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	345501	A. BUILDING _____ B. WING _____	C 01/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROASDAILE VILLAGE	2600 CROASDAILE FARM DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282 SS=J	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to follow a care plan intervention for staff to supervise residents in commons areas. This resulted in a fall causing a subdural hematoma which was later identified as the primary cause of death on a death certificate for 1 of 4 residents (Resident #1) whose care plans for falls were reviewed. Findings included: Immediate Jeopardy began on 12/25/15 during the lunch meal (exact time could not be established from review of progress notes and accident/incident reports) when Nurse #2 found Resident #1 lying on the floor of the dining room without staff being present in this commons area. The resident was diagnosed with a subarachnoid hemorrhage and subdural hematoma at the hospital. Immediate Jeopardy was removed on 01/26/16 at 5:00 PM when the facility provided and implemented a credible allegation of compliance. The facility will remain out of compliance at a scope and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy (D). The facility was in the process of full implementation of corrective action at that time. Resident #1 was admitted to the facility on 08/29/15. Her documented diagnoses included history of falls, dementia, osteoarthritis, and vitamin D deficiency.	F 282	1. How did we correct the deficient practice for each resident found to have been affected by the deficient practice? Resident #1 no longer resides at community. 2. How did we correct the deficient practice for other residents having the potential to be affected by the same deficient practice? All residents are at risk for having the potential to be affected by the same deficient practice. All resident events will continue to be reviewed daily by the Risk Committee and the residents care plan and care guide are updated at that time. Changes are made in the Electronic Medical Records (AOD) while the Risk Committee is meeting. Additional systematic changes for all	2/11/16

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

Electronically Signed | 02/11/2016

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F 282	Continued From page 1 Review of progress notes revealed Resident #1 fell on 09/26/15 and 10/01/15. A 10/13/15 interdisciplinary team (IDT) progress note documented Resident #1 fell on 10/09/15 at 4:32 PM when she attempted to stand unassisted from a chair in the living room. The intervention was "Continue to encourage resident to be in commons areas while awake as appropriate for safety and supervision." A 11/01/15 Resident Care Guide for Resident #1 documented, "Safety: Walks with walker. No alarms. Staff to provide stand by assist for transfers and ambulation for safety. Encourage resident to be in common areas for safety. Apply non-skid surface to w/c (wheelchair). Encourage resident to participate in diversional activities while in common area for safety. Do not leave resident unsupervised in common areas or hallways." Review of progress notes revealed Resident #1 fell on 11/02/15 and 11/11/15. A 11/12/15 progress note documented Resident #1, "Attempts to get up w/o (without) assistance while oblivious to safety. Maintained in common area for observation r/t hx (due to history) of falls and fall risk...." On 11/12/15 "I have a potential for fall related injuries. Resident requires assistance with transfers and requires 1 with ambulation (wears a left knee immobilizer)" was identified as problem in the resident's care plan. Approaches to this problem which were developed on 11/12/15 included "1. I require assistance with transfers and ambulation. Follow facility policy and MD orders for safe transfers. 2. Staff to provide cueing and supervision when ambulating. 3. Staff to provide safety checks Q (every) 45 minutes - 1 hour while in room. Staff to provide safety checks and offer toileting."	F 282	residents are noted below. 3. What did we put into place to ensure that deficient practice will not occur again? Fall Risk Assessments have been completed on all residents and care plans and care guides have been updated based on the updated Falls Risk Assessment. (2/11/16) Re-educated nurses and C.N.A.s on how to find and read resident care plans and care guides in Electronic Medical Records (Answers on Demand). (1/26/16) Re-educated Risk Committee and nurses on falls prevention and management policy and the completion of the resident care plan and care guide in the Electronic Medical Record system. (2/10/16) Care Plan policy has been reviewed and all licensed nurses have been re-educated. (1/28/16) The Risk Committee policy was revised by the QAPI Committee and falls will be reviewed daily. (1/28/16) Nurses and C.N.A□.'s are advised to the changes in residents care plan via our Alerts and	

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F 282	Continued From page 2 Review of progress notes revealed Resident #1 fell on 12/02/15 and 12/05/15. A 12/09/15 progress note documented Resident #1 was sitting in her wheelchair in the hallway, at 5:40 AM attempted to get up and ambulate without assistance, lost her balance, and fell backwards hitting her posterior head on the floor. Swelling the size of a golf ball was observed to the left side of the resident's head. The resident complained of pain to her head, and was transported to the emergency room. A 12/10/15 IDT progress note documented not to leave Resident #1 unsupervised in commons areas or the hallway. "...thoracic CT showed T8 fx (fracture) of unknown chronicity--surgery not beneficial, fitted with a ... brace, instructed to wear for 3 mos (months), f/u (follow-up) in 6 wks (weeks) with neurosurgery." On 12/10/15 an approach was added to Resident #1's care plan for fall risk: "4. Staff to not leave resident unsupervised in common area or hallways." An accident/incident report documented Resident #1 had an unwitnessed fall on 12/25/15. The resident was found on the dining room floor during the lunch meal, and it was surmised the resident hit her head due to a lump on the back right side of her head. The resident complained of pain all over, and was sent out to the ER. A 12/28/15 late entry progress note related to the fall on 12/25/15 documented the intervention put in place due to the fall was staff re-education about staying in dining room (a commons area) during meal times when residents were in the dining room eating. A 12/31/15 hospital discharge summary documented Resident #1 was hospitalized from 12/25/15 until 12/31/15. The primary diagnoses were subarachnoid hemorrhage (SAH) and	F 282	Messaging Module in our Electronic Medical Record system (Answers on Demand or AOD). (1/26/16) 100% nurse education on accessing care plans and alerts and messaging was completed This includes all PRN team members as well and all new hires. (1/26/16) 100% C.N.A. education on the importance of and reading the Resident ADL List/Resident Care Guide prior to providing any ADL care was completed. C.N.A. were also educated on the Alerts and Messaging system that sends updates of resident care plan needs. This includes all PRN team members as well and all new hires. (1/26/16) 4. How are we monitoring? Healthcare Administrator or designee will randomly audit 5 resident records per month to assure interventions put into place during the Risk Meetings are followed through and that team received Alert/Message regarding the new interventions. Those audits will be taken to the monthly QAPI meetings by the Healthcare Administrator or designee and QAPI members will address any trends or compliance issues.	

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subdural hematoma (SDH) as identified on CT study. "...On 12/31/15, patient was afebrile with stable vital signs and was transferred to an in-patient hospice facility for end of life care and comfort measures."
Review of Resident #1's 01/08/16 death certificate identified the primary cause of death as "subdural hematoma."
Review of in-servicing to all disciplines from 01/04/16 through 01/11/16 revealed staff were instructed to make sure residents in the commons areas (living rooms and dining rooms) were supervised, and staff were to sign off on a sheet every thirty minutes that they were present with audits to be completed twice each shift on a daily basis. There was no documentation that staff received in-servicing in regard to reviewing the care plan or care guide for updated fall interventions.
During interviews with nursing assistants (NAs)#5, #6, and #7 at 2:11 PM, 3:12 PM, and 3:35 PM respectively on 01/21/16 they stated they were aware that Resident #1 was supposed to be supervised by staff when in the commons areas. They reported this information was communicated to them by the nursing staff who reviewed the resident care plans and updates to those plans. They also commented this information was documented in Resident #1's electronic care guide which could be accessed using the hall computer kiosks.

At 5:40 PM on 01/21/16 the assistant director of nursing (ADON) stated all nurses had access to resident care plans via the computers located at the nursing stations, and NAs had access to resident care guides via the electronic kiosks located on the corridor walls of each unit.

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At 11:15 AM on 01/15/16 the minimum data set (MDS) coordinator stated interim care plans were developed by the admissions nurse, and the MDS team developed a more detailed care plan in conjunction with the completion of resident admission MDS assessments. She reported all nurses could and should be assessing the care plans on the computers at the nurse's stations. She commented supervisors developed care guides for the NAs to use in providing resident care. According to the MDS coordinator, supervisors pulled information from the care plans that was pertinent to the duties of the NAs and included it in the resident care guides. She reported all NAs could and should be assessing the care guides on the computer kiosks in the halls.

At 1:28 PM on 01/25/16 Nurse #2 stated she did not know how to access care plans in the facility's computer system. She explained the facility used to have care plan books which she used, but these books had been done away with since the facility began use of a new electronic record keeping system. She also commented she had not seen NAs accessing the computer kiosks to view resident care guides. However, she remarked that she had shared with the NAs that cared for Resident #1 that the resident needed supervision in commons areas when out of her room due to frequent falls. According to Nurse #2, she did not receive information about how to access electronic care plans/care guides or the importance of referring to the care plans/care guides for fall interventions during 01/04/16 - 01/11/16 staff in-servicing.

At 1:37 PM on 01/25/16 Nurse #3 stated she was a prn nurse, and since the facility began use of a

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new medical record system, she did not refer to the nursing care plans in the electronic record. She reported she received important information about residents in huddles between outgoing and incoming staff during change of shift. She commented she did not receive information about how to access electronic care plans/care guides or the importance of referring to the care plans/care guides for fall interventions during 01/04/16 - 01/11/16 staff in-servicing.

At 2:19 PM on 01/25/16 NA #4 stated she did not know how to access the electronic resident care guide system to obtain resident care information. She explained she received care information from the nursing assistant or nurse who had been working the previous shift during report. She commented she did not receive information about how to access electronic care plans/care guides or the importance of referring to the care plans/care guides for fall interventions during 01/04/16 - 01/11/16 staff in-servicing.

At 3:48 PM on 01/25/16 the acting director of nursing (DON)/facility administrator and the unit administrator stated the nursing staff should refer to the nursing care plans to become familiar with interventions in place to prevent resident falls, and the NAs should refer to the resident care guide for this information. They reported information about how to access electronic care plans/care guides and the importance of referring to the care plans/care guides for fall interventions was not part of the 01/04/16 - 01/11/16 staff in-servicing. However, they commented that "at risk" meetings were being held daily instead of weekly as of 01/18/16, and supervising nurses were required to report new fall interventions to the hall staff as of 01/04/16.

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The acting DON/facility administrator and the unit administrator were notified of the immediate jeopardy on 01/25/16 at 5:15 PM.

The facility provided the following credible allegation on 01/26/16 at 2:40 PM:

The acting DON/facility administrator and the unit administrator were notified of the immediate jeopardy on 01/25/16 at 5:15 PM.

The facility provided the following credible allegation on 01/26/16 at 2:40 PM:

1. How the facility corrected the deficient practice for each resident found to have been affected by the deficient practice: On 12/28/15, the facility completed an internal investigation for Resident #1 due to a fall on 12/25/15. In-servicing with team members began on 12/30/15 regarding resident supervision in common areas. Common area sign-off sheets were implemented 01/04/16 to assure supervision of residents in common areas. Unfortunately, the first resident passed away on 01/07/16 and [did not] return to our facility.

On 01//03/16, the facility began an internal investigation for Resident #2 due to a fall on 01/03/16. In-servicing with team members began on 01/03/16 regarding resident supervision in common areas and continued until 100% of team members were in-serviced. Common area sign-off sheets were implemented 01/04/16 to assure supervision of residents in common areas. The second resident involved was transferred from the hospital to another facility on 01/20/16 in [city] to receive extensive therapy. The resident's

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family said that she should be there 2-3 weeks and that their plan was to bring her back here once [she is] ready for discharge. We will continue supervising the common areas/dining rooms when she returns to assure that we have corrected the deficient practice for her as well as the other residents at risk for falling.

Audits of the common area supervision sign-off sheets began on 01/05/16. Those audits are completed by RN Supervisors and indicate which team member is supervising residents every 30 minutes.

2. How the deficient practice for other residents having the potential to be affected by the same deficient practice was corrected: A list containing residents at risk for falls was placed at each nursing station on 01/07/16 so team members would have heightened awareness of residents at risk for falling and serious injuries. All team members (including housekeeping, maintenance, dining, life enrichment and nursing) have been made aware of the need to supervise the common areas/dining room. All residents at risk for falling are given a different individualized intervention for falls based on their risk and needs. One of the interventions used for residents who are often in common areas instead of their rooms is for them to be supervised by team members. Some residents enjoy being in their rooms more and different interventions are put into place for those residents. Common area sign-off sheets for all common areas/dining rooms were implemented in an effort to supervise all residents at risk on 01/04/16. There is one team member supervising residents in dining room and one team member supervising residents in common area when residents are in

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those locations. Team members work together at the beginning of the shift to decide who is going to supervise when and they work out the schedule throughout their shift according to resident care needs.

Team members were already notified about the need for supervision prior to these incidents, however, re-enforcement and re-education was completed on 01/11/16 to assure compliance with supervision. Most in-services were completed by 01/08/16 and we [did not] allow team members to work until they received the in-service.

3. What the facility put in place to ensure that deficient practice will not occur again: On 01/04/16, the facility implemented a new sign-off sheet on team members supervising the common areas/dining room. The form indicates which team member supervised residents in the common areas/dining room in 30 minute increments. Team members initial the sign-off form when they are supervising residents in that area. If residents [are not] in the common areas (for example when they are sleeping), team members indicate that as well. Team members knew that the residents should be supervised but we implemented the sign-off sheets as an extra measure to assure that a team member was accountable at all times. Audits of the common area supervision sign-off sheets began on 01/05/16. Those audits are completed by RN Supervisors and indicate which team member is supervising residents every 30 minutes.

On 01/03/16, in-services began for all team members regarding supervision of residents at risk for falling while they are in common areas. 100% of team members were in-serviced by

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01/11/16. This included all PRN team members as well. Most in-services were completed by 01/08/16 and we [did not] allow team members to work until they received the in-service.

Our orientation/annual review checklist for new hires will include the review of supervision in common areas. The supervision in common areas was added to orientation/annual review checklist on 01/23/16.

Team members directly involved in the deficient practice for the first resident were in-serviced by 01/05/16.

Team members directly involved in the deficient practice for the second resident were in-serviced on 01/3/16 and disciplinary action was taken by 01/11/16 on all involved in the second resident issue.

Walkie-talkies were purchased on 01/26/16 for the C.N.A.'s and Nurses to carry in order to communicate emergencies when help is needed.

On 01/26/2016 at 5:00 PM, verification of the credible allegation was conducted via interviews with s upervising nurses, other licensed staff, and support staff who stated they received in-service education regarding the importance of following interventions to provide safety for residents who are at high risk for falls, such as referring to the nursing care plan and resident care guide alerts to check for new interventions, referring to the list of residents who are at risk for falls located at the nurse's station, and initialing a log to ensure adequate supervision to residents in the common areas of the facility. Interviews with the acting DON and the unit administrator confirmed the

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F 282	Continued From page 10 order for additional cameras to be installed and for communication equipment for alerting staff members for emergencies. Observations of the common areas of the facility revealed staff members were present upon each observation, and a review of the sign-in sheets for staff initials in 30 minute increments were complete.	F 282		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, physician interview, staff interview, and record review the facility failed to provide staff supervision in commons areas where residents were residing which resulted in serious injury to 2 of 4 residents (Resident #1 and #2) who were reviewed for falls which caused injury. (Resident #1 sustained a subdural hematoma which was later identified as the primary cause of death on a death certificate and Resident #2 sustained multiple bone fractures and hospitalization in intensive care). Findings included: Immediate Jeopardy for Resident #1 began on 12/25/15 during the lunch meal (exact time could not be established from review of progress notes and accident/incident reports) when Nurse #2 found Resident #1 lying on the floor of the dining	F 323	1. How did we correct the deficient practice for each resident found to have been affected by the deficient practice? Resident #1 and #2 no longer reside at community. 2. How did we correct the deficient practice for other residents having the potential to be affected by the same deficient practice? All residents at risk for falling are at risk for having the potential to be affected by	2/11/16

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F 323	Continued From page 11 room without staff being present in this commons area. The resident was diagnosed with a subarachnoid hemorrhage and subdural hematoma at the hospital. Immediate Jeopardy began for Resident #2 on 01/03/16 at 6:45 PM when Nurse #1 found Resident #2 lying face down on the floor beside a column in the common area of the facility with a contusion to the right forehead area and bruising radiating to the right eye. Immediate Jeopardy was removed on 01/26/16 at 5:00 PM when the facility provided and implemented a credible allegation of compliance. The facility will remain out of compliance at a scope and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy (D). The facility was in the process of full implementation of corrective action at that time. 1. Resident #1 was admitted to the facility on 08/29/15. Her documented diagnoses included history of falls, dementia, osteoarthritis, and vitamin D deficiency. Progress notes between 08/30/15 and 09/05/15 documented Resident #1 was alert with confusion, ambulated with a walker, and was unsteady in her gait. The resident's 09/05/15 admission minimum data set (MDS) documented her cognition was severely impaired, she required extensive assistance from a staff member with bed mobility/transferring/dressing/toilet use, she required limited assistance by a staff member for walking in her room and the corridor, was occasionally incontinent of urine, was frequently incontinent of bowel, and had one fall since admission with no injury. A 09/11/15 care plan progress note documented, "Some progress made with upright standing. Very poor perception of balance and safety.	F 323	the same deficient practice. All resident events will continue to be reviewed daily by the Risk Committee and the residents care plan and care guide are updated at that time. Changes are made in the Electronic Medical Records (Answers on Demand "AOD") while the Risk Committee is meeting. Additional systematic changes for all residents are noted below. 3. What did we put into place to ensure that deficient practice will not occur again? A list containing residents at risk for falls was placed at each nursing station so team members would have heightened awareness of residents at risk for falling and serious injuries. (1/7/16) Team members (including housekeeping, maintenance, dining, life enrichment and nursing) have been re-educated regarding resident supervision in the common areas/dining room. (1/11/16) Common area sign-off sheets were implemented for common areas/dining rooms in an effort to supervise all residents at risk. The	

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F 323	Continued From page 12 Weakness in ankles and legs noted. Safety is a concern for ambulation without standby assistance. Able to ambulate the length of the hallway. Moderate assistance needed for ADLs (activities of daily living) for self-care, with maximum cueing." An accident/incident report documented Resident #1 had a witnessed fall just outside the living room near the medication cart at 1:30 PM on 09/26/15. The report also documented the resident tried to get up without assistance, lost her balance, and staff were unable to catch the resident who hit the top left side of her head on the medication cart with no apparent injury. A 09/28/15 interdisciplinary team (IDT) progress note documented Resident #1's 09/26/15 fall was reviewed. It was noted the resident attempted to self-ambulate with her rollator in a common area. The intervention was for staff to provide cueing and supervision to the resident when she was ambulating. A 09/30/15 care plan progress note documented, "Balance continues to be a significant issue. Resident is unable to recognize when she is falling backward while standing and ambulating. She is able to participate in ADLs, but has no safety awareness ...needs supervision to standby assistance when ambulating due to balance and safety awareness." A 10/01/15 progress note documented Resident #1 was found in the floor. "No injuries. Unable to verbalize what she was attempting to do prior to fall. Confused at baseline." An accident/incident report documented Resident #1 had an unwitnessed fall in her room on 10/01/15 at 5:00 AM. The resident was found in a sitting position in the middle of the floor. The resident's brief was wet and soiled, but the resident's nursing assistant (NA) stated she had	F 323	sheet indicates which team member supervised residents in the common areas/dining room in 30 minute increments. Team members initial the sign-off form when they are supervising residents in that area. If residents aren't in the common areas (for example when they are sleeping), team members indicate that as well. (1/4/16) Audits of the common area supervision sign-off sheets are being completed and submitted to QAPI. (1/5/16) Our orientation/annual review checklist for new hires includes the review of supervision in common areas. The supervision in common areas was added to orientation/annual review checklist. (1/23/16) Walkie Talkies were purchased for the C.N.A.'s and Nurses to carry in order to communicate emergencies when help is needed in the common areas/dining rooms. (1/26/16) 4. How we are monitoring? RN Supervisors are monitoring the sign-off forms by randomly auditing the	

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F 323	Continued From page 13 checked the resident not too long before. However, she could not provide the exact time. The report documented there was a fall with no injury. A 10/04/15 IDT progress note documented Resident #1's 10/01/15 fall was reviewed. It was noted the resident attempted to get out of bed unassisted, and was incontinent of urine at the time of the fall. The intervention was for staff to do incontinent checks on the resident everyone to one and a half hours when Resident #1 was in bed. A 10/09/15 progress note document Resident #1 was found on the floor, and was unable to verbalize what happened. An accident/incident report documented Resident #1 had an unwitnessed fall on 10/09/15 at 4:32 PM. It was surmised the resident was sitting in a chair when she tried to get up unassisted and fell onto her side. A 10/13/15 IDT progress note documented Resident #1's 10/09/15 fall was reviewed. It was noted the resident attempted to stand unassisted in the living room. The intervention was "Continue to encourage resident to be in commons areas while awake as appropriate for safety and supervision." A 11/01/15 Resident Care Guide for Resident #1 documented, "Safety: Walks with walker. No alarms. Staff to provide stand by assist for transfers and ambulation for safety. Encourage resident to be in common areas for safety. Apply non-skid surface to w/c (wheelchair). Encourage resident to participate in diversional activities while in common area for safety. Do not leave resident unsupervised in common areas or hallways." A 11/02/15 progress note documented Resident #1 had a fall which was witnessed by a nursing	F 323	forms and checking to make sure team member is actually in the common areas supervising at all times and that they are initialing when they are supervising. Those audits will be taken to the monthly QAPI meetings and by the DON or designee and QAPI members will address any trends or compliance issues. (1/5/16)	

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student and her instructor in the commons area.
An accident/incident report documented Resident #1 had a witnessed fall on 11/02/15 at 7:20 PM. The resident was seen sliding out of her wheelchair as she tried to transfer to the couch in the living room. No injury was noted.
A 11/02/15 IDT progress note documented the intervention for Resident #1's fall was the application of a non-skid surface to the resident's wheelchair seat.
A 11/11/15 progress note documented Resident #1 was found in a sitting position outside her bathroom on the floor. The resident complained of pain to the top of her head. However, a computed tomography (CT) scan of the resident's head and x-rays of her spine, hip, and pelvis were negative for fracture/injury when the resident was assessed at the hospital.
An accident/incident report documented Resident #1 had an unwitnessed fall on 11/11/15 at 12:50 AM. There was a small amount of fecal matter on the resident's bed and a large bowel movement in the toilet. The fall caused an open wound to the right knee of less than three centimeters (cm) with scant bleeding.
A 11/11/15 IDT progress note documented the intervention for Resident #1's 11/11/15 fall was to provide safety checks every 45 - 60 minutes after giving the resident a laxative. Per facility investigation, it was found Resident #1 was given a laxative early in the day on 11/11/15 due to constipation.
A 11/12/15 progress note documented Resident #1, "Attempts to get up w/o (without) assistance while oblivious to safety. Maintained in common area for observation r/t hx (due to history) of falls and fall risk. Increased agitation/anxiety continues and initiates after dinner almost immediately. Difficult to redirect and get meds in

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her at that point w/o several attempts."
On 11/12/15 "I have a potential for fall related injuries. Resident requires assistance with transfers and requires 1 with ambulation (wears a left knee immobilizer)" was identified as problem in the resident's care plan. Approaches to this problem which were developed on 11/12/15 included "1. I require assistance with transfers and ambulation. Follow facility policy and MD orders for safe transfers. 2. Staff to provide cueing and supervision when ambulating. 3. Staff to provide safety checks Q (every) 45 minutes - 1 hour while in room. Staff to provide safety checks and offer toileting."
Resident #1's 11/20/15 quarterly MDS documented she had impaired short and long term memory, was moderately impaired in decision making skills, required extensive assist by a staff member with bed mobility/locomotion on the unit/dressing/toileting/hygiene, required extensive assist by two staff members with transfers, only walked in the room/corridor and locomoted off the unit once or twice during the look-back period, was occasionally incontinent of urine, was always continent of bowel, and had one fall with no injury and one fall with injury (but not major) since her last assessment.
An accident/incident report documented Resident #1 had a witnessed fall on 12/02/15 at 7:30 AM. It was noted the resident was sitting in her wheelchair in the living room, decided to get up, and sat on the floor without injury.
A 12/03/15 IDT progress note documented the new intervention for Resident #1 after her 12/02/15 fall was to encourage the resident to participate in diversional activities when in a commons area for safety.
A 12/05/15 progress note documented Resident #1 was found sitting on the floor undressed from

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the waist down as the NA was making rounds at 3:35 AM. The resident was last observed by the NA resting in bed at 3:15 AM the same morning.
An accident/incident report documented Resident #1 had an unwitnessed fall on 12/05/15 at 3:35 AM. The resident's bed sheets were wet, and the resident had removed her brief and pajama bottoms. The resident sustained a small skin tear to her right outer thigh.
A 12/07/15 IDT progress note documented the new intervention put in place for Resident #1 after her 12/05/15 fall was to complete checks on the resident every 45-60 minutes while she was in her room.
A 12/09/15 progress note documented Resident #1 was sitting in her wheelchair in the hallway, at 5:40 AM attempted to get up and ambulate without assistance, lost her balance, and fell backwards hitting her posterior head on the floor. Swelling the size of a golf ball was observed to the left side of the resident's head. The resident complained of pain to her head, and was transported to the emergency room.
12/09/15 hospital x-rays of the resident's thoracic spine documented, "Diffuse osteopenia...There is a compression fracture of what is favored to represent the T9 vertebral body, which appears new or increased compared to chest radiograph 11/11/15."
A 12/09/15 physician order documented, "...wear back brace whenever sitting up or standing x 3 months."
A 12/10/15 progress note documented, "Resident up at 12:30 AM. Noted insomnia with periods of agitation. Constant attempts to get up and ambulate without assistance. Resident in common area with staff for safety and supervision. Activities provided by staff for resident, kept calm for short period of time.

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Hydration and snack provided. Noted restlessness. Refused 6 AM meds, Refused to wear back brace."
A 12/10/15 IDT progress note documented not to leave Resident #1 unsupervised in commons areas or the hallway. "...thoracic CT showed T8 fx (fracture) of unknown chronicity--surgery not beneficial, fitted with a ... brace, instructed to wear for 3 mos (months), f/u (follow-up) in 6 wks (weeks) with neurosurgery."
On 12/10/15 an approach was added to Resident #1's care plan for fall risk: "4. Staff to not leave resident unsupervised in common area or hallways."
An accident/incident report documented Resident #1 had an unwitnessed fall on 12/25/15. The resident was found on the dining room floor during the lunch meal, and it was surmised the resident hit her head due to a lump on the back right side of her head. The resident complained of pain all over, and was sent out to the ER.
The resident's 12/25/15 discharge MDS documented she had impaired short term memory (her long term memory was not assessed), she was moderately impaired in decision making, and she had one fall with no injury and two falls with injury (but not major) since her last assessment.
A 12/28/15 late entry progress note related to the fall on 12/25/15 documented the intervention put in place due to the fall was staff re-education about staying in dining room (a commons area) during meal times when residents were in the dining room eating.
A 12/31/15 hospital discharge summary documented Resident #1 was hospitalized from 12/25/15 until 12/31/15. The primary diagnoses were subarachnoid hemorrhage (SAH) and subdural hematoma (SDH) as identified on CT

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study. "...On 12/31/15, patient was afebrile with stable vital signs and was transferred to an in-patient hospice facility for end of life care and comfort measures."
Review of Resident #1's 01/08/16 death certificate identified the primary cause of death as "subdural hematoma."
Observations on 01/20/16 and 01/21/16 revealed the unit living room and the dining room were not visible from the unit nurse's station. There was a wall/partition in front of these common areas which prevented staff from monitoring residents in these areas from the nursing station.
At 11:50 AM on 01/21/16 the interim director of nursing (DON)/facility administrator stated the facility always investigated falls with injury, and interviewed staff to determine if care approaches or systems needed to be changed to provide better care and needed to be incorporate into the facility's quality assurance (QA) process. She commented falls were going to happen in nursing homes, but the facility tried its best to prevent them. She reported the facility was alarm and restraint free, but if families requested a restraint or alarm, and the physician would sign off on them, then the facility would utilize them.
According to the facility investigation, the facility administrator explained Resident #1 fell on 12/25/15 at lunch in the dining room with no staff present. She reported a NA was pulled to the hall to change a resident which left the commons area without staff supervision. The administrator stated the facility began discussion on 12/30/15 about ways it could improve management and registered nurse (RN) presence in the facility to make sure safety interventions were in place and being followed. She reported on 01/04/16 formal in-servicing began with all disciplines to make sure staff were assigned and present in 30

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minutes increments when residents were residing in commons areas.
At 12:35 PM on 01/21/16 the physician/medical director stated she had cared for Resident #1 for a long time, and the resident had on-going and long term cognitive and psychiatric problems including extreme bouts with anxiety and depression. She reported the resident lacked safety awareness, and would try to ambulate and transfer without staff assistance because she wanted to remain independent. She commented the facility tried to avoid the use of restraints and alarms so about all the facility could do was to check on the resident frequently when she was in her room and to keep the resident in commons areas as much as possible where staff could supervise her.
At 2:11 PM on 01/21/16 NA # 5 stated Resident #1 was very confused, thinking that she was back in her home state working for a living. She reported the resident always tried to get up unassisted, but when attempts were made to redirect the resident, the resident would become verbally abusive, agitated, and anxious. The NA commented the staff tried to keep the resident in commons areas when she was out of bed so staff could supervise her.
At 3:12 PM on 01/21/16 NA #6 stated she took Resident #1 to the bathroom before the lunch meal began on 12/25/15. She reported there were supposed to be two NAs in the dining room during meals. She explained as lunch progressed on 12/25/15 she left the dining room to provide care to a resident on the hall, but NA #7 was still present in the dining room when she left.
At 3:35 PM on 01/21/16 NA #7 stated Resident #1 could be very confused at times, would try to get up unassisted, and staff kept the resident close in

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commons areas to keep an eye on her. She reported she and NA #6 were in the dining room at the beginning of the lunch meal on 12/25/15. According to NA #7, Nurse #2 approached her in the dining room, stating she needed her help because family was unhappy on the hall. The NA explained the nurse asked her to change a resident whose family was complaining about call bell response and the resident being wet and soiled. NA #7 commented when she left the dining room she did not notice that NA #6 was not present. She stated it was facility expectation that two NAs be present during meal to supervise and assist residents with eating.
At 3:50 PM on 01/21/16 Nurse #2 stated Resident #1 was confused, could not be redirected, and worked herself up into anxious and agitated states which sometimes involved crying spells. She reported the resident had numerous falls in the facility because she would try to get up unassisted. Nurse #2 remarked some of the fall interventions for this resident included staying close to the resident in commons areas, checking on the resident frequently when she was in her room, involving the resident in activities, offering the resident snacks, and placement of a non-skid cushion in the resident's wheelchair. According to Nurse #2, during the lunch meal on 12/25/15 a family member became upset about a resident on the hall due to call bell problems and the resident being wet and soiled. She reported she retrieved NA #7 from the dining room to change this resident while she took care of the call bell. She commented she though there was another NA in the dining room. Nurse #2 explained when she resolved the call bell issue, she noticed NA #7 was still changing the resident on the hall so she began walking back to the dining room. However, she reported before she could get there

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a dietary employee approached her stating that Resident #1 was on the dining room floor.
At 5:04 PM on 01/21/16 the unit administrator stated the living rooms and dining rooms were considered common areas, and it was the "community or cultural standard and facility expectation" that when residents were present in these areas that a staff member also be present to check on them and monitor their activities.
At 9:33 AM on 01/25/16 Nurse #4 (nurse manager) stated Resident #1 was not on hospice while residing in the facility between 08/29/15 and 12/25/15; nor did she know of any condition that would have shortened the resident's life span. She reported the resident had poor safety awareness, and was repeatedly trying to get up from the chair and bed without staff assistance. According to Nurse #4, there was a fall intervention in place when Resident #1 fell on 12/25/15 that she was not to be left unsupervised in any commons area.

The acting DON/facility administrator and the unit administrator were notified of the immediate jeopardy on 01/25/16 at 5:15 PM.

2. Resident #2 was admitted to the facility on 09/22/15 with diagnoses of hypertension and cerebral vascular accident.

The nursing care plan which was initiated on 09/23/15 included a goal dated 10/06/15 for Resident #2 to be free from fall related injuries. There were 2 interventions included on the nursing care plan to achieve this goal as follows:
1) Please assist with toileting and incontinence

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care every 2-3 hours and prn (as needed), and 2) Staff to have resident sit at table while in common area to prevent resident from falling forward. The second intervention included a date of 10/13/15.

A review of Resident #2's quarterly Minimum Data Set assessment dated 12/20/15 revealed she was moderately cognitively impaired for making decisions regarding her activities of daily living. The assessment also indicated that Resident #1 was totally dependent upon nursing staff for bed mobility and surface to surface transfers. Locomotion on the unit did not occur during this assessment period, however the assessment indicated the resident used a wheelchair for mobility. The same quarterly assessment of 12/20/15 also indicated Resident #2 was not steady on her feet, that she was only able to stabilize (balance) with staff assistance, and that she had a history of falls with injury.

Review the facility's fall investigation report revealed Resident #2 had a witnessed fall on 12/03/15 at 3:05 PM. The description of the fall indicated a nurse witnessed the resident standing up from her wheelchair while in the common area, and that the nurse ran to the resident to break her fall. The description also indicated that the resident denied any pain and stated, "I 'll stand up and fall again."

An interdisciplinary note dated 01/03/16 indicated that Resident #2 had a fall on 01/03/2016 and the resident was sent to the emergency room for an evaluation.

Another interdisciplinary note dated 01/05/16 indicated that on 01/03/16, Nurse #1 was on her

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way to another resident's room when she heard a loud noise, then ran toward the noise, and found Resident #2 on the floor in the common area with notable swelling to the "right frontal lobe with scant bleeding and bruising radiating to the right eye." The note was signed by Nurse #1.

Review of the facility's fall investigation report indicated that Resident #2's fall on 01/03/16 was unwitnessed.

An interview was conducted with Nurse #1 on 01/21/16 at 6:31 PM. She explained that when she heard the noise on 01/03/16 she ran to the common area toward the noise, and found Resident #2 on the floor next to a column in the common area, face down, with buttocks elevated, knees bent, and arms folded. Nurse #1 stated that she immediately called out for assistance, then assessed the resident and found the contusion to her right forehead area. Nurse #1 added that she was unable to get a blood pressure on Resident #2 after the fall due to pain the resident was having in her arm. She explained that she was aware that the resident was not to be left alone in the common area, but as a prn (who works only as needed in the facility) she was not aware of any other intervention to prevent falls for Resident #2.

In a follow-up interview with Nurse #1 on 01/26/16 at 10:50 AM, she stated that before the fall occurred on 01/03/16, she had witnessed the resident to be in her wheelchair at a table in the common area during the 3:00 PM to 11:00 PM shift before her fall, but she was not sure of the time. She stated when she found Resident #2 face down on the floor after her fall on 01/03/16, she was about 3 feet away from where she was

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last seen seated in her wheelchair at the table. Nurse #1 stated there were three nursing assistants (NAs) with her at that time, NA #1, NA #2, and NA #3. These nursing assistants were the only NAs who worked on the unit for the 3:00 to 11:00 PM shift on 01/03/16 on the unit. She also stated that Resident #2 was capable of unlocking her wheelchair and moving it on her own.

The administrator stated in an interview on 01/21/16 at 4:38 PM that there was an expectation that staff members needed to be present at all times in the common areas to supervise the residents. She explained that the expectation was not documented in a policy, but staff members were aware of the expectation.

During an interview with NA #1 on 01/26/16 at 10:20 AM, she stated she was on duty on 01/03/2016 at the time of Resident #2 ' s fall, but she did not witness the fall. NA #1 stated the time she last saw Resident #2 before her fall on 01/03/16, she was seated beside the table in the commons area, but was not pushed up to the table and that 2 other NAs were with her. NA #1 stated staff members were not supposed to leave the common area whenever any residents were there. NA #1 further explained she was providing care for another resident in his room at the time when Resident #2's fall occurred.

During an interview with NA #2 on 01/25/16 at 2:00 PM, she stated that she was on duty on 01/03/16 when Resident #2 fell, but she did not witness the fall. She explained that the staff were not supposed to leave Resident #2 alone in the common area, and that if a staff member needed to leave the common area, they were supposed

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to find someone else to stay in the common area before leaving. NA #2 stated that the last time she observed Resident #2 prior to her fall on 01/03/16, she was seated in her wheelchair in the common area with another NA.

On 01/26/16 at 4:15 PM, NA #3 stated in an interview that she was on duty on 01/03/16 during the 3:00 PM to 11:00 PM shift when Resident #2 fell, but did not witness the fall. NA #3 stated the last time she observed Resident #2 that day, she was in the common area in her wheelchair, seated at one of the tables. NA #3 stated she took a break, but she did not recall leaving Resident #2 unattended in the commons area. She also explained that before her fall that day, she was not aware of the intervention to keep the resident pushed up to a table to prevent her from falling forward.

A review of the facility's incident investigation report regarding Resident #2's fall on 01/03/16 revealed the fall was unwitnessed. The report indicated Nurse #1 administered first aid after she discovered her lying face down on the floor by the column. The emergency medical technicians were called, and Resident #2 left the facility via emergency medical transport at 7:33 PM. Resident #2's Discharge Summary from the hospital dated 01/19/16 indicated that Resident #2 was admitted to the hospital ' s surgical intensive care unit (SICU) on 01/03/16 following a fall at the skilled nursing facility, and that her injuries included:

1. a fracture at the base of the right greater trochanter (hip)
2. a fracture at the base of the dens at level C2 (fracture at the base of the second

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cervical spine bone at the neck)
3. C2 spinous process fracture (fracture on the outer portion of the second cervical bone in the neck)
4. T3 and T4 fractures (the third and fourth of twelve bones in the thoracic section of the spine)
5. right radius/ulna fracture (wrist)

Further review of the same Discharge Summary from the hospital dated 01/19/16 indicated Resident #2 had a right frontal scalp hematoma which extended to the eyelid, and that she remained in the SICU until 01/15/16 when she was transferred to the hospital ' s long term acute care section. Additionally, Resident #1 initially required a lidocaine drip for pain control, and the use of a Minerva brace (a cervical thoracic orthotic device and a thoracic collar to stabilize her spine fractures. Resident #2 was discharged from the hospital to another rehabilitation facility on 01/20/16.

Resident #2's physician stated in an interview on 01/21/16 at 12:36 PM, that the resident had osteoporosis, and that the injuries she received during the fall on 01/03/16 were possibly more extensive due to her osteoporosis. The physician also stated she would have wanted to nursing staff to follow nursing interventions in place to provide safety for the resident.

The acting DON/facility administrator and the unit administrator were notified of the immediate jeopardy on 01/25/16 at 5:15 PM.

The facility provided the following credible allegation on 01/26/16 at 2:40 PM:

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1. How the facility corrected the deficient practice for each resident found to have been affected by the deficient practice: On 12/28/15, the facility completed an internal investigation for Resident #1 due to a fall on 12/25/15. In-servicing with team members began on 12/30/15 regarding resident supervision in common areas. Common area sign-off sheets were implemented 01/04/16 to assure supervision of residents in common areas. Unfortunately, the first resident passed away on 01/07/16 and [did not] return to our facility.

On 01//03/16, the facility began an internal investigation for Resident #2 due to a fall on 01/03/16. In-servicing with team members began on 01/03/16 regarding resident supervision in common areas and continued until 100% of team members were in-serviced. Common area sign-off sheets were implemented 01/04/16 to assure supervision of residents in common areas. The second resident involved was transferred from the hospital to another facility on 01/20/16 in [city] to receive extensive therapy. The resident's family said that she should be there 2-3 weeks and that their plan was to bring her back here once [she is] ready for discharge. We will continue supervising the common areas/dining rooms when she returns to assure that we have corrected the deficient practice for her as well as the other residents at risk for falling.

Audits of the common area supervision sign-off sheets began on 01/05/16. Those audits are completed by RN Supervisors and indicate which team member is supervising residents every 30 minutes.

2. How the deficient practice for other residents

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having the potential to be affected by the same deficient practice was corrected: A list containing residents at risk for falls was placed at each nursing station on 01/07/16 so team members would have heightened awareness of residents at risk for falling and serious injuries. All team members (including housekeeping, maintenance, dining, life enrichment and nursing) have been made aware of the need to supervise the common areas/dining room. All residents at risk for falling are given a different individualized intervention for falls based on their risk and needs. One of the interventions used for residents who are often in common areas instead of their rooms is for them to be supervised by team members. Some residents enjoy being in their rooms more and different interventions are put into place for those residents. Common area sign-off sheets for all common areas/dining rooms were implemented in an effort to supervise all residents at risk on 01/04/16. There is one team member supervising residents in dining room and one team member supervising residents in common area when residents are in those locations. Team members work together at the beginning of the shift to decide who is going to supervise when and they work out the schedule throughout their shift according to resident care needs.

Team members were already notified about the need for supervision prior to these incidents, however, re-enforcement and re-education was completed on 01/11/16 to assure compliance with supervision. Most in-services were completed by 01/08/16 and we [did not] allow team members to work until they received the in-service.

3. What the facility put in place to ensure that

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deficient practice will not occur again: On 01/04/16, the facility implemented a new sign-off sheet on team members supervising the common areas/dining room. The form indicates which team member supervised residents in the common areas/dining room in 30 minute increments. Team members initial the sign-off form when they are supervising residents in that area. If residents [are not] in the common areas (for example when they are sleeping), team members indicate that as well. Team members knew that the residents should be supervised but we implemented the sign-off sheets as an extra measure to assure that a team member was accountable at all times. Audits of the common area supervision sign-off sheets began on 01/05/16. Those audits are completed by RN Supervisors and indicate which team member is supervising residents every 30 minutes.

On 01/03/16, in-services began for all team members regarding supervision of residents at risk for falling while they are in common areas. 100% of team members were in-serviced by 01/11/16. This included all PRN team members as well. Most in-services were completed by 01/08/16 and we [did not] allow team members to work until they received the in-service.

Our orientation/annual review checklist for new hires will include the review of supervision in common areas. The supervision in common areas was added to orientation/annual review checklist on 01/23/16.

Team members directly involved in the deficient practice for the first resident were in-serviced by 01/05/16.

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Team members directly involved in the deficient practice for the second resident were in-serviced on 01/3/16 and disciplinary action was taken by 01/11/16 on all involved in the second resident issue.

Walkie-talkies were purchased on 01/26/16 for the C.N.A.'s and Nurses to carry in order to communicate emergencies when help is needed.

On 01/26/2016 at 5:00 PM, verification of the credible allegation was conducted via interviews with s upervising nurses, other licensed staff, and support staff who stated they received in-service education regarding the importance of following interventions to provide safety for residents who are at high risk for falls, such as referring to the nursing care plan and resident care guide alerts to check for new interventions, referring to the list of residents who are at risk for falls located at the nurse's station, and initialing a log to ensure adequate supervision to residents in the common areas of the facility. Interviews with the acting DON and the unit administrator confirmed the order for additional cameras to be installed and for communication equipment for alerting staff members for emergencies. Observations of the common areas of the facility revealed staff members were present upon each observation, and a review of the sign-in sheets for staff initials in 30 minute increments were complete.