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F 000	INITIAL COMMENTS A complaint survey was conducted from 1/28/19 through 1/31/19. Immediate Jeopardy was identified at: CFR 483.21 at tag F656 at a scope and severity J CFR 483.25 at tag F689 at a scope and severity J The tag F689 constituted Substandard Quality of Care. One additional citation was identified during the complaint survey at CFR 483.20 (Tag F641 at a scope and severity of D). Immediate Jeopardy began on 12/4/18 and was removed on 1/31/19. A partial extended survey was conducted.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to accurately code the Minimum Data Set (MDS) assessment to indicate a resident ' s balance during transitions and walking, her history of falls, and the use of a wander guard for 1 of 3 residents reviewed for Accidents (Resident #3). The findings included: 1-a) Resident #3 was admitted to the facility on 6/1/17. Her cumulative diagnoses included Alzheimer ' s disease, anxiety disorder, depression, repeated falls, and unspecified abnormalities of gait and mobility.	F 641	Resident number 3 was discharged from the facility on 12/4/2018. The facility is unable to submit a correction to the inaccurate MDS Assessment. A 100% audit was conducted by a third party MDS consultant of the most recent MDS assessment completed for all residents current as of 2/2/2019 to identify areas of inaccuracy by 2/14/2019 with all areas of concern addressed with appropriate modifications completed. The previous MDS nurse is no longer employed with the facility and the current	2/22/19

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

Electronically Signed | 02/18/2019

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F 641	Continued From page 1 Resident #3 ' s last annual Minimum Data Set (MDS) assessment dated 6/5/18 indicated the resident had severely impaired cognitive skills for daily decision making. Section G indicated the resident required extensive assistance with two plus (2+) persons physical assist for bed mobility and transfers. Resident #3 required extensive assistance with one person physical assist for dressing, toilet use, and personal hygiene. The resident required supervision only from staff for locomotion on/off the unit and for eating. Section G0300 of the MDS assessment addressed the resident ' s balance during transitions and walking. The coding within this section indicated "Activity did not occur" for each of the following areas: A. Moving from seated to standing position; B. Walking (with assistive device if used); C. Turning around and facing the opposite direction while walk; D. Moving on and off toilet; E. Surface-to-surface transfer (transfer between bed and chair or wheelchair. An interview was conducted on 1/29/19 at 11:00 AM with the facility ' s MDS Nurse in the presence of the facility ' s Compliance Officer. During the interview, the nurse was asked what resources were used to complete Section G of a resident ' s MDS. She reported using interviews with nursing assistants and nurses, observations, and a review of the electronic documentation of ADLs for the 7-day look back period. A follow-up interview was conducted on 1/30/18 at 1:36 PM with the MDS Nurse in the presence of the facility ' s Compliance Officer. Upon request, the MDS Nurse reviewed Section G0300	F 641	personnel responsible for MDS submissions have been educated that all MDS completions are to be completed accurately using direct observations and elements of the clinical record to reflect the resident□s status to include areas such as resident balance during transitions and walking, history of falls, and the use of a wander guard. This education was completed by the facility DON on 2/12/2019. A third party consultant company was hired to review accuracy of MDS coding to further review this process for compliance. In order to monitor success of this corrective action, the third party consultant company will review all completed MDS assessments weekly for 12 weeks to ensure accuracy of the MDS assessment completion. The results of these audits will be reported to the QA committee with all identified areas of concern corrected immediately.	

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F 641	Continued From page 2	F 641		

of Resident #3 ' s last three MDS assessments. After reviewing the 6/5/18 MDS assessment, the nurse confirmed all answers within this section were coded to indicate the "Activity did not occur." During the interview, the MDS Nurse was asked if this coding was correct. The MDS Nurse responded by stating the person completing the MDS may not have witnessed these activities at the time the assessment was done. When asked if it would be acceptable to use an alternate source of information to obtain this information (such as nursing staff report), the nurse answered, "You could, yes." Upon further inquiry, the MDS Nurse reported "at least some" of the activities coded as not occurring did actually occur for Resident #3 during the 7-day look back period for this MDS assessment.

An interview was conducted on 1/31/19 at 10:20 AM with the facility ' s Administrator. During the interview, the Administrator stated her expectation for MDS coding was for the individual completing the assessment to take into consideration a holistic picture of the resident based on observations, documentation within the clinical records, and direct patient care staff feedback. When asked if she would expect the MDS coding to be accurate, the Administrator stated, "Absolutely."

1-b) Resident #3 was admitted to the facility on 6/1/17. Her cumulative diagnoses included Alzheimer ' s disease, anxiety disorder, depression, repeated falls, and unspecified abnormalities of gait and mobility.

Resident #3 ' s quarterly Minimum Data Set (MDS) assessment dated 9/5/18 indicated the resident had severely impaired cognitive skills for

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F 641	Continued From page 3	F 641		

daily decision making. Section G indicated the resident required limited assistance with one person physical assist for bed mobility and extensive assistance with one person physical assist for transfers, dressing, toileting, and personal hygiene. The resident required supervision only from staff for locomotion on/off the unit and for eating. Section G0300 of the assessment addressed the resident ' s balance during transitions and walking. The coding within this section indicated "Activity did not occur" for each of the following areas:
A. Moving from seated to standing position;
B. Walking (with assistive device if used);
C. Turning around and facing the opposite direction while walk;
D. Moving on and off toilet;
E. Surface-to-surface transfer (transfer between bed and chair or wheelchair.

An interview was conducted on 1/29/19 at 11:00 AM with the facility ' s MDS Nurse in the presence of the facility ' s Compliance Officer. During the interview, the nurse was asked what resources were used to complete Section G of a resident ' s MDS. She reported using interviews with nursing assistants and nurses, observations, and a review of the electronic documentation of ADLs for the 7-day look back period.

A follow-up interview was conducted on 1/30/18 at 1:36 PM with the MDS Nurse in the presence of the facility ' s Compliance Officer. Upon request, the MDS Nurse reviewed Section G0300 of Resident #3 ' s last three MDS assessments. After reviewing the 9/5/18 MDS assessment, the nurse confirmed all answers within this section were coded to indicate the "Activity did not occur." During the interview, the MDS Nurse was asked if

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this coding was correct. The MDS Nurse responded by stating the person completing the MDS may not have witnessed these activities at the time the assessment was done. When asked if it would be acceptable to use an alternate source of information to obtain this information (such as nursing staff report), the nurse answered, "You could, yes." Upon further inquiry, the MDS Nurse reported "at least some" of the activities coded as not occurring did actually occur for Resident #3 during the 7-day look back period for this MDS assessment.

An interview was conducted on 1/31/19 at 10:20 AM with the facility ' s Administrator. During the interview, the Administrator stated her expectation for MDS coding was for the individual completing the assessment to take into consideration a holistic picture of the resident based on observations, documentation within the clinical records, and direct patient care staff feedback. When asked if she would expect the MDS coding to be accurate, the Administrator stated, "Absolutely."

1-c) Resident #3 was admitted to the facility on 6/1/17. Her cumulative diagnoses included Alzheimer ' s disease, anxiety disorder, depression, repeated falls, and unspecified abnormalities of gait and mobility.

Resident #3 ' s quarterly Minimum Data Set (MDS) assessment dated 12/3/18 indicated the resident had severely impaired cognitive skills for daily decision making. Section G indicated the resident required extensive assistance with one person physical assist for bed mobility, dressing, toileting, and personal hygiene. The resident required extensive assistance with 2+ person

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physical assist for transfers. Locomotion on/off the unit was reported to have occurred only once or twice during the 7-day look back period with only set-up help required. The resident needed supervision only for eating. Section G0300 of the assessment addressed the resident ' s balance during transitions and walking. The coding within this section indicated "Activity did not occur" for each of the following areas:
A. Moving from seated to standing position;
B. Walking (with assistive device if used);
C. Turning around and facing the opposite direction while walk;
D. Moving on and off toilet;
E. Surface-to-surface transfer (transfer between bed and chair or wheelchair.

An interview was conducted on 1/29/19 at 11:00 AM with the facility ' s MDS Nurse in the presence of the facility ' s Compliance Officer. During the interview, the nurse was asked what resources were used to complete Section G of a resident ' s MDS. She reported using interviews with nursing assistants and nurses, observations, and a review of the electronic documentation of ADLs for the 7-day look back period.

A follow-up interview was conducted on 1/30/18 at 1:36 PM with the MDS Nurse in the presence of the facility ' s Compliance Officer. Upon request, the MDS Nurse reviewed Section G0300 of Resident #3 ' s last three MDS assessments. After reviewing the 12/3/18 MDS assessment, the nurse confirmed all answers within this section were coded to indicate the "Activity did not occur." During the interview, the MDS Nurse was asked if this coding was correct. The MDS Nurse responded by stating the person completing the MDS may not have witnessed these activities at

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F 641	Continued From page 6	F 641		

the time the assessment was done. When asked if it would be acceptable to use an alternate source of information to obtain this information (such as nursing staff report), the nurse answered, "You could, yes." Upon further inquiry, the MDS Nurse reported "at least some" of the activities coded as not occurring did actually occur for Resident #3 during the 7-day look back period for this MDS assessment.

An interview was conducted on 1/31/19 at 10:20 AM with the facility ' s Administrator. During the interview, the Administrator stated her expectation for MDS coding was for the individual completing the assessment to take into consideration a holistic picture of the resident based on observations, documentation within the clinical records, and direct patient care staff feedback. When asked if she would expect the MDS coding to be accurate, the Administrator stated, "Absolutely."

1-d) Resident #3 was admitted to the facility on 6/1/17 from another nursing home or swing bed. Her cumulative diagnoses included Alzheimer ' s disease, anxiety disorder, depression, repeated falls, and unspecified abnormalities of gait and mobility.

A review of Resident #3 ' s medical record and Falls Scene Investigation Report dated 7/22/18 revealed the resident had a fall with no injury on 7/22/18.

Resident #3 ' s quarterly Minimum Data Set (MDS) assessment dated 9/5/18 indicated the resident had severely impaired cognitive skills for daily decision making. Section J of the MDS assessment indicated the resident did not have

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any falls since completion of her prior assessment (dated 6/5/18).

An interview was conducted on 1/30/18 at 9:22 AM with the MDS Nurse in the presence of the facility ' s Compliance Officer. Upon request, the MDS Nurse reviewed Resident #3 ' s quarterly MDS assessment dated 9/5/18. After reviewing Section J of the MDS, the MDS Nurse confirmed no falls were reported as having occurred since Resident #3 ' s prior assessment. When the MDS Nurse reviewed the resident ' s electronic medical record, she reported seeing a Nursing Note dated 7/23/18 which indicated the resident had experienced a fall on 7/22/18. At that time, the MDS Nurse stated the 9/5/18 MDS assessment should have reported the resident had one fall since her prior assessment.

An interview was conducted on 1/31/19 at 10:20 AM with the facility ' s Administrator. During the interview, the Administrator stated her expectation for MDS coding was for the individual completing the assessment to take into consideration a holistic picture of the resident based on observations, documentation within the clinical records, and direct patient care staff feedback. When asked if she would expect the MDS coding to be accurate, the Administrator stated, "Absolutely."

1-e) Resident #3 was admitted to the facility on 6/1/17 from another nursing home or swing bed. Her cumulative diagnoses included Alzheimer ' s disease, anxiety disorder, depression, repeated falls, and unspecified abnormalities of gait and mobility.

Resident #3 ' s quarterly Minimum Data Set

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F 641	Continued From page 8 (MDS) assessment dated 12/3/18 indicated the resident had severely impaired cognitive skills for daily decision making. Section P of the assessment indicated a wander/elopement alarm was not used for this resident. An interview was conducted on 1/29/19 at 11:00 AM with the facility ' s MDS Nurse in the presence of the facility ' s Compliance Officer. Upon request, the MDS Nurse reviewed Resident #3 ' s quarterly MDS assessment dated 12/3/18. After reviewing Section P of the MDS, the MDS Nurse confirmed the assessment did not indicate a wander/elopement alarm was used for this resident. The MDS Nurse reported she would need to review Resident #3 ' s records in more detail to determine whether or not a wander/elopement alarm was used during the MDS 7-day look back period. Upon her request, a follow-up interview was conducted on 1/29/19 at 12:27 PM with the MDS Nurse. During the interview, the MDS Nurse reported Resident #3 did have a wander guard in place (a wander/elopement alarm) at the time of the 12/3/18 MDS assessment. The nurse reported the wander guard was included on the resident ' s care plan, but it had not been coded correctly on the MDS assessment.	F 641		
F 656 SS=J	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		1/31/19

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F 656	Continued From page 9 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff and physician interviews, and facility and hospital record reviews, the facility failed to develop a comprehensive	F 656	On December 4, 2018, Resident 3 experienced a fall post-transfer of one person assist to the bed, at which point	

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F 656	Continued From page 10 person-centered care plan that accurately reflected the care needs and safety measures required to care for a resident, including the need for two-person assistance with transfers and the assistance required immediately after a transfer 1 of 3 sampled residents reviewed for accidents (Resident #3). Resident #3 experienced a fall from the side of her bed, while being assisted by one staff member which resulted in a fall and the resident experienced an injury to her forehead. Resident #3 was sent to the hospital for evaluation and treatment and passed away later that day from an intracerebral hemorrhage (bleeding around or within the brain itself). Immediate Jeopardy began on 12/4/18 when Nursing Assistant (NA) #1 transferred Resident #3 from her recliner to the bed with a stand and pivot maneuver without additional staff assistance and Resident #3 fell forward off of the bed, striking her head on the floor. At the time of the fall, the resident ' s Care Plan did not specify she required two-person assistance with transfers and was not stable sitting on the side of the bed by herself. Immediate Jeopardy was removed as of 1/31/19 when the facility implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a scope and severity level "D" (no actual harm with potential for more than minimal harm that is not immediate jeopardy) for the facility to continue staff education and ensure monitoring systems put into place are effective. The findings included: Resident #3 was admitted to the facility on 6/1/17. Her cumulative diagnoses included Alzheimer ' s disease, anxiety disorder, depression, repeated	F 656	she sat on the bed as the nurse aide discontinued hands-on physical assistance in order to slide the linen further back. At this time, this resident leaned forward and fell onto the floor. Resident 3 was immediately sent to the Emergency Department of Granville Health System status post-fall and expired on 12/4/2018. The staff that left the resident sitting untouched while in the room is no longer working with the facility. 1. Resident 3 was sent to the Emergency Department as a result of the above incident. It was identified by analysis on 1/29/2019 that the care plan failed to provide sufficient information regarding the resident□s transferring needs and other safety needs as recommended by therapy via therapy evaluation documentation on 6/28/2018 for a 2-person moderate to maximum assist during transfers. As a result, the resident was transferred via one person assist. 2. To address the particular process leading to the deficiency, an audit of 100% of resident care plans was initiated and to be completed on 1/29/2019. The residents□ care plans are available to facility staff in order to identify areas of each resident□s care plan needed for daily care and activities of daily living. The audit was conducted on 1/29/2019 by the Treatment Nurse, Staff Development Coordinator, Clinical Nurse Manager, and Director of Nursing to cross-reference transfer needs and other safety concerns identified, such as sitting balance on each resident□s care plan to ensure that the	

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F 656	Continued From page 11 falls, and unspecified abnormalities of gait and mobility. Resident #3 ' s last annual Minimum Data Set (MDS) assessment dated 6/5/18 indicated the resident had severely impaired cognitive skills for daily decision making. Section G indicated the resident required extensive assistance with two plus (2+) persons physical assist for bed mobility and transfers A review of the resident ' s Care Area Assessment (CAA) Worksheet for ADL (Activities of Daily Living) / Functional / Rehabilitation Potential (dated 6/8/18) included an analysis of findings. These findings read, in part: " ...She is alert to self only ...She requires assistance with bed mobility, toileting and transfers ..." A review of the CAA Worksheet for Falls (dated 6/8/18) included a description of the nature of this problem/condition, which noted the resident had a fall during the past quarter without injury, had a diagnosis of Alzheimer ' s dementia, and exhibited daily confusion. A decision was made to include both ADLs and Falls in the resident ' s care plan. Resident #3 ' s Care Plan (dated 6/8/18) included the following areas of focus, in part: --Resident requires assist with ADLs on a daily basis related to a diagnosis of Alzheimer ' s. The care plan interventions indicated the resident, "Can stand and pivot with transfers." The Care Plan did not indicate how many staff members were required to assist the resident with transfers. --Resident has a history of falls. --Resident is at risk for falls. Has impaired safety awareness.	F 656	information was correct and consistent with recommendations from the Rehabilitation Department. The MDS consultant and Director of Nursing corrected all resident care plans on 1/29/2019 to reflect residents accurate needs for transfer assistance and identified safety concerns, to include the number of staff necessary to perform the tasks. On January 30, 2019, care plan updates reflecting residents accurate needs for transfer assistance and safety concerns, to include number of staff necessary to perform the tasks, were completed and updated care guides were placed in each resident s closet by administrative staff replacing the existing care guides. Education will be initiated on 1/30/2019 with all nurses and nurse aides, to include agency staff working within the facility, regarding the process for updates to the residents care plan, the location of the care plan data, and the proper recourse for accessing the necessary information if the care plan data does not contain pertinent information for each resident s care. Facility staff as well as agency staff are to be educated on this information upon orientation with the facility and/or the nurse staffing agency prior to working directly with residents within the facility. 3. Facility MDS nurse, Treatment Nurse, Staff Development Coordinator, Clinical Nurse Manager and Director of Nursing were all educated on 1/30/2019 by facility Administrator on the expectation that the resident s care plan is to reflect the resident s actual needs and any	

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F 656	Continued From page 12 A review of Resident #3 ' s medical record revealed a Therapy Screen was requested by nursing staff on 6/20/18. The screen was completed by a Physical Therapist (PT) on 6/22/18. PT notations dated 6/22/18 indicated he spoke with nursing staff. Staff reported Resident #3 was having increased difficulty with transfers and would benefit from a Physical Therapy evaluation. The PT completed an evaluation on 6/28/18. A Functional Assessment of the resident ' s sitting balance indicated she required contact guard assist (CGA) for both static and dynamic (gentle challenges to balance) balance while sitting on the side of a bed. The PT ' s Treatment Plan for Resident #3 read: "Pt (patient) performs bed mobility, transfers and gait at baseline. No further skilled PT (physical therapy) is required at this time. Recommend NSG (nursing) perform OOB (out of bed) to chair daily by 2 person assist or Hoyer lift." Further review of Resident #3 ' s Care Plan dated 6/8/18 related to ADL care was conducted. No revisions had been made to the care plan interventions as a result of the 6/28/18 Physical Therapy evaluation. The Care Plan interventions continued to read, "Can stand and pivot with transfers." The Care Plan did not indicate the resident needed two-person assistance with transfers (or a Hoyer lift) as recommended by PT, nor did it include safety measures required based on the PT ' s assessment of Resident #3 ' s instability while sitting on the side of the bed which included her need for contact guard assist with both static and dynamic balance. Resident #3 ' s quarterly Minimum Data Set (MDS) assessment dated 9/5/18 indicated the resident had severely impaired cognitive skills for	F 656	additional key safety measures required, including transfer needs and other safety concerns, based on observations, documented assessments and data from direct care personnel, such as therapy evaluation documentation. A copy of all therapy recommendations will be submitted to the Telephone Order box for review by the clinical and interdisciplinary MDS team in order to communicate changes in resident needs for transfers as well as safety concerns. A 100% in-service training of all therapy staff by the facility Rehabilitation Department Director regarding the placement of a copy of therapy documentation in the Telephone Order box for nurse management review was completed on 1/30/2019. No therapy staff member will be allowed to work until he or she has received the education. All residents receiving therapy, including Physical, Occupational, and Speech Therapy will be reviewed on a daily basis with the MDS interdisciplinary team, with changes to residents□ transfer and other safety measures required being updated in each resident□s care plan immediately by the Facility MDS nurse, Treatment Nurse, Staff Development Coordinator, Clinical Nurse Manager and/or Director of Nursing. All changes in transfer needs and updated safety concerns will be submitted to and reviewed by the Director of Nursing, or designee, for a period of 4 months beginning 1/30/2019. Any changes will be communicated to front line staff in the morning huddle meeting. Clinical Managers are to communicate	

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daily decision making. Section G indicated the resident required limited assistance with one person physical assist for bed mobility and extensive assistance with one person physical assist for transfers.

A review of the resident ' s Care Plan (dated 9/12/18) related to ADL care was conducted. The Care Plan interventions continued to read, "Can stand and pivot with transfers." The Care Plan interventions continued to read, "Can stand and pivot with transfers." The Care Plan did not indicate the resident needed two-person assistance with transfers (or a Hoyer lift) as recommended by PT on 6/28/18, nor did it include safety measures required based on the PT ' s assessment of Resident #3 ' s instability while sitting on the side of the bed which included her need for contact guard assist with both static and dynamic balance.

Resident #3 ' s quarterly Minimum Data Set (MDS) assessment dated 12/3/18 indicated the resident had severely impaired cognitive skills for daily decision making. Section G indicated the resident required extensive assistance with one person physical assist for bed mobility and extensive assistance with 2+ person physical assist for transfers. She required extensive assistance from staff for all of her other ADLs, with the exception of needing supervision only for eating and being totally dependent on staff for bathing.

The resident ' s Care Plan, which was in place on 12/4/18, related to ADL care included interventions which continued to read, "Can stand and pivot with transfers." The Care Plan did not indicate how many staff members were required

changes with their present staff for the day.

4. Monitoring will be done by the facility Administrator, or designee, to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements by auditing Medicare Worksheets using the Therapy Recommendation Audit Tool 5 x weekly for 4 weeks, then weekly x 4 weeks, then monthly x 2 months to ensure that all new recommendations for residents on therapy caseload have been reviewed by the interdisciplinary MDS team with the respective updates made to the care plan, as appropriate. Should the nurse completing the care plan updates have concerns regarding the recommendation for resident assistance need changes given by the therapy department, the nurse will be required to document an assessment and/or rationale for the changes to the care plan made based upon nursing judgement, observation, and documentation from direct care personnel. This rationale should include validation of the assistance needed for the resident□s activities of daily living to appropriately meet the resident□s care needs. The attending physician is to then be notified of the care plan update generated based upon nursing judgement, observation, and documentation from direct care personnel along with the recommendation from therapy as soon as possible. The monitoring tool was developed on 1/30/2019 following completion of the

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F 656	Continued From page 14 to assist the resident with transfers or any additional safety measures required due the resident ' s instability while sitting on the side of the bed. Resident #3 ' s next Care Plan review date was scheduled for 12/11/18. A review of Resident #3 ' s (undated) Individual Service Plan (ISP) which was in place on 12/4/18, was provided by the facility. An ISP (also known as a Care Guide) is a printed summary of individual patient needs, which includes information for direct care nursing staff on the assistance required to meet the ADL care needs for a resident. Each individual resident ' s ISP is posted on the inside of his/her closet door. Resident #3 ' s ISP included "Special Instructions" which read, in part: "Resident with worsening dementia ...Can stand and pivot with transfers ..." Additionally, the resident ' s ISP included a section entitled, "Transferring." Comments noted in the transferring section read in its entirety, "Can stand and pivot with transfers." Review of Resident #3 ' s medical record included a Nursing Note for Falls, written by Nurse #1 and dated 12/4/18 at 11:25 PM. The note indicated Nurse #1 was called to the resident ' s room at approximately 9:20 PM by a Nursing Assistant (NA). Upon entering the room, Resident #3 was lying on the floor on her left side. She was responsive and attempting to get up. Her vital signs were checked while she was lying on the floor. Her blood pressure was noted to be 142/73; pulse 86; and respiration rate 18. The resident was able to state her name. She appeared to be "shaken up and had a large knot above left eye." A partial assessment was done and the resident was moved to the bed with a	F 656	Care Plan audit by facility Treatment Nurse, Staff Development Coordinator, Clinical Nurse Manager and/or Director of Nursing. Monitoring of transfer assistance and other identified safety concerns provided by direct patient care staff will be conducted by Facility MDS nurse, Treatment Nurse, Staff Development Coordinator, Clinical Nurse Manager and/or Director of Nursing utilizing the Transfer Audit Tool (developed 1/31/2019) 5 x weekly for 4 weeks, then weekly x 4 weeks, then monthly x 2 months to ensure that the care plan is adhered to by direct patient care staff per resident needs and safety. The results of these audits are to be reported to the QAPI committee. The QA committee was notified and signed acknowledgement of this plan 1/29/2019. A third party was hired to audit the MDS process on at least a routine monthly basis to ensure that the care plan and MDS process are accurate and appropriate for the residents□ needs.	

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Hoyer lift so a thorough assessment could be achieved. Once the resident was placed in bed, her vital signs were checked again. At that time, her blood pressure was 111/92, pulse 95, and respiration rate 20. The resident was asked her name again and she begin to state her first name but wasn't able to finish the rest because she became unresponsive. Vital signs where again checked at 9:43 PM and her blood pressure was noted to be 85/70; pulse 69; and respirations were reported to be labored. Resident #3 ' s oxygen saturation (O2 sat) was taken and noted to be 75%. The resident was placed on 2 liters of oxygen/minute. Her O2 sat increased to 85% and 95%, but began "to plummet" back to 80-85%. Her physician was called, informed of the fall and resident status, and an order was received to send Resident #3 to the Emergency Department (ED) for evaluation. Emergency Medical Services (EMS) were called and the resident was transported to the hospital.

A review of Resident #3 ' s hospital records indicated the resident arrived at the ED on 12/4/18 at 10:10 PM. Hospital notes indicated the resident was unresponsive and experienced full cardiac arrest. Additional details in the hospital records indicated the resident had stable vital signs upon EMS arrival, but had pulseless electrical activity (PEA) on monitor prior to transport to the hospital. PEA refers to cardiac arrest in which the electrocardiogram shows a heart rhythm that should produce a pulse, but does not. The resident was reported as arriving to the ED with cardiopulmonary resuscitation (CPR) in progress. Resuscitation was discontinued on 12/4/18 at 10:18 PM. The treating physician noted, "Given large trauma to the forehead and quick decline, I suspect she

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herniated acute intracranial hemorrhage (a type of bleeding that occurs inside the skull or cranium condition)." A review of Resident #3 ' s death certificate indicated her cause of death was intracerebral hemorrhage (bleeding around or within the brain itself); accidental fall. The approximate interval of onset to death was noted on the death certificate as, "minutes."

A review of Resident #3 ' s Fall Scene Investigation Report from 12/4/18 included a statement from the nursing assistant (NA #1) who was working with the resident at the time of the incident.

A review of the statement written by NA #1 attached to Resident #3 ' s Fall Scene Investigation Report from 12/4/18 was completed. The statement read: "(The resident) was an assist stand and pivot. After I helped get patient on the side of the bed. Bed was in a low position. Patient tried to take off her own shoes. Patient didn ' t give me time to put her feet on bed. When patient leaned forward all her weight went forward and couldn ' t stop her from falling. The patient did not fall during transfer. Patient fell after leaning forward trying to take off shoes. Patient is very heavy even though she is an assist and sometimes her weight just take her in whatever direction she going. Patient hit her head on the floor. After patient fell I immediately called my nurse. Nurse came patient was in shock but she started talking to my nurse. She was trying to get up. She said she wanted to get up. Me and nurse got patient up with Hoyer lift off the floor. Patient was responsive when asked her name again she said her name. Then patient went unresponsive. Incident happened at 9:20 PM."

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A telephone interview was conducted with NA #1 on 1/28/19 at 8:15 PM. The NA reported she worked at the facility as an Agency (temporary) nursing assistant approximately two times a week from September 2018 to December 2018. Her hall assignments at the facility rotated, but the NA reported she had worked with Resident #3 in the past. When asked about the resident ' s fall on 12/4/18, the NA reported she was helping her get ready for bed "because she was 1 person assist." NA #1 reported she transferred Resident #3 from her recliner to the bed and positioned the resident sitting on the side of the bed. She stated, "It was so weird ...because she was sitting down on the bed and it was like she reached down to take off her shoes." The NA reported she saw and heard the resident hit her head on the floor. She noted the bed was in the low position. Immediately after the resident fell, NA#1 stated she went and got the nurse (who was nearby). The nurse started talking to the resident and she was able to say her full name. When asked, NA #1 reported she could not recall anything else the resident said. She reported another NA went to get the Hoyer lift. Resident #3 was transferred onto her bed and was reported to still be talking after the transfer. However, NA #1 stated the resident started shaking and was getting cool and then warm to the touch. She reported they knew something was wrong at that point, so the nurse told her to get another nurse (which she did). Upon further inquiry, the NA reported Resident #3 usually seemed to be stable sitting at the side of the bed. When the resident appeared to reach and lean forward, the NA reported she thought it might have been her weight that made her fall. NA #1 stated she (the NA) usually took the resident ' s shoes and socks off for her, so she

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was not sure why the resident would have tried to take her shoes off herself. When asked how she would know what a resident ' s individual needs were for safe transfers, for instance, she stated, "I would look at the care guide, ask another aide that worked there more often, or the nurse." NA #1 reported after the incident with Resident #3 occurred on 12/4/18, she talked with other nursing staff and looked at the care guide in the resident ' s closet to be sure she had done everything right. When asked what the care guide noted, she reported she thought it indicated the resident was one person assist for transfers. She stated that "a lot of people" told her the resident was one-person assist.

A follow-up telephone interview was conducted with NA #1 on 1/29/19 at 9:55 AM and on 1/29/19 at 4:08 PM. During the interviews, the NA reported Resident #3 ' s bed covers were only ½ way down when she transferred the resident and sat her on the side of the bed. After the resident was transferred and sitting on the side of the bed, the NA tried to pull the covers down more. NA #1 reported she was standing towards the foot of the bed on the same side the resident was sitting. She stated the, "bed covers were just tiny bit under her." When asked, the NA stated she didn ' t think pulling those bed covers from under the resident would have made the resident fall forward. Upon further inquiry, the NA stated she thought the resident may have felt the bed covers move from under her when the NA tried to fix them. NA #1 stated her hands were on the bed covers at the time of the resident ' s fall; she was not touching the resident when she fell to the floor. When asked how long the resident was sitting on the bed before falling forward, NA #1 stated she had, "literally just sat her down on the

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bed." When asked if the NA had ever been made aware that it may be unsafe for this resident to sit on the side of the bed, she stated she had not. During the interview, NA #1 was asked what kind of orientation she received before caring for residents at the facility. She reported the Agency she worked for required her to sign papers for every facility with job descriptions. However, the NA stated when she came to the facility, she did not know the residents.

A telephone interview was conducted on 1/29/19 at 4:09 PM with the PT who completed Resident #3 ' s Physical Therapy screen on 6/22/18 and evaluation on 6/28/18. During the interview, the PT reported he was familiar with the resident and her history at the time the evaluation was completed. The PT reported the resident ' s "sitting balance was not great." He reported Resident #3 ' s history had shown that on one day the resident would do terrific and the next day she would barely do much at all. The PT stated he recommended a 2-person assist or Hoyer lift for transfers as a safety measure. He reported the CGA for static and dynamic sitting balance was technically an assessment of what he saw during the evaluation and was the reason why he made the recommendation for transfers using 2-person assist or a Hoyer lift. The PT noted sitting balance was evaluated on the side of a bed; and, the resident may or may not be holding on to a grab bar or something. When asked how Resident #3 ' s balance would have been in a regular chair or recliner with a back and arms, he reported this would be much different and she did not need CGA to be safe. A follow-up interview was conducted with the PT on 1/30/19 at 11:45 AM. During this interview, the PT reported he would have preferred to evaluate the resident for

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safety if her needs had changed and she required less assistance for transfers. However, he also indicated it would have been acceptable for a Registered Nurse (RN) at the facility to assess the resident and make such a change. When asked how results of resident screens and evaluations would be communicated to the facility ' s staff, the PT reported the facility ' s Rehab Manager would track these so he would be aware of any PT recommendations made.

An interview was conducted on 1/30/19 at 9:22 AM with the MDS Nurse in the presence of the facility ' s Compliance Officer. During the interview, the nurse was asked how PT recommendations were communicated to the resident ' s direct care nursing staff. The MDS nurse reported a recommendation from PT was typically shared in the administrative morning meeting and communicated to the staff via the resident ' s care plan. She reported a change in the care plan would generate a change in the resident ' s ISP as well as the electronic information available to the direct care staff. When asked if the PT recommendations made for Resident #3 on 6/28/18 were reflected on the resident ' s care plan, the MDS nurse stated they were. Upon further inquiry, however, the MDS nurse was unable to locate this information on Resident #3 ' s care plan.

An interview was conducted on 1/29/19 at 12:15 PM with Nurse #2. Nurse #2 was a hall nurse who reported she routinely cared for Resident #3. During the interview, the nurse was asked about the resident ' s need for staff assistance to transfer. In response, the nurse stated the resident was usually one person assist to transfer from her recliner chair to the bed. However,

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Nurse #2 reported that depending on the day and time of day, Resident #3 may need two-person assistance for a transfer. When asked how a NA would know whether 1 or 2 person assistance was required for a transfer, the nurse stated she would always tell a nursing assistant to look at the ISP located on the inside of the resident ' s closet. When informed the resident ' s ISP did not indicate whether she required 1- or 2-person assistance with transfers, the nurse added that she herself could also be a resource for the NAs to ask any questions they may have. Upon inquiry as to whether or not the resident could safely sit on the side of the bed, the nurse stated, "For me, no." Nurse #2 reported that depending on the Resident #3 ' s state of mind and level of confusion, Resident #3 could decide to lean forward or to get up unsafely.

An interview was conducted on 1/29/19 at 12:33 PM with NA #2. NA #2 reported she was routinely assigned to care for Resident #3. During the interview, the NA was asked to describe the process she used to transfer Resident #3 from her recliner to the bed. The NA started by stating, "It depends." She reported if the resident was having a good day, she could transfer the resident herself. If Resident #3 wasn ' t having such a good day, the transfer would require 2-person assist. When asked how a new nursing assistant would know how to safely transfer the resident, NA #2 reported she may find out from the off-going NA during shift report or from review of the resident ' s ISP. Upon review of the Resident #3 ' s ISP, NA #2 confirmed the ISP did not indicate how many staff members were required to transfer the resident safely. When asked about Resident #3 ' s ability to sit on the side of the bed, the NA stated Resident #3 could

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not be left sitting on the side of the bed. NA #2 reported the resident needed the nursing assistant to finish the maneuver and to put her legs up on the bed after she was transferred to the bed. Upon further inquiry as to whether or not Resident #3 would be safe sitting on the side of the bed, NA #2 responded by saying, "No, you would have to do what you ' re going to do right then."

Upon request, a follow-up interview was conducted on 1/30/19 at 10:25 AM with NA #2. During the interview, the NA was asked how many people it took to safely transfer Resident #3 from her chair to the bed. The NA stated, "It depends ...on 4 days it may be 1 person and on 3 days of the week it may be two people." She reported this was not necessarily dependent on the day, but more dependent on the moment and circumstances of the resident ' s dementia at the time. When asked how a new NA or an Agency NA would know whether one or two people were required to safely transfer the resident, the NA stated they would get a report from the off-going NA. However, she also stated the report given at 3:00 PM may not reflect the resident ' s needs when the next NA actually needed to transfer her at 5:00 PM. Upon further inquiry, NA #2 reported the ISP (kept in the resident ' s closet) should have indicated the resident could transfer by "stand and pivot with assist of 1 person or 2." She noted the second person would have been there for safety and extra man power. During the interview, NA #2 reported if the resident sat on the side of the bed, she would definitely have to be within arms ' reach of the nursing assistant. NA #2 added that she typically would not even do that and would not have left Resident #3 by the side of the bed if she had to do something. She

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stated, "It was best to go ahead and swing her feet up."

An interview was conducted on 1/29/19 at 3:35 PM with NA #3. NA #3 reported she was familiar with Resident #3 and had helped to care for her on multiple occasions. During the interview, the NA reported that she could usually transfer the resident herself but would need a second person if the resident seemed to be weak at the time of the transfer. When asked if the resident could safely sit at the side of the bed, NA #3 stated, "No ma ' am ...not at all." When asked to explain her response, the NA stated she would be worried about the resident falling.

A telephone interview was conducted on 1/29/19 at 4:49 PM with Resident #3 ' s Medical Doctor (MD), who also served as the facility ' s Medical Director. During the interview, the MD was asked if it was possible the resident experienced an adverse event (such as a stroke) that may have caused her to fall on 12/4/18. The MD stated it was possible, but it would be impossible to know for sure. At that time, staff accounts of the resident ' s fall were briefly discussed with the MD and included NA #1 ' s report of seeing and hearing Resident #3 hit her head and the resident having a large hematoma on her head. In response, the physician reported while this situation did not make it impossible that the resident had a CVA (stroke) prior to the fall, it made this scenario less likely.

An interview was conducted on 1/29/19 at 5:40 PM with the facility ' s Administrator and Compliance Officer. During the interview, the Administrator confirmed Resident #3 ' s care plan (dated 6/6/18 through 12/4/18) did not reflect the

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Physical Therapist ' s 6/28/18 recommendations which indicated the resident should be transferred with 2-person assist or a Hoyer lift. Resident #3 ' s care plan indicated she could stand and pivot for transfers, with no indication of how many staff members were required to assist her. Additionally, there was no documentation of another assessment being completed to reflect the staff assistance needed to transfer this resident safely or other safety measures required to ensure the resident was safe when sitting on the side of the bed. Upon inquiry, the Administrator reported PT recommendations were discussed in the stand-up interdisciplinary team meeting held each morning. The morning meeting included therapy staff and the MDS nurse. The Administrator stated the MDS nurse should have immediately put the PT ' s recommendation into the resident ' s electronic care plan. She reported this had not been done. The care plan updates would have automatically been incorporated into the resident ' s ISP to guide direct care staff on the ADL assistance required to safely meet the resident ' s needs.

A follow-up interview was conducted on 1/30/19 at 11:16 AM with the facility ' s Administrator and Compliance Officer. When the Administrator was asked if she would expect a resident ' s care plan to reflect the staff assistance necessary to ensure a resident ' s safety, she stated, "Absolutely." The Administrator also stated that if the resident ' s need for staff assistance changed, she would expect the change to be assessed and documented, and the care plan (along with the ISP) to be updated accordingly.

A second follow-up interview was conducted on 1/31/19 at 10:20 AM with the Administrator.

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During this interview, the Administrator stated her expectation for care plans was that all of the information placed in the care plan took into consideration the holistic picture of the resident based on observations and assessments of the resident ' s care needs, documentation within the clinical records, and direct patient care staff feedback. She reported care plans should be completed in a way that would thoroughly educate patient care staff on the resident ' s needs, including needs for safety.

On 1/30/19 at 1:00 PM, the facility ' s Administrator and Compliance Officer were informed of the immediate jeopardy. The facility provided an acceptable credible allegation of Immediate Jeopardy removal on 1/31/19 at 11:43 AM. The allegation of compliance indicated:

Brantwood Nursing and Rehab (1/31/19)
Credible Allegation of Removal of Immediate Jeopardy
F656 Care Plans

Resident 3 experienced a fall post-transfer of 1-person to the bed, at which point she was sat on the bed as the nurse aide removed her physical assistance to slide the linen further back. At this time, this resident leaned forward and fell onto the floor. Resident 3 was immediately sent to the Emergency Department of Granville Health Systems status post-fall and expired on 12/4/2018. The staff that left the resident sitting untouched while in the room is no longer working with the facility.
1. Resident 3 was sent to the Emergency Department as a result of the above incident. It was identified by analysis on 1/29/2019 that the

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care plan failed to provide sufficient information regarding the resident ' s transferring needs as recommended by therapy via therapy evaluation documentation on 6/28/2018 for a 2-person moderate to maximum assist during transfers. As a result, the resident was transferred via one person assist.

2. To address the particular process leading to the deficiency, an audit of 100% of resident care plans was initiated and to be completed on 1/29/2019. The resident ' s care plan are available to facility staff in order to identify areas of each resident ' s care plan needed for daily care and activities of daily living. The audit was conducted on 1/29/2019 by the Treatment Nurse, Staff Development Coordinator, Clinical Nurse Manager, and Director of Nursing to cross-reference resident ' s care planned transfer needs to ensure that the information was correct and consistent with recommendations from the Rehabilitation department. All issues are to be corrected on the resident care plans by the MDS consultant and Director of Nursing immediately on 1/29/2019 to reflect residents ' accurate needs for transfer assistance, to include number of staff to perform the tasks. Care Plan updates reflecting residents ' accurate needs for transfer assistance, to include number of staff to perform the tasks were completed, and each resident ' s updated care guide have been placed in resident ' s closet replacing the prior by administrative staff on 1/30/2019.

3. Facility MDS nurse, Treatment Nurse, Staff Development Coordinator, Clinical Nurse Manager and Director of Nursing were all educated on 1/30/2019 by facility Administrator on the expectation that items generated in the

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resident ' s care plan, to include the need for transfer needs for each resident, are to reflect the resident ' s actual needs based on observations, documented assessments and data from direct care personnel, such as therapy evaluation documentation. A copy of all therapy recommendations will be submitted to the "Telephone Order" box for review by the clinical and interdisciplinary MDS team in order to communicate changes in resident needs for transfers during business days. A 100% in-service of all therapy staff regarding the placement of a copy of therapy documentation in the "Telephone Order" box for nurse management review was initiated on 1/30/2019 provided by the facility Rehabilitation Department Director to be completed by 2/8/2019 with no staff working beyond that date until he or she has received the education. All resident ' s on therapy caseload, to include Physical, Occupational and Speech Therapy will be reviewed on a daily basis with the MDS interdisciplinary team, with changes to resident ' s transfer needs being updated in the resident ' s care plan immediately by the Facility MDS nurse, Treatment Nurse, Staff Development Coordinator, Clinical Nurse Manager and/or Director of Nursing. All changes in transfer needs will be submitted to and reviewed by the Director of Nursing, or designee, for a period of 4 months beginning 1/30/2019. Education will be initiated on 1/30/2019 with all nurses and nurse aides, to include agency staff working within the facility, regarding the process for updates to the resident ' s care plan, the location of the care plan data and the proper recourse for accessing the necessary information if the care plan data does not contain pertinent information for each resident ' s care. Facility staff as well as agency staff are to be educated upon orientation with the facility and/or

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the nurse staffing agency prior to working directly with residents within the facility on this information as well.

4. Monitoring will be done by facility Administrator, or designee, to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements by auditing Medicare Worksheets using the Therapy Recommendation Audit Tool 5 x weekly for 4 weeks, then weekly x 4 weeks, then monthly x 2 months to ensure that all new recommendations for residents on therapy caseload have been reviewed by the interdisciplinary MDS team with the respective updates made to the care plan, as appropriate. Should the nurse completing the care plan updates have concerns regarding the recommendation for resident assistance need changes given by the therapy department, the nurse will be required to document an assessment and/or rationale for the changes to the care plan made based upon nursing judgement, observation, and documentation from direct care personnel. This rationale, should include validation of the assistance needed for the resident ' s activities of daily living to appropriately meet the resident ' s care needs. The attending physician is to then be notified of the care plan update generated based upon nursing judgement, observation, and documentation from direct care personnel along with the recommendation from therapy as soon as possible. The monitoring tool was developed on 1/30/2019 following completion of the Care Plan audit by facility Treatment Nurse, Staff Development Coordinator, Clinical Nurse Manager and/or Director of Nursing. The results of this audit are to be reported to the QAPI

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F 656	Continued From page 29 committee. The QA committee was notified and signed acknowledgement of this plan 1/29/2019. The facility ' s credible allegation of Immediate Jeopardy removal was validated on 1/31/19 at 1:20 PM. The validation was evidenced by interviews with both licensed nursing staff and non-licensed nursing staff on where to locate information regarding safety measures necessary for the transfer and ADL assistance needed to ensure a resident ' s safety, including the number of persons required to safely transfer a resident. Review of on-going in-service records revealed licensed and unlicensed staff were in-serviced prior to working on the floor. A review of residents ' therapy recommendations along with updated care plans and ISP records was also conducted as part of the validation process.	F 656		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff and physician interviews, and facility and hospital record reviews, the facility failed to use two staff members to transfer a resident and provide the required assistance immediately after the transfer to ensure the resident sat safely on the side of her bed for 1 of 3 sampled residents reviewed for accidents	F 689	On December 4, 2018 Resident 3 experienced a fall post-transfer of one person assist to the bed, at which point she sat on the bed as the nurse aide discontinued hands-on physical assistance in order to slide the linen further back. At this time, this resident	1/31/19

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(Resident #3). Resident #3 experienced a fall from the side of her bed, while being assisted by one staff member which resulted in an injury to the resident ' s forehead. Resident #3 was sent to the hospital for evaluation and treatment and passed away later that day from an intracerebral hemorrhage (bleeding around or within the brain itself).

Immediate Jeopardy began on 12/4/18 when Nursing Assistant (NA) #1 transferred Resident #3 from her recliner to the bed with a stand and pivot maneuver and assist of one and Resident #3 fell forward off of the bed, striking her head on the floor. Immediate Jeopardy was removed as of 1/31/19 when the facility implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a scope and severity level "D" (no actual harm with potential for more than minimal harm that is not immediate jeopardy) for the facility to continue staff education and ensure monitoring systems put into place are effective.

The findings included:

Resident #3 was admitted to the facility on 6/1/17. Her cumulative diagnoses included Alzheimer ' s disease, anxiety disorder, depression, repeated falls, and unspecified abnormalities of gait and mobility.

Resident #3 ' s last annual Minimum Data Set (MDS) assessment dated 6/5/18 indicated the resident had severely impaired cognitive skills for daily decision making. Section G indicated the resident required extensive assistance with two plus (2+) persons physical assist for bed mobility and transfers

leaned forward and fell onto the floor. Resident 3 was immediately sent to the Emergency Department of Granville Health System status post-fall and expired on 12/4/2018. The staff that left the resident sitting untouched while in the room is no longer working with the facility.

1. Resident 3 was sent to the Emergency Department as a result of the above incident. It was identified by analysis on 1/29/2019 that the resident was not provided necessary balancing assistance post-transfer to prevent accidents and incidents per the recommendations provided by therapy via therapy evaluation documentation on 6/28/2018 for a 2-person moderate to maximum assist during transfers. The staff working directly with the resident during the incident was not directly made aware of the safety concerns with sitting balance while on the side of the bed for this resident.

2. To address the particular process leading to the deficiency, an audit of 100% of resident care plans was initiated and to be completed on 1/29/2019. The residents□ care plans are available to facility staff in order to identify areas of each resident□s care plan needed for daily care and activities of daily living. The audit was conducted on 1/29/2019 by the Treatment Nurse, Staff Development Coordinator, Clinical Nurse Manager, and Director of Nursing to cross-reference transfer needs and other safety concerns identified, such as sitting balance on each resident□s care plan to ensure that the information was correct and consistent

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F 689	Continued From page 31 A review of the resident ' s Care Area Assessment (CAA) Worksheet for ADL (Activities of Daily Living) / Functional / Rehabilitation Potential (dated 6/8/18) included an analysis of findings. These findings read, in part: " ...She is alert to self only ...She requires assistance with bed mobility, toileting and transfers ..." A review of the CAA Worksheet for Falls (dated 6/8/18) included a description of the nature of this problem/condition, which noted the resident had a fall during the past quarter without injury, had a diagnosis of Alzheimer ' s dementia, and exhibited daily confusion. A decision was made to include both ADLs and Falls in the resident ' s care plan. Resident #3 ' s Care Plan (dated 6/8/18) included the following areas of focus, in part: --Resident requires assist with ADLs on a daily basis related to a diagnosis of Alzheimer ' s. The care plan interventions indicated the resident, "Can stand and pivot with transfers." The Care Plan did not indicate how many staff members were required to assist the resident with transfers. --Resident has a history of falls. --Resident is at risk for falls. Has impaired safety awareness. A review of Resident #3 ' s medical record revealed a Therapy Screen was requested by nursing staff on 6/20/18. The screen was completed by a Physical Therapist (PT) on 6/22/18. PT notations dated 6/22/18 indicated he spoke with nursing staff. Staff reported Resident #3 was having increased difficulty with transfers and would benefit from a Physical Therapy evaluation. The PT completed an evaluation on 6/28/18. A Functional Assessment of the resident	F 689	with recommendations from the Rehabilitation Department. The MDS consultant and Director of Nursing corrected all resident care plans on 1/29/2019 to reflect residents accurate needs for transfer assistance and identified safety concerns, to include the number of staff necessary to perform the tasks. On January 30, 2019, care plan updates reflecting residents accurate needs for transfer assistance and safety concerns, to include number of staff necessary to perform the tasks, were completed and updated care guides were placed in each resident s closet by administrative staff replacing the existing care guides. Education will be initiated on 1/30/2019 with all nurses and nurse aides, to include agency staff working within the facility, regarding the process for updates to the residents care plan, the location of the care plan data, and the proper recourse for accessing the necessary information if the care plan data does not contain pertinent information for each resident s care. Facility staff as well as agency staff are to be educated on this information upon orientation with the facility and/or the nurse staffing agency prior to working directly with residents within the facility. 3. Facility MDS nurse, Treatment Nurse, Staff Development Coordinator, Clinical Nurse Manager and Director of Nursing were all educated on 1/30/2019 by facility Administrator on the expectation that the resident s care plan is to reflect the resident s actual needs and any additional key safety measures required,	

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F 689	Continued From page 32 ' s sitting balance indicated she required contact guard assist (CGA) for both static and dynamic (gentle challenges to balance) balance while sitting on the side of a bed. The PT ' s Treatment Plan for Resident #3 read: "Pt (patient) performs bed mobility, transfers and gait at baseline. No further skilled PT (physical therapy) is required at this time. Recommend NSG (nursing) perform OOB (out of bed) to chair daily by 2 person assist or Hoyer lift." A review of Resident #3 ' s Care Plan dated 6/8/18 related to ADL care was conducted. No changes had been made to the care plan interventions as a result of the Physical Therapy evaluation. The Care Plan interventions continued to read, "Can stand and pivot with transfers." The Care Plan did not indicate how many staff members were required to assist the resident with transfers. A review of the resident ' s medical record did not include another assessment (from any discipline) specifically related to a change in the staff assistance required to safely transfer Resident #3. Resident #3 ' s quarterly Minimum Data Set (MDS) assessment dated 9/5/18 indicated the resident had severely impaired cognitive skills for daily decision making. Section G indicated the resident required limited assistance with one person physical assist for bed mobility and extensive assistance with one person physical assist for transfers. Further review of the resident ' s Care Plan (dated 9/12/18) related to ADL care was conducted. The Care Plan interventions continued to read, "Can	F 689	including transfer needs and other safety concerns, based on observations, documented assessments and data from direct care personnel, such as therapy evaluation documentation. A copy of all therapy recommendations will be submitted to the Telephone Order box for review by the clinical and interdisciplinary MDS team in order to communicate changes in resident needs for transfers as well as safety concerns. A 100% in-service training of all therapy staff by the facility Rehabilitation Department Director regarding the placement of a copy of therapy documentation in the Telephone Order box for nurse management review was completed on 1/30/2019. No therapy staff member will be allowed to work until he or she has received the education. All residents receiving therapy, including Physical, Occupational, and Speech Therapy will be reviewed on a daily basis with the MDS interdisciplinary team, with changes to residents□ transfer and other safety measures required being updated in each resident□s care plan immediately by the Facility MDS nurse, Treatment Nurse, Staff Development Coordinator, Clinical Nurse Manager and/or Director of Nursing. All changes in transfer needs and updated safety concerns will be submitted to and reviewed by the Director of Nursing, or designee, for a period of 4 months beginning 1/30/2019. Any changes will be communicated to front line staff in the morning huddle meeting. Clinical Managers are to communicate changes with their present staff for the	

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stand and pivot with transfers." The Care Plan did not indicate how many staff members were required to assist the resident with transfers.

Resident #3 ' s quarterly Minimum Data Set (MDS) assessment dated 12/3/18 indicated the resident had severely impaired cognitive skills for daily decision making. Section G indicated the resident required extensive assistance with one person physical assist for bed mobility and extensive assistance with 2+ person physical assist for transfers. She required extensive assistance from staff for all of her other ADLs, with the exception of needing supervision only for eating and being totally dependent on staff for bathing.

The resident ' s current Care Plan related to ADL care included interventions which continued to read, "Can stand and pivot with transfers." The Care Plan did not indicate how many staff members were required to assist the resident with transfers. Resident #3 ' s next Care Plan review date was scheduled for 12/11/18.

A review of Resident #3 ' s most recent (undated) Individual Service Plan (ISP) was provided by the facility. An ISP (also known as a Care Guide) is a printed summary of individual patient needs, which includes information for direct care nursing staff on the assistance required to meet the ADL care needs for a resident. Each individual resident ' s ISP is posted on the inside of his/her closet door. Resident #3 ' s ISP included "Special Instructions" which read, in part: "Resident with worsening dementia ...Can stand and pivot with transfers ..." Additionally, the resident ' s ISP included a section entitled, "Transferring." Comments noted in the transferring section read

day.

4. Monitoring will be done by the facility Administrator, or designee, to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements by auditing Medicare Worksheets using the Therapy Recommendation Audit Tool 5 x weekly for 4 weeks, then weekly x 4 weeks, then monthly x 2 months to ensure that all new recommendations for residents on therapy caseload have been reviewed by the interdisciplinary MDS team with the respective updates made to the care plan, as appropriate. Should the nurse completing the care plan updates have concerns regarding the recommendation for resident assistance need changes given by the therapy department, the nurse will be required to document an assessment and/or rationale for the changes to the care plan made based upon nursing judgement, observation, and documentation from direct care personnel. This rationale should include validation of the assistance needed for the resident□s activities of daily living to appropriately meet the resident□s care needs. The attending physician is to then be notified of the care plan update generated based upon nursing judgement, observation, and documentation from direct care personnel along with the recommendation from therapy as soon as possible. The monitoring tool was developed on 1/30/2019 following completion of the Care Plan audit by facility Treatment

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F 689	Continued From page 34 in its entirety, "Can stand and pivot with transfers." Review of Resident #3 ' s medical record included a Nursing Note for Falls, written by Nurse #1 and dated 12/4/18 at 11:25 PM. The note indicated Nurse #1 was called to the resident ' s room at approximately 9:20 PM by a Nursing Assistant (NA). Upon entering the room, Resident #3 was lying on the floor on her left side. She was responsive and attempting to get up. Her vital signs were checked while she was lying on the floor. Her blood pressure was noted to be 142/73; pulse 86; and respiration rate 18. The resident was able to state her name. She appeared to be "shaken up and had a large knot above left eye." A partial assessment was done and the resident was moved to the bed with a Hoyer lift so a thorough assessment could be achieved. Once the resident was placed in bed, her vital signs were checked again. At that time, her blood pressure was 111/92, pulse 95, and respiration rate 20. The resident was asked her name again and she begin to state her first name but wasn't able to finish the rest because she became unresponsive. Vital signs where again checked at 9:43 PM and her blood pressure was noted to be 85/70; pulse 69; and respirations were reported to be labored. Resident #3 ' s oxygen saturation (O2 sat) was taken and noted to be 75%. The resident was placed on 2 liters of oxygen/minute. Her O2 sat increased to 85% and 95%, but began "to plummet" back to 80-85%. Her physician was called, informed of the fall and resident status, and an order was received to send Resident #3 to the Emergency Department (ED) for evaluation. Emergency Medical Services (EMS) were called and the resident was transported to the hospital.	F 689	Nurse, Staff Development Coordinator, Clinical Nurse Manager and/or Director of Nursing. Monitoring of transfer assistance and other identified safety concerns provided by direct patient care staff will be conducted by Facility MDS nurse, Treatment Nurse, Staff Development Coordinator, Clinical Nurse Manager and/or Director of Nursing utilizing the Transfer Audit Tool (developed 1/31/2019) 5 x weekly for 4 weeks, then weekly x 4 weeks, then monthly x 2 months to ensure that the care plan is adhered to by direct patient care staff per resident needs and safety. The results of these audits are to be reported to the QAPI committee. The QA committee was notified and signed acknowledgement of this plan 1/29/2019.	

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A review of the 12/4/18 EMS Records for Resident #3 was conducted. The records revealed EMS was dispatched to the facility at 9:40 PM and they arrived to the facility at 9:43 PM. Documentation on the EMS report indicated Resident #3 had a head injury after experiencing a fall, with respiratory failure and progression to cardiac arrest. EMS left the facility at 10:10 PM with Resident #3, arriving at the hospital at 10:11 PM.

A review of Resident #3 ' s hospital records indicated the resident arrived at the ED on 12/4/18 at 10:10 PM. Hospital notes indicated the resident was unresponsive and experienced cardiac full arrest. Additional details in the hospital records indicated the resident had stable vital signs upon EMS arrival, but had pulseless electrical activity (PEA) on monitor prior to transport to the hospital. PEA refers to cardiac arrest in which the electrocardiogram shows a heart rhythm that should produce a pulse, but does not. The resident was reported as arriving to the ED with cardiopulmonary resuscitation (CPR) in progress. Resuscitation was discontinued on 12/4/18 at 10:18 PM. The treating physician noted, "Given large trauma to the forehead and quick decline, I suspect she herniated acute intracranial hemorrhage (a type of bleeding that occurs inside the skull or cranium condition)." A review of Resident #3 ' s death certificate indicated her cause of death was intracerebral hemorrhage (bleeding around or within the brain itself); accidental fall. The approximate interval of onset to death was noted on the death certificate as, "minutes."

A review of Resident #3 ' s Fall Scene

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Investigation Report from 12/4/18 included statements from the nursing assistant (NA #1) who was working with the resident at the time of the incident. It also included a statement from the hall nurse who initially responded to the NA ' s request for help after the fall.

A review of the statement written by NA #1 attached to Resident #3 ' s Fall Scene Investigation Report from 12/4/18 was completed. The statement read: "(The resident) was an assist stand and pivot. After I helped get patient on the side of the bed. Bed was in a low position. Patient tried to take off her own shoes. Patient didn ' t give me time to put her feet on bed. When patient leaned forward all her weight went forward and couldn ' t stop her from falling. The patient did not fall during transfer. Patient fell after leaning forward trying to take off shoes. Patient is very heavy even though she is an assist and sometimes her weight just take her in whatever direction she going. Patient hit her head on the floor. After patient fell I immediately called my nurse. Nurse came patient was in shock but she started talking to my nurse. She was trying to get up. She said she wanted to get up. Me and nurse got patient up with Hoyer lift off the floor. Patient was responsive when asked her name again she said her name. Then patient went unresponsive. Incident happened at 9:20 PM."

A telephone interview was conducted with NA #1 on 1/28/19 at 8:15 PM. The NA reported she worked at the facility as an Agency (temporary) nursing assistant approximately two times a week from September 2018 to December 2018. Her hall assignments at the facility rotated, but the NA reported she had worked with Resident #3 in the

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past. When asked about the resident ' s fall on 12/4/18, the NA reported she was helping her get ready for bed "because she was 1 person assist." NA #1 reported she transferred Resident #3 from her recliner to the bed and positioned the resident sitting on the side of the bed. She stated, "It was so weird ...because she was sitting down on the bed and it was like she reached down to take off her shoes." The NA reported she saw and heard the resident hit her head on the floor. She noted the bed was in the low position. Immediately after the resident fell, NA#1 stated she went and got the nurse (who was nearby). The nurse started talking to the resident and she was able to say her full name. When asked, NA #1 reported she could not recall anything else the resident said. She reported another NA went to get the Hoyer lift. Resident #3 was transferred onto her bed and was reported to still be talking after the transfer. However, NA #1 stated the resident started shaking and was getting cool and then warm to the touch. She reported they knew something was wrong at that point, so the nurse told her to get another nurse (which she did). Upon further inquiry, the NA reported Resident #3 usually seemed to be stable sitting at the side of the bed. When the resident appeared to reach and lean forward, the NA reported she thought it might have been her weight that made her fall. NA #1 stated she (the NA) usually took the resident ' s shoes and socks off for her, so she was not sure why the resident would have tried to take her shoes off herself. When asked how she would know what a resident ' s individual needs were for safe transfers, for instance, she stated, "I would look at the care guide, ask another aide that worked there more often, or the nurse." NA #1 reported after the incident with Resident #3 occurred on 12/4/18, she talked with other

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nursing staff and looked at the care guide in the resident ' s closet to be sure she had done everything right. When asked what the care guide noted, she reported she thought it indicated the resident was one person assist for transfers. She stated that "a lot of people" told her the resident was one-person assist.

A follow-up telephone interview was conducted with NA #1 on 1/29/19 at 9:55 AM and on 1/29/19 at 4:08 PM. During the interviews, the NA reported Resident #3 ' s bed covers were only ½ way down when she transferred the resident and sat her on the side of the bed. After the resident was transferred and sitting on the side of the bed, the NA tried to pull the covers down more. NA #1 reported she was standing towards the foot of the bed on the same side the resident was sitting. She stated the, "bed covers were just tiny bit under her." When asked, the NA stated she didn ' t think pulling those bed covers from under the resident would have made the resident fall forward. Upon further inquiry, the NA stated she thought the resident may have felt the bed covers move from under her when the NA tried to fix them. NA #1 stated her hands were on the bed covers at the time of the resident ' s fall; she was not touching the resident when she fell to the floor. When asked how long the resident was sitting on the bed before falling forward, NA #1 stated she had, "literally just sat her down on the bed." When asked if the NA had ever been made aware that it may be unsafe for this resident to sit on the side of the bed, she stated she had not. During the interview, NA #1 was asked what kind of orientation she received before caring for residents at the facility. She reported the Agency she worked for required her to sign papers for every facility with job descriptions. However, the

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NA stated when she came to the facility, she did not know the residents.

A review of the statement written by Nurse #1 attached to Resident #3 ' s Fall Scene Investigation Report from 12/4/18 was completed. The statement read, in part: "Follow-up on documentation which is noted in Residents chart at approx. (approximately) 2120 (9:20 PM), 12/4/18. I was called into resident ' s room by the CNA (certified nursing assistant) and found the resident lying on the floor on left side partial assessment was performed on Resident. She was able to move both lower extremities and both upper extremities, pupils were checked and appeared WNL (within normal limits) resident was able to speak and give me full name. [Name] a floor nurse called EMS and RP (Responsible Party) simultaneously at approx. 2147 (9:47 PM) ... Between 2120 (9:20 PM) and observing residents changing condition an assisting aid obtained the lift, resident was still responsive throughout the transfer. Once resident was placed in bed V/S (vital signs) were re-obtained resident was still responsive being able to state name. Upon entering room sheets were pulled back."

An interview was conducted on 1/28/19 at 5:45 PM with Nurse #1. Nurse #1 confirmed she was the hall nurse who was assigned to care for Resident #3 on 12/4/18 at the time of her fall. The nurse reported she was passing meds around 9:20 PM when NA #1 peeked her head out Resident #3 ' s room and called for the nurse. Upon entering her room, she saw the resident was on the floor lying on her side. She was moving around a little bit and trying to get up. The nurse asked her name and she was

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responsive. Nurse #1 stated the resident wanted to get up; she was able to move her upper and lower extremities. Nurse #1 reported she did a mini-assessment and one set of vital signs while the resident was on the floor. The mini-assessment included a check for bleeding, a check of the resident ' s grips, movement of extremities and pupils, and asked the resident her name. The nurse and NA #1 then used a Hoyer lift to get Resident #3 onto the bed. Nurse #1 reported the resident was still responsive when she was sitting up in the Hoyer lift. Once they got the resident onto the bed, she got another set of vital signs, which were within normal limits and stable. The nurse reported Resident #3 was still able to state her name while she was in the bed and as the nurse began to start another assessment. When Resident #3 started shaking a little bit, the nurse felt she needed more assistance and another floor nurse came to help. Nurse #1 recalled the resident was still breathing but was no longer responsive; her eyes were open. A third nurse brought in oxygen and administered 2 liters per minute of oxygen via nasal cannula. The resident ' s code status was checked, 911 was called, and the MD and RP were notified of the situation. EMS arrived and the resident was taken to the hospital.

A telephone interview was conducted on 1/29/19 at 4:09 PM with the PT who completed Resident #3 ' s Physical Therapy screen on 6/22/18 and evaluation on 6/28/18. During the interview, the PT reported he was familiar with the resident and her history at the time the evaluation was completed. The PT reported the resident ' s "sitting balance was not great." He reported Resident #3 ' s history had shown that on one day the resident would do terrific and the next day she

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would barely do much at all. The PT stated he recommended a 2-person assist or Hoyer lift for transfers as a safety measure. He reported the CGA for static and dynamic sitting balance was technically an assessment of what he saw during the evaluation and was the reason why he made the recommendation for transfers using 2-person assist or a Hoyer lift. The PT noted sitting balance was evaluated on the side of a bed; and, the resident may or may not be holding on to a grab bar or something. When asked how Resident #3 ' s balance would have been in a regular chair or recliner with a back and arms, he reported this would be much different and she did not need CGA to be safe. A follow-up interview was conducted with the PT on 1/30/19 at 11:45 AM. During this interview, the PT reported he would have preferred to evaluate the resident for safety if her needs had changed and she required less assistance for transfers. However, he also indicated it would have been acceptable for a Registered Nurse (RN) at the facility to assess the resident and make such a change.

An interview was conducted on 1/30/19 at 9:22 AM with the MDS Nurse in the presence of the facility ' s Compliance Officer. During the interview, the nurse was asked how PT recommendations were communicated to the resident ' s direct care nursing staff. The MDS nurse reported a recommendation from PT was typically shared in the administrative morning meeting and communicated to the staff via the resident ' s care plan. She reported a change in the care plan would generate a change in the resident ' s ISP and the electronic information available to the direct care staff. When asked if the PT recommendations made for Resident #3 on 6/28/18 were reflected on the resident ' s care

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plan, the MDS nurse stated they were. Upon further inquiry, however, the MDS nurse was unable to locate this information on Resident #3 ' s care plan. The nurse then reported that even though PT made a recommendation, there may have been a discussion that the recommendations were not appropriate and the resident ' s care plan would reflect what staff should actually do. When asked if another assessment was done to ensure the resident ' s ADLs (including transfers) could be safely completed, the MDS nurse indicated she thought it was, but she was unsure where the assessment would have been documented.

An interview was conducted on 1/29/19 at 12:15 PM with Nurse #2. Nurse #2 was a hall nurse who reported she routinely cared for Resident #3. During the interview, the nurse was asked about the resident ' s need for staff assistance to transfer. In response, the nurse stated the resident was usually one person assist to transfer from her recliner chair to the bed. However, Nurse #2 reported that depending on the day and time of day, Resident #3 may need two-person assistance for a transfer. When asked how a NA would know whether 1 or 2 person assistance was required for a transfer, the nurse stated she would always tell a nursing assistant to look at the ISP located on the inside of the resident ' s closet. When informed the resident ' s ISP did not indicate whether she required 1- or 2-person assistance with transfers, the nurse added that she herself could also be a resource for the NAs to ask any questions they may have. Upon inquiry as to whether or not the resident could safely sit on the side of the bed, the nurse stated, "For me, no." Nurse #2 reported that depending on the Resident #3 ' s state of mind and level of

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confusion, Resident #3 could decide to lean forward or to get up unsafely.

An interview was conducted on 1/29/19 at 12:33 PM with NA #2. NA #2 reported she was routinely assigned to care for Resident #3. During the interview, the NA was asked to describe the process she used to transfer Resident #3 from her recliner to the bed. The NA started by stating, "It depends." She reported if the resident was having a good day, she could transfer the resident herself. If Resident #3 wasn ' t having such a good day, the transfer would require 2-person assist. When asked how a new nursing assistant would know how to safely transfer the resident, NA #2 reported she may find out from the off-going NA during shift report or from review of the resident ' s ISP. Upon review of the Resident #3 ' s ISP, NA #2 confirmed the ISP did not indicate how many staff members were required to transfer the resident safely. When asked about Resident #3 ' s ability to sit on the side of the bed, the NA stated Resident #3 could not be left sitting on the side of the bed. NA #2 reported the resident needed the nursing assistant to finish the maneuver and to put her legs up on the bed after she was transferred to the bed. Upon further inquiry as to whether or not Resident #3 would be safe sitting on the side of the bed, NA #2 responded by saying, "No, you would have to do what you ' re going to do right then."

Upon request, a follow-up interview was conducted on 1/30/19 at 10:25 AM with NA #2. During the interview, the NA was asked how many people it took to safely transfer Resident #3 from her chair to the bed. The NA stated, "It depends ...on 4 days it may be 1 person and on 3

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days of the week it may be two people." She reported this was not necessarily dependent on the day, but more dependent on the moment and circumstances of the resident ' s dementia at the time. When asked how a new NA or an Agency NA would know whether one or two people were required to safely transfer the resident, the NA stated they would get a report from the off-going NA. However, she also stated the report given at 3:00 PM may not reflect the resident ' s needs when the next NA actually needed to transfer her at 5:00 PM. Upon further inquiry, NA #2 reported the ISP (kept in the resident ' s closet) should have indicated the resident could transfer by "stand and pivot with assist of 1 person or 2." She noted the second person would have been there for safety and extra man power. During the interview, NA #2 reported if the resident sat on the side of the bed, she would definitely have to be within arms ' reach of the nursing assistant. NA #2 added that she typically would not even do that and would not have left Resident #3 by the side of the bed if she had to do something. She stated, "It was best to go ahead and swing her feet up."

An interview was conducted on 1/29/19 at 3:35 PM with NA #3. NA #3 reported she was familiar with Resident #3 and had helped to care for her on multiple occasions. During the interview, the NA reported that she could usually transfer the resident herself but would need a second person if the resident seemed to be weak at the time of the transfer. When asked if the resident could safely sit at the side of the bed, NA #3 stated, "No ma ' am ...not at all." When asked to explain her response, the NA stated she would be worried about the resident falling.

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A telephone interview was conducted on 1/29/19 at 4:49 PM with Resident #3 ' s Medical Doctor (MD), who also served as the facility ' s Medical Director. During the interview, the MD was asked if it was possible the resident experienced an adverse event (such as a stroke) that may have caused her to fall on 12/4/18. The MD stated it was possible, but it would be impossible to know for sure. At that time, staff accounts of the resident ' s fall were briefly discussed with the MD and included NA #1 ' s report of seeing and hearing Resident #3 hit her head and the resident having a large hematoma on her head. In response, the physician reported while this situation did not make it impossible that the resident had a CVA (stroke) prior to the fall, it made this scenario less likely.

An interview was conducted on 1/29/19 at 5:40 PM with the facility ' s Administrator and Compliance Officer. During the interview, the Administrator confirmed Resident #3 ' s care plan (dated 6/6/18 through 12/4/18) did not reflect the Physical Therapist ' s 6/28/18 recommendations which indicated the resident should be transferred with 2-person assist or a Hoyer lift. Resident #3 ' s care plan indicated she could stand and pivot for transfers, with no indication of how many staff members were required to assist her. Additionally, there was no documentation of another assessment being completed to reflect the staff assistance needed to transfer this resident safely or other safety measures required to ensure the resident was safe when sitting on the side of the bed. Upon inquiry, the Administrator reported PT recommendations were discussed in the stand-up interdisciplinary team meeting held each morning. The morning meeting included therapy staff and the MDS

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nurse. The Administrator stated the MDS nurse should have immediately put the PT ' s recommendation into the resident ' s electronic care plan. She reported this had not been done. The care plan updates would have automatically been incorporated into the resident ' s ISP to guide direct care staff on the ADL assistance required to safely meet the resident ' s needs.

A follow-up interview was conducted on 1/31/19 at 10:20 AM with the Administrator. During this interview, the Administrator stated her expectation was that the resident care needs and safety needs would be assessed and care plans updated as needed. She also reported she expected the residents ' plan of care to be utilized by the patient care staff in order to ensure that residents ' care needs and safety needs would be met.

On 1/30/19 at 1:00 PM, the facility ' s Administrator and Compliance Officer were informed of the immediate jeopardy. The facility provided an acceptable credible allegation of Immediate Jeopardy removal on 1/31/19 at 11:43 AM. The allegation of compliance indicated:

Brantwood Nursing and Rehab (1/31/19)
Credible Allegation of Removal of Immediate Jeopardy
F689-Accidents

On December 4, 2018 Resident 3 experienced a fall post-transfer of one person assist to the bed, at which point she sat on the bed as the nurse aide discontinued hands-on physical assistance in order to slide the linen further back. At this time, this resident leaned forward and fell onto

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the floor. Resident 3 was immediately sent to the Emergency Department of Granville Health System status post-fall and expired on 12/4/2018. The staff that left the resident sitting untouched while in the room is no longer working with the facility.

1. Resident 3 was sent to the Emergency Department as a result of the above incident. It was identified by analysis on 1/29/2019 that the resident was not provided necessary balancing assistance post-transfer to prevent accidents and incidents per the recommendations provided by therapy via therapy evaluation documentation on 6/28/2018 for a 2-person moderate to maximum assist during transfers. The staff working directly with the resident during the incident was not directly made aware of the safety concerns with sitting balance while on the side of the bed for this resident.

2. To address the particular process leading to the deficiency, an audit of 100% of resident care plans was initiated and to be completed on 1/29/2019. The residents ' care plans are available to facility staff in order to identify areas of each resident ' s care plan needed for daily care and activities of daily living. The audit was conducted on 1/29/2019 by the Treatment Nurse, Staff Development Coordinator, Clinical Nurse Manager, and Director of Nursing to cross-reference transfer needs and other safety concerns identified, such as sitting balance on each resident ' s care plan to ensure that the information was correct and consistent with recommendations from the Rehabilitation Department. The MDS consultant and Director of Nursing corrected all resident care plans on 1/29/2019 to reflect residents ' accurate needs

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for transfer assistance and identified safety concerns, to include the number of staff necessary to perform the tasks. On January 30, 2019, care plan updates reflecting residents ' accurate needs for transfer assistance and safety concerns, to include number of staff necessary to perform the tasks, were completed and updated care guides were placed in each resident ' s closet by administrative staff replacing the existing care guides. Education will be initiated on 1/30/2019 with all nurses and nurse aides, to include agency staff working within the facility, regarding the process for updates to the residents ' care plan, the location of the care plan data, and the proper recourse for accessing the necessary information if the care plan data does not contain pertinent information for each resident ' s care. Facility staff as well as agency staff are to be educated on this information upon orientation with the facility and/or the nurse staffing agency prior to working directly with residents within the facility.

3. Facility MDS nurse, Treatment Nurse, Staff Development Coordinator, Clinical Nurse Manager and Director of Nursing were all educated on 1/30/2019 by facility Administrator on the expectation that the resident ' s care plan is to reflect the resident ' s actual needs and any additional key safety measures required, including transfer needs and other safety concerns, based on observations, documented assessments and data from direct care personnel, such as therapy evaluation documentation. A copy of all therapy recommendations will be submitted to the "Telephone Order" box for review by the clinical and interdisciplinary MDS team in order to communicate changes in resident needs for

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transfers as well as safety concerns. A 100% in-service training of all therapy staff by the facility Rehabilitation Department Director regardingthe placement of a copy of therapy documentation in the "Telephone Order" box for nurse management review was initiated on 1/30/2019 to be completed by 2/8/2019. No therapy staff member will be allowed to work beyond 2/8/2019 until he or she has received the education.
All residents receiving therapy, including Physical, Occupational, and Speech Therapy will be reviewed on a daily basis with the MDS interdisciplinary team, with changes to residents ' transfer and other safety measures required being updated in each resident ' s care plan immediately by the Facility MDS nurse, Treatment Nurse, Staff Development Coordinator, Clinical Nurse Manager and/or Director of Nursing. All changes in transfer needs and updated safety concerns will be submitted to and reviewed by the Director of Nursing, or designee, for a period of 4 months beginning 1/30/2019. Any changes will be communicated to front line staff in the morning huddle meeting. Clinical Managers are to communicate changes with their present staff for the day.

4. Monitoring will be done by the facility Administrator, or designee, to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements by auditing Medicare Worksheets using the Therapy Recommendation Audit Tool 5 x weekly for 4 weeks, then weekly x 4 weeks, then monthly x 2 months to ensure that all new recommendations for residents on therapy caseload have been reviewed by the interdisciplinary MDS team with the respective updates made to the care plan, as

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appropriate. Should the nurse completing the care plan updates have concerns regarding the recommendation for resident assistance need changes given by the therapy department, the nurse will be required to document an assessment and/or rationale for the changes to the care plan made based upon nursing judgement, observation, and documentation from direct care personnel. This rationale should include validation of the assistance needed for the resident ' s activities of daily living to appropriately meet the resident ' s care needs. The attending physician is to then be notified of the care plan update generated based upon nursing judgement, observation, and documentation from direct care personnel along with the recommendation from therapy as soon as possible. The monitoring tool was developed on 1/30/2019 following completion of the Care Plan audit by facility Treatment Nurse, Staff Development Coordinator, Clinical Nurse Manager and/or Director of Nursing. Monitoring of transfer assistance and other identified safety concerns provided by direct patient care staff will be conducted by Facility MDS nurse, Treatment Nurse, Staff Development Coordinator, Clinical Nurse Manager and/or Director of Nursing utilizing the Transfer Audit Tool (developed 1/31/2019) 5 x weekly for 4 weeks, then weekly x 4 weeks, then monthly x 2 months to ensure that the care plan is adhered to by direct patient care staff per resident needs and safety. The results of these audits are to be reported to the QAPI committee. The QA committee was notified and signed acknowledgement of this plan 1/29/2019.

The facility ' s credible allegation of Immediate Jeopardy removal was validated on 1/31/19 at 1:20 PM. The validation was evidenced by

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F 689	Continued From page 51 interviews with both licensed nursing staff and non-licensed nursing staff on where to locate information regarding safety measures necessary for the transfer and ADL assistance needed to ensure a resident ' s safety, including the number of persons required to safely transfer a resident. Review of on-going in-service records revealed licensed and unlicensed staff were in-serviced prior to working on the floor. A review of residents ' therapy recommendations along with updated care plans and ISP records was also conducted as part of the validation process.	F 689		