated (procedure where a flexible tube is placed through the mouth or nose into the trachea to aid with breathing), Eliquis (anticoagulant) was reversed (refers to the administration of medication to rapidly reverse the anticoagulant effect), and a chest tube was placed for the pneumothorax. Resident #1's injury was nonsurvivable, her family elected hospice care and Resident #1 passed away on 02/15/24.

The findings included:

Resident #1 was admitted to the facility on

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02/02/24 with diagnoses that included left hip fracture, hypotension (low blood pressure), paroxysmal atrial fibrillation (type of irregular heartbeat), and fatigue.

A physician order dated 02/02/24 for Resident #1 read, Eliquis 2.5 milligrams (mg) twice a day at 8:00 AM and 8:00 PM.

The Medical Doctor (MD) history and physical progress note dated 02/05/24 revealed in part, Resident #1's past medical history included frontal hematoma.

A nurse progress note dated 02/13/24 at 2:00 AM written by Nurse #1 read in part, Resident #1 had an unwitnessed fall at approximately 1:30 AM and was found lying on her right side on the floor between the bed and wall with her head positioned at the nightstand. Resident #1 was assessed and had a laceration above the outer portion of the right eye, bruise to the right side of the right thumb, a small red area to her right shoulder, and a hematoma approximately the size of a quarter to the top right side of the head. Ice pack and steri-strips were applied. Neurological checks were initiated and initial vital signs were blood pressure (BP) 127/82, pulse 79, respiratory (breathing) rate 18, temperature 97.7, and oxygen saturation 93% on room air.

During a telephone interview on 03/05/24 at 12:31 PM, Nurse #1 confirmed she was Resident #1's assigned nurse on 02/13/24 during the hours of 11:00 PM to 7:00 AM. Nurse #1 recalled around 1:30 AM she was sitting at the Nurses' station and Nurse Aide (NA) #1 had just walked past headed down the hallway Resident #1 resided when they heard a loud noise. NA #1 looked into

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Resident #1's room and informed Nurse #1 she was on the floor. Nurse #1 stated upon immediately entering the room, Resident #1 was observed lying on her right side on the floor in-between the wall and bed with her head near the nightstand. She noticed blood on the floor and upon assessment, Resident #1 had a cut in the eyebrow area of the right eye, bruising to the right hand, and a small hematoma on the top right side of her head with no other injuries or obvious fractures. The eye area was cleaned with steri-strips applied and staff held ice packs to her forehead due to the swelling. Nurse #1 recalled Resident #1 denied any pain other than pointing to the right eye area and Tylenol (over the counter pain medication) was administered per standing order. Nurse #1 recalled Resident #1 stating she was reaching for the water pitcher on the nightstand when she fell out of bed and the best she could determine was Resident #1 must have missed or lost her balance when reaching over to the nightstand. Nurse #1 confirmed Resident #1 was on an anticoagulant medication and although she had obvious head injury, she used her nursing judgement when making the decision not to send Resident #1 out to the hospital for an evaluation at the time of her fall. Nurse #1 added from the time Resident #1 was found on the floor and up until her (Nurse #1) shift ended, Resident #1 was talking normal, displayed no respiratory distress, neurological checks were completed per facility protocol and her vital signs and neurological checks were normal. Resident #1 was assisted back into bed with a fall mat placed on the floor in-between the bed and wall as a safety precaution and monitored the remainder of the shift. Nurse #1 explained based on her assessment of Resident #1, she did not feel that Resident #1 was in any

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immediate danger as Resident #1 was alert and talking with no altered level of consciousness or uncontrolled bleeding and confirmed she did not call the MD or on-call provider at the time of the fall but did place a note in the physician communication book.

A nurse progress note dated 02/13/24 at 8:03 AM written by Nurse #3 read in part, NA went into Resident #1's room and noted she was having slow, struggled respirations. Vitals obtained and noted a blood pressure of 130/74, respiratory rate 7, pulse 100, and oxygen saturation at 88%. Ice placed on Resident #1's head and new orders obtained to send her to the Emergency Department (ED) for evaluation.

During an interview on 03/05/24 at 1:45 PM, Nurse #3 recalled on the morning of 02/13/24 right around shift change between 7:30 AM and 7:40 AM, she was notified by NA #2 that something was wrong with Resident #1 and she was not breathing right. Upon entering the room, Nurse #3 stated Resident #1's head was tilted to the right side, as she normally did when she slept, and when she straightened Resident #1's head, Resident #1 had a hematoma to the forehead which she described as a big pump knot (refers to a lump or swelling on the head) that covered the right side of the forehead and eye. In addition, Resident #1 was drooling from the right side of the mouth and breathing with gasps which she described as Cheyne-Stokes (breathing pattern that involves a period of fast, shallow breathing followed by slow, heavier breathing). Nurse #1 explained Resident #1 was a full code so oxygen was provided at 15 liters per minute (LPM) via a non-rebreather mask (device used to assist in the delivery of higher concentrations of

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oxygen), she obtained physician orders to send Resident #1 to the ED, EMS was notified, ice was placed on the hematoma to reduce the swelling, and she started sternal rubs to keep Resident #1 awake and breathing until EMS arrived to transport her to the hospital.

During an interview on 03/06/24 at 1:20 PM, Nurse #4 recalled on the morning of 02/13/24 sometime around the start of the shift, NA #2 stated Resident #1 wasn't breathing right and she went with Nurse #3 to Resident #1's room to assess. Upon entering the room, Nurse #4 recalled Resident #1 was breathing with small gasps, had bruising to her right side around the eye area with steri-strips in place and appeared gray-looking. Resident #1 was non-verbal and able to open her eyes but her pupils were fixed straight ahead. Nurse #4 stated they got the crash cart ready just in case it was needed but Nurse #3 was able to keep Resident #1 alert and breathing with sternal rubs until EMS arrived at the facility, took over and transported her to the hospital.

Review of the hospital records dated 02/13/24 revealed Resident #1 presented to the ED for evaluation following a fall at the skilled nursing facility with obvious head trauma and was on anticoagulant medication. Resident #1 was diagnosed with a subdural hematoma (buildup of blood on the surface of the brain) with shift (displacement of brain tissue along the center of the brain). Resident #1 was intubated (procedure where a flexible tube is placed through the mouth or nose into the trachea to aid with breathing), she was on anticoagulant medication that was reversed (refers to the administration of medication to rapidly reverse the anticoagulant

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effect) and also found to have left-sided pneumothorax (when air leaks into the space between the lung and chest causing the lung to collapse) and a chest tube was placed for the pneumothorax. Resident #1's injury was nonsurvivable, her family elected hospice care and Resident #1 passed away on 02/15/24.

During an interview on 03/05/24 at 2:38 PM, the Director of Nursing (DON) confirmed she was notified by Nurse #1 of Resident #1's fall during third shift on 02/13/24. The DON explained they did not automatically notify the MD/provider or send a resident on anticoagulant medication out to the hospital for an evaluation following a fall, even with obvious head injury, but rather went by the nurse's judgement and if neurological checks were normal, they continued to monitor unless the resident had an acute change in condition. The DON stated Nurse #1 used her nursing judgement and following the fall, Resident #1 was monitored frequently, her vital signs and neurological checks remained normal and she had no acute change in condition throughout the remainder of the shift. The DON stated it wasn't until first shift when NA #2 started rounds that Resident #1 was noticed to appear different than she had been earlier. Resident #1 was assessed by Nurse #3 who noticed Resident #1's oxygen saturation was low, she was given a non-rebreather mask, and EMS was notified for an emergent hospital transfer.

During an interview on 03/06/24 at 11:00 AM, the Administrator recalled on 02/13/24 when she arrived at the facility between 6:30 AM and 7:00 AM, she was informed by staff that Resident #1 had fallen during the night but was doing fine and her vitals signs and neurological checks were

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normal. The Administrator explained sometime just after the start of first shift, she was in the area when NA #2 reported Resident #1 was not breathing right. The Administrator went into the room with the nurse and recalled Resident #1 was lying in bed, she had a pump knot on her forehead with steri-strips applied to the cut and she was difficult to arouse but her eyes would flutter when you called her name. The Administrator went out to the nurses' station to check Resident #1's code and transfer status and when she returned to the room, Resident #1's breathing was very shallow and the nurse stated EMS had already been notified. EMS arrived pretty quickly and transported Resident #1 to the hospital. The Administrator explained prior to this incident, they had never had a statement in their fall policy or fall protocol about immediately notifying the MD when a resident on anticoagulant medication had a fall. She further explained the expectation was for the nurse to initiate neurological checks, assess the resident and the decision to call the MD/on-call provider and/or send the resident out to the hospital was based on the clinical assessment and nurses' judgement.

During a telephone interview on 03/05/24 at 1:12 PM, the Medical Doctor (MD) confirmed he was not notified on 02/13/24 when Resident #1, who was on anticoagulant medication, fell at 1:30 AM and sustained a head injury. The MD could not recall the date but stated when he was notified of Resident #1's fall, he was told the nurse did not call the provider or send Resident #1 out to the hospital for evaluation and decided to monitor her with neurological checks. Then around 6:30 AM Resident #1 started showing acute changes, she was sent out to the hospital for an evaluation and

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from what he had heard, the outcome was not positive. The MD stated he was unaware Resident #1 was also diagnosed with pneumothorax and felt that would be more of an issue than a fall with head trauma and if she had symptoms of pneumothorax while at the facility following her fall, he would have expected her to have some respiratory difficulties but she didn't. He explained since Resident #1's respiratory, vital signs and neurological checks were normal, even if she had gone to the hospital immediately following her fall, it was likely a Computerized Tomography (abbreviated as CT and refers to an imaging technique that produces detailed internal images of the body) scan would not have detected anything and the hospital may have just sent her back to the facility. He stated the symptoms could have definitely progressed over a few hours and when Resident #1 did show an acute change in condition, he restated staff recognized the acute change and sent Resident #1 to the hospital. The MD explained stated at the time, the facility did not have a policy or fall protocol for notifying the provider when a resident on anticoagulant medication had a fall. The MD stated he could not say for sure if Resident #1 had been sent to the hospital immediately after her fall there would have been a different outcome but had he been notified, he would have erred on the side of caution and given orders for her to be sent to the hospital for an evaluation.

The Administrator was informed of Immediate Jeopardy on 03/06/24 at 11:10 AM.

The facility provided the following Corrective Action Plan with a compliance date of 03/05/24:

Address how corrective action will be

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accomplished for those residents found to have been affected by the deficient practice:

1. The facility failed to notify the physician when Resident #1 who was on Eliquis, an anticoagulant medication, had an unwitnessed fall on 2/13/24 at approximately 1:30 AM. The Resident was found lying on her right side on the floor between her bed and the wall with her head positioned at the nightstand. Resident #1 has a bruise to the top portion of the right wrist approximately the size of a quarter, a bruise to the right side of right thumb, a small red area to her right shoulder, and a hematoma approximately the size of a quarter to the top right side of the head.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

2. All residents have the potential to be affected by this practice. On 2/14/24 the Director of Nursing (DON) and the Unit Managers reviewed residents who had a fall during the last 30 days and were on anticoagulant medications. The falls were reviewed to ensure the Medical Director/Nurse Practitioner (NP)/on-call provider were notified of falls and told the resident was on an anticoagulant. No new concerns were found.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

3. The measures that have been put in place to ensure the deficient practice does not recur are as follows:

On 2/14/24 the Regional Operations Manager

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educated the Administrator, DON, Assistant Director of Nursing, and Nursing Leadership on notifying the physician/NP or on-call when a resident on an anticoagulant has an unwitnessed fall or a fall with a head injury immediately.
Beginning 2/14/24 The Director of Nursing, Assistant Director of Nursing and Nursing Leadership provided education to the nurses regarding notifying the physician/NP or on-call immediately when a resident on an anticoagulant has an unwitnessed fall or a fall with a head injury. The Director of Nursing was educated by the Administrator on 2/14/23 that she would be in charge of tracking all staff to ensure they received education and ensuring no staff will work without receiving this education. Any new hires will receive education prior to the start of their shift, it will be the responsibility of the Director of Nursing to ensure this is completed.
On 3/4/24 The Director of Regulatory Compliance educated the Administrator and Director of Nursing on notifying the physician/NP/on-call immediately when a resident has an unwitnessed fall or a fall with a head injury.
On 3/4/24 The Director of Nursing and the Staff Development Nurse provided education to all Nursing Staff in person and over the phone with the Staff giving the trainer verbal feedback to ensure education was understood, to immediately call the MD/NP/on-call if a resident has a unwitnessed fall or a fall with a head injury. The Director of Nursing was educated by the Administrator on 3/4/23 that she would be in charge of tracking all staff to ensure they received education and ensuring no staff will work without receiving this education. Any new hires will receive education prior to the start of their shift, it will be the responsibility of the Director of Nursing to ensure this is completed. Education will be

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completed by 3/4/24.
On 3/4/24 the policy for Notification of Change was updated to say: when a resident has an unwitnessed fall or a fall with a head injury the physician/NP/on-call provider should be notified immediately.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

4. The DON or designee will audit five (5) residents twice weekly for 4 weeks, then weekly for 8 weeks to ensure physician and NP are notified of any unwitnessed falls or falls with head injury who are on an anticoagulant immediately. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the DON monthly for three (3) months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary.

Date of compliance 3/5/24.

The Corrective Action plan was validated on 03/06/24 and concluded the facility implemented an acceptable corrective action plan on 03/05/24 as evidenced by facility documentation and staff interviews. Review of the in-service sign-in sheets dated 02/14/24 revealed all staff/all departments received education that a resident on anticoagulant medication who had fall must be assessed by the nurse and the MD/provider must be immediately notified. Interviews with facility

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F 580	Continued From page 13 staff revealed they received in-service education regarding the facility's fall protocol and were able to verbalize what to do when a resident had a fall and who to notify of the fall. Interviews with nurses revealed they received additional education on 03/04/24 regarding the change to the facility's fall protocol and verbalized they were to call the MD/provider immediately anytime a resident had a fall with or without injury and regardless if the resident was on anticoagulant medication. Review of the facility's monitoring tools dated 02/15/24 through 03/05/24 revealed they were completed as outlined in the corrective action plan with no concerns identified.	F 580		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and Medical Doctor (MD) and staff interviews, the facility failed to recognize the seriousness of a head injury following a fall and seek medical treatment for a resident on Eliquis (anticoagulant medication) with a history of brain bleeds for 1 of 3 residents reviewed for accidents (Resident #1). On 02/13/24 at approximately 1:30 AM Resident #1 was found lying on the floor of her room in between the bed and wall with her head next to	F 684	Past noncompliance: no plan of correction required.	

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the nightstand. Upon assessment by Nurse #1, Resident #1 had a laceration to the right eyebrow area, a quarter-sized hematoma to the right forehead, and bruising to the right hand. Resident #1 exhibited no signs of respiratory distress. Neurological checks (refers to an assessment of motor and sensory responses, such as reflexes, to determine if the nervous system is impaired) were initiated, vital signs were obtained, and all were noted within normal limits. Resident #1 was assisted back to bed and monitored throughout the remainder of the shift with continued neuro checks and vital signs that were noted within normal limits. Between 7:30 AM and 7:40 AM Resident #1 was observed having trouble breathing and Emergency Medical Services (EMS) were called to transport her to a local hospital. Resident #1 was diagnosed with a subdural hematoma (buildup of blood on the surface of the brain) with shift (displacement of brain tissue along the center of the brain) and left-sided pneumothorax (when air leaks into the space between the lung and chest causing the lung to collapse). Resident #1 was intubated (procedure where a flexible tube is placed through the mouth or nose into the trachea to aid with breathing), anticoagulant medication was reversed (refers to the administration of medication to rapidly reverse the anticoagulant effect), and a chest tube was placed for the pneumothorax. Resident #1's injury was nonsurvivable, her family elected hospice care and Resident #1 passed away on 02/15/24.

The findings included:

Resident #1 was admitted to the facility on 02/02/24 with diagnoses that included left hip fracture, hypotension (low blood pressure),

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paroxysmal atrial fibrillation (type of irregular heartbeat), and fatigue.

A nursing admission observation assessment dated 02/02/24 revealed Resident #1 was oriented to person, place, time and situation. She was able to stand and pivot from the wheelchair with one-person physical assistance and had weakness in all extremities with no functional limitations in range of motion.

A physician order dated 02/02/24 for Resident #1 read, Eliquis 2.5 milligrams (mg) twice a day at 8:00 AM and 8:00 PM.

The Medical Doctor (MD) history and physical progress note dated 02/05/24 revealed in part, Resident #1's past medical history included frontal hematoma.

The discharge Minimum Data Set (MDS) dated 02/13/24 revealed Resident #1's cognition was not assessed. She required partial/moderate staff assistance with rolling left and right and total staff assistance with transfers. Resident #1 received antianxiety, antidepressant, anticoagulant and opioid medications during the MDS assessment period.

A nurse progress note dated 02/13/24 at 2:00 AM written by Nurse #1 read in part, Resident #1 had an unwitnessed fall at approximately 1:30 AM and was found lying on her right side on the floor between the bed and wall with her head positioned at the nightstand. Resident #1 was assessed and had a laceration above the outer portion of the right eye, bruise to the right side of the right thumb, a small red area to her right shoulder, and a hematoma approximately the

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size of a quarter to the top right side of the head. Ice pack and steri-strips were applied. Neurological checks were initiated and initial vital signs were blood pressure (BP) 127/82, pulse 79, respiratory (breathing) rate 18, temperature 97.7, and oxygen saturation 93% on room air.

During a telephone interview on 03/05/24 at 12:31 PM, Nurse #1 confirmed she was Resident #1's assigned nurse on 02/13/24 during the hours of 11:00 PM to 7:00 AM. Nurse #1 recalled around 1:30 AM she was sitting at the Nurses' station, Nurse Aide (NA) #1 had just walked past the nurses' station and was headed down the hallway Resident #1 resided when they heard a loud noise. NA #1 looked into Resident #1's room and informed Nurse #1 she was on the floor. Nurse #1 stated upon immediately entering the room, she noticed Resident #1's bed was in a low position and Resident #1 was lying on her right side on the floor in-between the wall and bed with her head near the nightstand. She noticed blood on the floor and upon assessment, Resident #1 had a cut in the eyebrow area of the right eye, bruising to the right hand, and a small hematoma on the top right side of her head with no other injuries or obvious fractures. The eye area was cleaned with steri-strips applied and staff held ice packs to her forehead due to the swelling. Nurse #1 recalled Resident #1 denied any pain other than pointing to the right eye area and Tylenol (over the counter pain medication) was administered per standing order. Nurse #1 recalled Resident #1 stating she was reaching for the water pitcher on the nightstand when she fell out of bed and the best she could determine was Resident #1 must have missed or lost her balance when reaching over to the nightstand. Nurse #1 confirmed Resident #1 was on an

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anticoagulant medication and although she had obvious head injury, she used her nursing judgement when making the decision not to send Resident #1 out to the hospital for an evaluation at the time of her fall. Nurse #1 added from the time Resident #1 was found on the floor and up until her (Nurse #1) shift ended, Resident #1 was talking normal, displayed no respiratory distress, neurological checks were completed per facility protocol and her vital signs and neurological checks were normal. Resident #1 was assisted back into bed with a fall mat placed on the floor in-between the bed and wall as a safety precaution and monitored the remainder of the shift. Nurse #1 confirmed she did not call the MD or on-call provider at the time of the fall but did place a note in the physician communication book. Nurse #1 explained based on her assessment of Resident #1, she did not feel that Resident #1 was in any immediate danger as Resident #1 was alert and talking with no altered level of consciousness or uncontrolled bleeding.

During a joint telephone interview with Nurse #2 on 03/06/24 at 5:33 AM, NA #1 recalled on 02/13/24 sometime between 1:00 AM and 2:00 AM, she was walking down the hall and happened to look inside Resident #1's room and found her lying on the floor beside her bed. NA #1 stated she was not sure how Resident #1 fell out of bed onto the floor and stated Resident #1 must have fallen while she was trying to reach for something. NA #1 stated she immediately notified Nurse #1 who came to the room to assess Resident #1. NA #1 recalled Resident #1 had a cut above her eye and was talking but did not recall if she had any bumps, hematomas or any other injury. NA #1 explained after Resident #1 was assisted back into bed, she (NA #1)

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obtained Resident #1's vital signs periodically throughout the remainder of the shift and did not recall Resident #1 displaying any signs of distress.

During a joint telephone interview with NA #1 on 03/06/24 at 5:33 AM, Nurse #2 stated she had gone into Resident #1's room with Nurse #1 after being notified Resident #1 was on the floor. Upon entering the room, Nurse #2 observed Resident #1 lying on the floor between the bed and wall and Resident #1 had stated she fell out of bed while trying to reach for the water pitcher. Nurse #2 stated Resident #1 had a cut right above her eyebrow but did not recall seeing any hematomas and explained Nurse #1 did most of the assessment. Nurse #2 stated while in the room, Resident #1 was talking and asking for a drink of water and displayed no signs of distress.

Review of the neurological checklist revealed Resident #1's vital signs were monitored every 15 minutes for the first hour, every 30 minutes for the second hour, then hourly up until she was sent out to the hospital for evaluation. The last neurological check was documented at 5:30 AM and revealed Resident #1 had a BP of 132/69, pulse of 84, and respiratory rate of 17. Resident #1 was oriented to person only, opened her eyes spontaneously and purposefully, her pupils were 3 millimeters (normal range in adults varies from 2 mm to 4 mm in bright light and 4 mm to 8 mm in the dark) equal in size and reactive, and she had normal hand, arm and leg movement.

A nurse progress note dated 02/13/24 at 8:03 AM written by Nurse #3 read in part, NA went into Resident #1's room and noted she was having slow, struggled respirations. Vitals obtained and

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noted a blood pressure of 130/74, respiratory rate 7, pulse 100, and oxygen saturation at 88%. Ice placed on Resident #1's head and new orders obtained to send her to the Emergency Department (ED) for evaluation.

During an interview on 03/05/24 at 1:45 PM, Nurse #3 recalled on the morning of 02/13/24, right around shift change between 7:30 AM and 7:40 AM, she was notified by NA #2 that something was wrong with Resident #1 and she was not breathing right. Upon entering the room, Nurse #3 stated Resident #1's head was tilted to the right side, as she normally did when she slept, and when she straightened Resident #1's head, Resident #1 had a hematoma to the forehead which she described as a big pump knot (refers to a lump or swelling on the head) that covered the right side of the forehead and eye. In addition, Resident #1 was drooling from the right side of the mouth and breathing with gasps which she described as Cheyne-Stokes (breathing pattern that involves a period of fast, shallow breathing followed by slow, heavier breathing). Nurse #1 explained Resident #1 was a full code so oxygen was provided at 15 liters per minute (LPM) via a non-rebreather mask (device used to assist in the delivery of higher concentrations of oxygen), she obtained physician orders to send Resident #1 to the ED for evaluation, EMS was notified, ice was placed on the hematoma to reduce the swelling, and she started sternal rubs to keep Resident #1 awake and breathing until EMS arrived to transport her to the hospital.

During an interview on 03/05/24 at 2:02 PM, NA #2 confirmed she was assigned to provide care to Resident #1 on 02/13/24 during the hours of 7:00 AM to 3:00 PM. NA #2 explained at the start of

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her shift, she did rounds with NA #1 for shift report and NA #1 had informed her that Resident #1 fell out of bed during the night, bumped her head and had some bruising that would likely get darker. NA #1 also reported to NA #2 that neurological checks and vital signs were completed on Resident #1 throughout the shift and everything was fine. NA #2 recalled as they were talking and she looked into the room, Resident #1 lying in bed with her head tilted to the right, which was how she normally slept, and she could see somewhat of a knot/bruising to Resident #1's forehead and Resident #1 appeared to be breathing fine at that time. Around 7:15 AM when she was assisting another resident to the dining room for breakfast, NA #2 looked into Resident #1's room as she passed by and it looked like she had a little tremor. She assisted the other resident to the dining room and went straight back to Resident #1's room and noticed it wasn't a tremor but rather Resident #1 was breathing with small gasps. NA #2 stated she immediately notified Nurse #3 and Nurse #4 who came to the room to assess Resident #1.

During an interview on 03/06/24 at 1:20 PM, Nurse #4 recalled on the morning of 02/13/24 sometime around the start of the shift, NA #2 stated Resident #1 wasn't breathing right and she went with Nurse #3 to Resident #1's room to assess. Upon entering the room, Nurse #4 recalled Resident #1 was breathing with small gasps, had bruising to her right side around the eye area with steri-strips in place and appeared gray-looking. Resident #1 was non-verbal and able to open her eyes but her pupils were fixed straight ahead. Nurse #4 stated they got the crash cart ready just in case it was needed but Nurse #3 was able to keep Resident #1 alert and

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breathing with sternal rubs until EMS arrived at the facility, took over and transported her to the hospital.

The Emergency Medical Services (EMS) report dated 02/13/14 noted a call was received at 7:59 AM and at 8:01 AM they were with Resident #1 at the facility. The EMS report indicated that upon arrival, Resident #1 was unconscious and was receiving supplemental oxygen at 15 LPM via a non-rebreather mask which was continued throughout care. Resident #1 had a large hematoma over her right eye that was swelling outward and Cushing's Triad (low heart rate, irregular respirations and a widened pulse pressure indicative on increased pressure in the brain), hypertension and bradycardia (low heart rate) alongside abnormal breathing were noted with a strong suspicion of intracranial hemorrhage (brain bleeding). During transport to the hospital, Resident #1 continued to display shallow breathing with increasing periods of irregularity and the hospital was notified to prepare for Diffuse Axonal Injury (abbreviated as DAI and refers to a type of traumatic brain injury resulting from a blunt injury to the brain) upon arrival.

Telephone attempt on 03/06/24 at 11:21 AM for an interview with the EMS Responder was unsuccessful.

The hospital radiology report dated 02/13/24 confirmed Resident #1 had an acute left large subdural hemorrhage with at least 1.5 centimeters rightward midline shift with subfalcine herniation (displaced brain tissue that moves under the falx cerebri which is the membrane that divides the two cerebral hemispheres of the brain), right supratentorial subarachnoid

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hemorrhage (bleeding in the space that surrounds the brain), hemorrhage along the falx, right and left tentorium, and left temporal horn and fourth ventricle intraventricular hemorrhage (bleeding inside or around the spaces in the brain that contain the cerebral spinal fluid), subarachnoid hemorrhage along the brainstem, and an anterior right scalp hematoma.

Review of the hospital records dated 02/13/24 revealed Resident #1 presented to the ED for evaluation following a fall at the skilled nursing facility with obvious head trauma and was on anticoagulant medication. Resident #1 was diagnosed with a subdural hematoma (buildup of blood on the surface of the brain) with shift (displacement of brain tissue along the center of the brain). Resident #1 was intubated (procedure where a flexible tube is placed through the mouth or nose into the trachea to aid with breathing), she was on anticoagulant medication that was reversed (refers to the administration of medication to rapidly reverse the anticoagulant effect) and also found to have left-sided pneumothorax (when air leaks into the space between the lung and chest causing the lung to collapse) and a chest tube was placed. Resident #1's injury was nonsurvivable, her family elected hospice care and Resident #1 passed away on 02/15/24.

During an interview on 03/05/24 at 2:38 PM, the Director of Nursing (DON) was unable to recall the exact time she was notified by Nurse #1 of Resident #1's fall on 02/13/24 but stated it was sometime early morning shortly after Resident #1 had fallen. The DON recalled Nurse #1 had reported they had just completed first rounds, which was usually around 1:00 AM, and after

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providing care, Resident #1 asked for a drink of water which was provided by NA #1 before leaving the room. The DON stated she seemed to recall NA #1 walked down the hall to answer another resident's call light after leaving Resident #1's room and she was walking back up the hall, she looked into Resident #1's room and observed her lying on the floor in between the bed and wall with her head near the nightstand. NA #1 immediately called for Nurse #1 who went to the room and upon assessment, Resident #1 had a cut above her eye and a small hematoma upon on her forehead with no other deformities or obvious fractures identified. The DON explained they did not automatically send a resident on anticoagulant medication out to the hospital for an evaluation following a fall, even with obvious head injury, but rather went by the nurse's judgement and if neurological checks were normal, they continued to monitor unless the resident had an acute change in condition. The DON stated Nurse #1 used her nursing judgement and following the fall, Resident #1 was monitored frequently, her vital signs and neurological checks remained normal and she had no acute change in condition throughout the remainder of the shift. The DON stated it wasn't until first shift when NA #2 started rounds that Resident #1 was noticed to appear different than she had been earlier. Resident #1 was assessed by Nurse #3 who noticed Resident #1's oxygen saturation was low, she was given a non-rebreather mask, and EMS was notified for an emergent hospital transfer.

During an interview on 03/06/24 at 11:00 AM, the Administrator recalled on 02/13/24 when she arrived at the facility between 6:30 AM and 7:00 AM, she was informed by staff that Resident #1 had fallen during the night but was doing fine and

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her vitals signs and neurological checks were normal. The Administrator explained when she questioned staff about what happened, staff reported they heard a noise and when they went into Resident #1's room to check, she was lying on the floor between the bed and wall with her head near the nightstand. Staff also reported at the time of the fall, Resident #1 was alert, talking and told Nurse #1 she had knocked the water pitcher off the nightstand and fell out of bed trying to grab it. Nurse #1 stated Resident #1 was monitored throughout the shift with no acute change in condition. Then sometime just after the start of first shift, the Administrator was in the area when NA #2 reported Resident #1 was not breathing right. The Administrator went into the room with the nurse and recalled Resident #1 was lying in bed, she had a pump knot on her forehead with steri-strips applied to the cut and she was difficult to arouse but her eyes would flutter when you called her name. The Administrator went out to the nurses' station to check Resident #1's code and transfer status and when she returned to the room, Resident #1's breathing was very shallow and the nurse stated EMS had already been notified. EMS arrived pretty quickly and transported Resident #1 to the hospital. The Administrator explained prior to his incident, they had never had a statement in their fall policy or fall protocol about immediately notifying the MD when a resident on anticoagulant medication had a fall. She further explained the expectation was for the nurse to initiate neurological checks, assess the resident and the decision to call the MD/on-call provider and/or send the resident out to the hospital was based on the clinical assessment and nurses' judgement.

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During a telephone interview on 03/05/24 at 1:12 PM, the Medical Doctor (MD) confirmed he was not notified on 02/13/24 when Resident #1, who was on anticoagulant medication, fell at 1:30 AM and sustained a head injury. The MD could not recall the date but stated when he was notified of Resident #1's fall, he was told the nurse did not call the provider or send Resident #1 out to the hospital for evaluation and decided to monitor her with neurological checks. Then around 6:30 AM Resident #1 started showing acute changes, she was sent out to the hospital for an evaluation and from what he had heard, the outcome was not positive. The MD stated he was unaware Resident #1 was also diagnosed with pneumothorax and felt that would be more of an issue than a fall with head trauma and if she had symptoms of pneumothorax while at the facility following her fall, he would have expected her to have some respiratory difficulties but she didn't. He explained since Resident #1's respiratory, vital signs and neurological checks were normal, even if she had gone to the hospital immediately following her fall, it was likely a Computerized Tomography (abbreviated as CT and refers to an imaging technique that produces detailed internal images of the body) scan would not have detected anything and the hospital may have just sent her back to the facility. He stated the symptoms could have definitely progressed over a few hours and when Resident #1 did show an acute change in condition, he restated staff recognized the acute change and sent Resident #1 to the hospital. The MD stated at the time, the facility did not have a policy or fall protocol for notifying the provider when a resident on anticoagulant medication had a fall. The MD stated he could not say for sure if Resident #1 had been sent to the hospital immediately after

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her fall there would have been a different outcome but had he been notified, he would have erred on the side of caution and given orders for her to be sent to the hospital for an evaluation.

The Administrator was informed of Immediate Jeopardy on 03/06/24 at 11:10 AM.

The facility provided the following Corrective Action Plan with a compliance date of 03/05/24:

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:

1. The facility failed to notify the Medical Director (MD)/Nurse Practitioner (NP) or on-call provider when Resident #1 had an unwitnessed fall on 2/13/24 immediately. Resident #1 was on Eliquis, an anticoagulant medication. Nurse #1 assessed the resident; initiated neuro checks with all vital signs noted to be within normal limits.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

2. An audit of current residents with falls during the last 30 days was completed by the Director of Nursing and the Staff Development Nurse on 2/14/24 to identify any other residents possibly affected by the same practice. There were no negative findings.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

3. Beginning 2/14/24 all staff in all departments

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were trained by the Director of Nursing and Staff Development Nurse on the following: residents must always be assessed after falls and if the resident is on an anticoagulant the MD/NP/on-call should be notified immediately. Staff were educated to review all residents with falls and medication record to verify if they are receiving an anticoagulant and to ensure the provider is notified immediately of a fall. The Director of Nursing was educated by the Administrator on 2/14/23 that she would be in charge of tracking all staff to ensure they received education and ensuring no staff will work without receiving this education. Any new hires will receive education prior to the start of their shift, it will be the responsibility of the Director of Nursing to ensure this is completed. Education to be completed by 3/4/24.

On 3/4/24 the policy for Notification of Change was updated to say: when a resident has an unwitnessed fall or a fall with a head injury the MD/NP/on-call should be notified immediately.

On 3/4/24 The Director of Regulatory Compliance educated the Administrator and Director of Nursing on notifying the physician/NP/on-call immediately when a resident has an unwitnessed fall or a fall with a head injury.

On 3/4/24 The Director of Nursing and the Staff Development Nurse provided education to all Nursing Staff to immediately call the MD/NP/on-call if a resident has an unwitnessed fall or a fall with a head injury. Staff will not be allowed to work before training is completed. The education will be added to the new hire orientation training. Staff will give the trainer verbal feedback to ensure education was

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understood. The Director of Nursing was educated by the Administrator on 3/4/23 that she would be in charge of tracking all staff to ensure they received education and ensuring no staff will work without receiving this education. Any new hires will receive education prior to the start of their shift, it will be the responsibility of the Director of Nursing to ensure this is completed. Education will be completed by 3/4/24.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

4. The Director of Nursing and/or designee will review the daily fall report to ensure all unwitnessed falls and falls with a head injury were reported to the physician immediately for 4 weeks, then 4 falls a week for 4 weeks, and then 3 falls a week for one month. The Director of Nursing or designee will bring these audits to 3 consecutive QAPI meetings. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.

Date of compliance 3/5/24.

The Corrective Action plan was validated on 03/06/24 and concluded the facility implemented an acceptable corrective action plan on 03/05/24 as evidenced by facility documentation and staff interviews. Review of the in-service sign-in sheets dated 02/14/24 revealed all staff/all departments received education that a resident on anticoagulant medication who had a fall must be assessed by the nurse and the MD/provider must be immediately notified. Interviews with facility staff revealed they received in-service

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F 684	Continued From page 29 education regarding the facility's fall protocol and were able to verbalize what to do when a resident had a fall and who to notify of the fall. Interviews with nurses revealed they received additional education on 03/04/24 regarding the change to the facility's fall protocol and verbalized they were to call the MD/provider immediately anytime a resident had a fall with or without injury and regardless if the resident was on anticoagulant medication. Review of the facility's monitoring tools dated 02/15/24 through 03/05/24 revealed they were completed as outlined in the corrective action plan with no concerns identified.	F 684		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information	F 867		3/8/24

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will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

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F 867	Continued From page 31 §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI	F 867		

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F 867	Continued From page 32 program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification and complaint investigation survey completed on 03/26/21. This was for two repeat deficiencies in the areas of quality of care and notification that were originally cited during the recertification and complaint investigation survey completed on 03/26/21 and subsequently recited during the complaint investigation completed on 03/06/24. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA Program. The findings included: This tag is cross referenced to: F580: Based on record review and Medical Doctor (MD) and staff interviews, the facility failed to notify the MD or on-call provider when Resident #1, who was on anticoagulant medication and had a history of brain bleeds, had an unwitnessed fall with obvious head injury for 1 of 3 residents reviewed for accidents and notification.	F 867	The facility failed to maintain implemented procedures and monitor the interventions the committee put into place following the recertification and complaint investigation survey of 3/24/21. This was for 2 deficiencies recited on the current complaint investigation survey of 3/6/24 in the areas of: Notification of Change (F580) and Quality of Care/Professional Standards (F684). The continued failure during two surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Performance Improvement (QAPI) program. On 3/7/24 the Quality Assurance Committee held a meeting to review the purpose and function of the Quality Assurance Performance Improvement (QAPI) Committee as well as reviewing the ongoing compliance related to the issues regarding the F580 and F684 tags received on the complaint survey of 3/6/24 and the recertification and complaint survey of 3/24/21. By 3/7/24, the Regional Clinical Manager	

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F 867	Continued From page 33 During the recertification and complaint investigation survey of 03/26/21, the facility failed to notify the Physician when a resident's Computerized Tomography (CT) scan had been cancelled by the facility. F684: Based on record review and Medical Doctor (MD) and staff interviews, the facility failed to recognize the seriousness of a head injury following a fall and seek medical treatment for a resident on Eliquis (anticoagulant medication) with a history of brain bleeds for 1 of 3 residents reviewed for accidents (Resident #1). During the recertification and complaint investigation survey of 03/26/21, the failed to ensure a resident who had an unwitnessed fall with head injury resulting in hematomas and bruising received a Computerized Tomography (CT) scan as ordered by the Nurse Practitioner. During an interview on 03/06/24 at 3:10 PM, the Administrator revealed it was hard to determine where the breakdown occurred regarding the repeat deficiencies. She explained following the incident with Resident #1 on 02/13/24, they implemented an internal plan of correction and the QA committee would be reviewing and discussing how the monitoring/audits were going when they met later this month (March 2024). The Administrator added she planned to continue with the processes that were put into place indefinitely.	F 867	educated the Administrator, the Director of Nursing, and the Staff Development Coordinator on the appropriate functioning of the QAPI Committee and the purpose of the Committee to include identifying issues and correction of repeat deficiencies, use of rounding tools, daily review of documentation, and observations during leadership rounds. By 3/7/24, the Regional Clinical Manager will provide weekly oversight for 12 weeks and will validate the facility's progress, review corrective actions and dates of completion. The Administrator will be responsible for ensuring QAPI committee concerns are addressed through further training or other interventions. By 3/7/24, the Administrator educated the QAPI committee members consisting of Medical Director, Director of Nursing, Staff Development Coordinator, Unit Managers, Minimum Data Set Nurse, Wound Nurse, Activities Director, Dietary Manager, Environmental Services Manager, Director of Social Services, and the Director of Rehabilitation, on weekly risk review of the audit findings for compliance and/or revision when necessary. The QAPI committee will continue to meet monthly to identify issues related to quality assessment and assurance activities as needed and will develop and implement appropriate plans of action for identified facility concerns. Completion date 3/8/2024	