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F 000	INITIAL COMMENTS A complaint survey was conducted from 1/7/20 through 1/9/20. Event ID# EM7W11 The survey team entered the facility on 1/7/20 to conduct a complaint survey and exited on 1/9/20. Additional information was obtained on 1/14/20. Therefore, the exit date was changed to 1/14/20. 3 of the 14 allegations were substantiated resulting in deficiencies.	F 000		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to provide ambulation as specified in the plan of care for 2 of 2 residents reviewed for range of motion (Resident #7 and Resident # 9).	F 688	Barbour Court Nursing and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order	2/15/20

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

Electronically Signed | 02/06/2020

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F 688	Continued From page 1 The findings included: 1. Resident #7 was admitted to the facility on 6/29/17 with diagnoses that included hypertension and diabetes mellitus. Resident #7's most recent Minimum Data Set assessment dated 12/5/19, a quarterly assessment revealed she was assessed to be cognitively intact with no behaviors. She was assessed to be dependent with ambulation. Resident #7 ' s Care Plan dated 12/5/19 revealed an intervention that read in part, "ambulate with rolling walker standby assist 50 feet 6 of 7 days per week. Monitor for pain to R knee and hip. Roll wheelchair behind resident." The care plan specified this being done by the restorative nurse aide or the nurse aide. Restorative nursing documentation from 12/5/19 to 1/3/20 revealed Resident #7 received restorative ambulation on 12/5/19 only. An interview with the resident was conducted on 1/8/20 at 10:30 AM. She stated she had not received any ambulation with stand by assistance since it had been added to her care plan. Resident #7 stated she was not aware she was to receive assistance with restorative services until a nurse aide informed her that she had refused services last week. The resident stated she was unaware of these services. Resident #7 stated that it was her understanding that restorative services were not available because the restorative aides were assigned to work on the halls.	F 688	to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Barbour Court Nursing and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Barbour Court Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. On 1/29/20, the Director of Nursing placed a therapy referral/screen for resident #7 to evaluate the need for continued restorative ambulation and range of motion. On 1/13/20, the therapy staff completed a Rehabilitation Services Referral/Screen for resident #9 to assess for any changes in mobility. No significant changes noted. Resident does not currently reside in the facility. On 1/29/20, the Minimum Data Set nurse (MDS) initiated a 100% audit of all residents receiving restorative services to include restorative ambulation and range of motion (ROM). This audit is to ensure residents are receiving service according to the plan of care with no decline in function. The Director of Nursing and Unit Managers will address all areas of concern identified during the audit to include completion of restorative tasks per	

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F 688	Continued From page 2 During an interview on 1/7/20 at 2:35 PM Restorative Aide #1 stated she was working a floor assignment that day and had not done restorative on any residents other than those working on her individual floor assignment which did not include Resident #7. She further stated other nurse aides were supposed to do restorative on their assigned residents when she was pulled to the floor to work as a nurse aide. She stated she was pulled to the floor to work most of the time. She indicated had not done restorative with Resident #7 except on 12/5/19. An interview was conducted with NA #4 on 1/7/20 at 2:40 PM who stated she did not know she was supposed to do restorative on her assigned residents when the restorative aides were assigned to work on the floor as a nurse aide and had not had time to do so. During an interview with NA #14 on 1/7/20 at 2:43 PM she stated she did not know she was supposed to do restorative when restorative aides were assigned to work on the floor as a nurse aide and did not know how. NA #14 stated she believed special training was required for restorative services. An interview was conducted with NA #2 on 1/8/20 at 2:26 PM who stated she was assigned Resident #7 on 1/8/20. She stated she did not have time to perform restorative services with Resident #7 but was aware it should have been done. An interview with the Director of Nursing (DON) was conducted on 1/8/20 at 11:30 AM. She stated she did not know why restorative ambulation was only performed for Resident #7	F 688	plan of care, therapy referral as indicated and education of staff. Audit will be completed by 1/31/20. On 1/29/20, the Director of Nursing initiated an in-service and training video with all nurses and nursing assistants in regards to Restorative Services with emphasis on (1) Restorative program, (2) completing tasks per plan of care and (3) documentation to include completion of task or resident refusal. In-service will be completed by 2/15/20 . All newly hired nurses and nursing assistants will be in-serviced by an administrative nurse during orientation in regards to Restorative Services. An audit of 10 residents receiving restorative services to include resident #7 and resident #9 with emphasis on restorative ambulation and range of motion will be completed by the unit manager and/or designee utilizing the Restorative Audit Tool three (3) times a week for four (4) weeks, weekly for four (4) weeks then monthly for one (1) month to ensure all residents are receiving service according to the plan of care with no decline in function. The Assistant Director of Nursing and/or Unit Managers will address all areas of concern identified during the audit to include completion of restorative tasks per plan of care, therapy referral as indicated and education of staff. The Director of Nursing will review and initial the Restorative Audit Tool three (3) times a week for four (4) weeks, weekly for four (4) weeks then monthly for one (1) month to ensure all areas of concern were addressed.	

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F 688	Continued From page 3 on 12/5/19. The DON indicated Resident #7 should have been ambulated by the assigned nurse aide if the restorative aides were given a hall assignment. 2. Resident #9 was admitted to the facility on 2/27/18 with diagnoses that included diabetes and hypertension. Resident #9 ' s most recent Minimum Data Set assessment dated 10/22/19, a quarterly assessment revealed he was assessed to be cognitively intact with no behaviors. He was assessed to be dependent with ambulation. Resident #9 ' s Care Plan dated 12/5/19 revealed an intervention that read in part, "ambulate with rolling walker with minimal assist and wheelchair follow 100 feet 6 of days per week." The care plan specified this being done by the restorative nurse aide or the nurse aide. Restorative nursing documentation from 12/8/19 to 1/8/20 revealed Resident #9 received restorative ambulation only on 12/11/19, 12/12/19, and 12/19/19. During an interview on 1/8/20 at 3:00 PM Resident #9 stated he was not receiving restorative ambulation because the restorative aides were often given a hall assignment. He reported that if anyone stated he was refused ambulation that was incorrect. Resident #9 indicated he could not remember the last time he received restorative ambulation. During an interview on 1/7/20 at 2:35 PM Restorative Aide #1 stated Resident #9 was to receive restorative ambulation six times a week.	F 688	The Director of Nursing will present the results of the Restorative Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee Meeting monthly for three (3) months. The QAPI Committee will meet and review the Restorative Audit Tool monthly for three (3) months to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 688	Continued From page 4	F 688		

She was working a floor assignment that day and had not done restorative on any residents other than those working on her individual floor assignment which did not include Resident #9. She further stated other nurse aides were supposed to do restorative on their assigned residents when she was pulled to the floor to work as a nurse aide. Restorative Aide # 1 confirmed had not received restorative ambulation since 12/19/19 as documented. She stated she was pulled to the floor frequently as a nurse aide.

An interview was conducted with NA #4 on 1/7/20 at 2:40 PM who stated she did not know she was supposed to do restorative on her assigned residents when the restorative aides were assigned to work on the floor as a nurse aide and had not had time to do so.

During an interview with NA #14 on 1/7/20 at 2:43 PM she stated she did not know she was supposed to do restorative when the restorative aides were assigned to work on the floor as a nurse aide and did not know how. NA #14 stated she believed special training was required for restorative services.

An interview was conducted with Restorative Aide #1 on 1/8/20 at 2:15 PM she stated Resident #9 would refuse to ambulate if he was awaiting care from nursing related to his catheter. She stated she would check back and provide services after catheter care had been provided.

An interview was conducted with NA #2 on 1/8/20 at 2:26 PM who stated she was assigned Resident #9 on 1/8/20. She stated she did not have time to perform restorative services with

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F 688	Continued From page 5 Resident #9 but was aware it should have been done. An interview with the Director of Nursing (DON) was conducted on 1/8/20 at 11:30 AM. She stated she was unsure why restorative ambulation was not done according to the care plan for Resident #9. The DON indicated Resident #9 should have been ambulated by the assigned nurse aide if the restorative aides were given a hall assignment.	F 688		
F 689 SS=G	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 observation, record review, staff interview, family interview, nurse practitioner interview, neurological physician assistant interview, and physician interview the facility failed to provide supervision to prevent falls for one (Resident # 2) of three sampled residents who were reviewed for falls. Resident #2, suffered a laceration to his head and was identified to have a worsening of a subdural hematoma which was deemed subacute or chronic in nature. The findings included: Resident # 2 was initially admitted to the facility on 10/31/19 after a hospital stay for an acute	F 689	On 1/29/20, a falls assessment for resident #2 was completed by the unit manager. This assessment was to re-evaluate resident #2 risk for falls and to ensure appropriate safety interventions were in place. The care plan and care guide will updated for any new safety interventions. All residents with the potential of being affected, the 200 hall nurses station was relocated to Nurse Station 1 to ensure a clear line of sight and increased visibility. On 1/29/20, the Facility Consultant initiated a 100% audit of all falls for the	2/15/20

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F 689	Continued From page 6 intracranial hemorrhage (bleeding into the brain area). According to the hospital discharge summary, dated 10/31/19, the resident's initial CT Scan when he first presented to the hospital showed a left occipital parenchymal hemorrhage with extension to the left lateral ventricle and third ventricle and a left subdural hematoma. Other diagnoses included hypertensive urgency, chronic obstructive pulmonary disease, cachexia, seizure disorder, and diabetes. Resident # 2's admission Minimum Data Set assessment, dated 11/6/19, revealed the resident was severely cognitively impaired, and needed extensive to total assistance with his activities of daily living. He was dependent on staff for transfers. The resident's care plan revealed it had last been updated on 11/28/19. This current care plan noted the resident was at risk for falls because of his history of falls, actual falls and multiple risk factors. The care plan also noted the resident had a history of intercranial hemorrhage. The facility's goal for the resident was that he not sustain serious injury through the next care plan review date. Care planned interventions were listed as the following: Assist the resident to negotiate his barriers as necessary; Rehab therapy as ordered; fall mat on the floor when in bed; Fall preventive intervention: toilet about 2 hours after lunch meal for BM; Fall Risk Protocol; MD evaluation and review of resident's fall potential, possible causative and/or contributing factors; observe and intervene for factors causing falls, i.e. bowel/bladder needs, mobility, transfers, etc.; Resident to wear proper and no slip footwear. Resident # 2's nursing notes between 11/08/19 to	F 689	past 30 days. This audit is to ensure all incidents were investigated for root cause with appropriate interventions initiated based on the root cause, resident was assessed following incident, physician /Resident Representative (RR) notified, and care plan/care guide updated for all safety interventions. The Director of Nursing and/or Unit Managers will address all areas of concern identified during the audit to include assessment of resident, investigating incident to determine root cause, initiating appropriate interventions based on root cause, notification of Physician/RR and updating care plan/care guide with any new interventions. The audit will be completed by 1/30/20. The follow-up to the audits will be completed on 2/5/2020. 100% in-service of nurses was initiated by the Director of Nursing on 1/29/20 in regards to (1) Incidents to include assessment of resident, obtaining statements, determining the root cause and initiation of appropriate intervention based on root cause, completion of incident report in electronic record, notification of physician and RR, and updating care plan/care guide (2) Root Cause Analysis to include definition of root cause, steps to determine root cause and presenting investigative findings to the Quality Assurance Performance Improvement Team to review all possible actions that can prevent reoccurrence. In-services will be completed by 2/15/20. All newly hired nurses will be in-serviced by an administrative nurse during orientation in regards to Incidents and	

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F 689	Continued From page 7 12/24/19 revealed the following incidents. On 11/8/19 at 3:15 PM Nurse # 1 documented in the medical record Resident # 2 was found on the floor on the right side of his bed and was trying to sit up. He was alert and confused. The nurse documented the resident had no injury from the fall. Interview with Nurse # 1 on 1/7/20 at 4:05 PM revealed she worried about the resident because he tended to sit on the side of the bed. She had assessed the resident following the 11/8/19 fall and he had no injuries. On 1/8/20 at 9:15 AM the facility's 11/8/19 investigation was reviewed with the DON (Director of Nursing). According to the investigation and the DON interview, following the 11/8/19 fall the facility educated the staff the resident would need increased supervision with his new environment and also educated the resident to use his call bell. According to the DON, the resident was new to the facility and they were in the phase in which they were trying to determine his level of calling for help and compliance with doing so. According to the DON, the resident was placed in a low bed, which was close to the floor, upon admission. On 11/10/19 at 2:42 PM Nurse # 2 documented in the medical record Resident # 2 was noted lying on the floor on his right side in a fetal position with a small cut above the left eye. The nurse noted no other injury was found and neurological checks were initiated. The nurse also noted she talked to staff and the family about not leaving the resident unattended in his room while in a wheelchair and that staff were to take the resident	F 689	Root Cause Analysis. The DON will complete a review of five (5) resident incidents for falls weekly for eight (8) weeks then monthly for one (1) month utilizing the Falls Audit Tool. This audit is to ensure all incidents for falls were investigated for root cause with appropriate interventions initiated based on the root cause, resident was assessed following the incident, the physician /Resident Representative (RR) were notified, and the care plan/care guide were updated for all new interventions. The Unit Managers will address all areas of concern identified during the audit to include assessment of the resident, initiation of further safety interventions based on the root cause, notification of the physician/RR, updating care plan for new safety interventions and re-education of staff. The Director of Nursing will review and initial the Falls Audit Tool weekly for eight (8) weeks then monthly for one (1) month to ensure all areas of concern were addressed. The Director of Nursing will forward the Falls Audit Tool to the Executive Quality Assurance Performance Improvement Committee (QAPI) monthly for three (3) months. The Executive QAPI Committee will meet monthly for three (3) months and review the Falls Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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to the nursing station if in a wheelchair.

On 1/8/20 at 2:15 PM Nurse # 2 was interviewed and reported she did not recall any further injury other than the small cut from the fall of 11/10/19.

On 1/8/20 at 9:15 AM the facility's 11/10/19 investigation was reviewed with the DON. According to the investigative report and the DON interview, the incident had occurred on 11/10/19 at 12:30 PM and was documented at 2:42 PM in the medical record. The resident had sustained a small cut above the left eye with no other injury noted. The facility's new intervention was not to leave the resident up in a wheelchair while in his room. Staff were to take him to the nursing station.

On 11/14/19 at 11:38 AM Nurse # 2 documented in the medical record Resident # 2 was noted lying on the floor on his left side. According to the note, the resident had been at the nursing station at the time of the incident. A witness had stated he had been standing at the nursing station and heard a loud thump on the wall of the nurse's station. When he turned around Resident # 2 was on the floor. The resident was assessed for injury and none found. After the family member was contacted a determination was made to send the resident out to the hospital for evaluation.

On 1/9/20 at 2:15 PM Nurse # 2 was interviewed and reported the resident had no visible injury from the 11/14/19 fall. Therapy had finished working with the resident and had left him at Nursing Station # 1 for supervision on 11/14/19, but he stood up and fell.

On 1/8/20 at 9:15 AM the facility's 11/14/19

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investigation was reviewed with the DON. According to the investigative report and the DON interview, the incident had occurred on 11/14/19 at 10:45 AM. The resident was at the nursing station and a maintenance staff member was present but did not reach the resident in time to avoid the incident. After Resident # 2 returned to the facility from the hospital the DON stated a mattress was placed by the bedside in his room.

Review of hospital records revealed Resident # 2 was hospitalized from 11/14/19 to 11/15/19. During this time, it was determined the resident had a urinary tract infection. A head CT scan was conducted on 11/14/19 at the hospital which revealed no intracranial hemorrhage or acute process. Resident # 2 returned to the facility on 11/15/19 with orders for antibiotics for a urinary tract infection.

On 11/30/19 at 1:04 PM Nurse # 3 documented in the medical record that a Nurse Aide had been walking past Resident # 2's room at 12:00 PM and observed the resident crawling around on the floor mat. The resident was assessed, found to have no injury, and the resident was assisted to bed. At the time of the incident the nurse documented the bed was in the lowest position and the fall mat was in place.

On 1/9/20 at 2:50 PM Nurse # 3 was interviewed and reported the resident had been making multiple attempts to get up that day and swinging his legs over the bed. When he was found, he was on the floor mat and was not hurt.

On 1/8/20 at 9:15 AM the facility's 11/30/19 investigation was reviewed with the DON. According to the investigative report and the DON

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interview, the fall mat had successfully prevented injury and it was continued as part of his care plan.

On 12/3/19 at 4:26 PM Nurse # 2 documented in the medical record Resident # 2 had been found lying on the floor at the entrance of his room on his right side. The resident was assessed and found to have no injuries. He began to independently get up on his hands and knees to attempt to stand. Staff then assisted him to stand. He started to walk in the hallway and he was assisted to do so. The staff noted the resident smelled of feces, and they placed him on the toilet at which time he had a large bowel movement.

Nurse # 2 was interviewed on 1/9/20 at 2:15 PM and reported the resident had last been seen in bed before he was found at the entrance to his room on the floor. It appeared as if he was starting to have a bowel movement and therefore, they toileted him. He was not hurt.

On 1/8/20 at 9:15 AM the facility's 12/3/19 investigation was reviewed with the DON. According to the investigative report and DON interview the incident had occurred at 2:40 PM on 12/3/19 and had been documented at 4:26 PM. The resident had been restless at the time of the incident and toileting seemed to help. A new intervention was added to the resident's care that he should be toileted after lunch.

On 12/5/19 at 3:01 PM Nurse # 2 documented in the medical record Resident # 2 was found sitting at the foot of his bed on the floor. The nurse noted the Nurse Practitioner (NP) assessed the resident following the fall. He was assisted to the

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bathroom.

Nurse # 2 was interviewed on 1/9/20 at 2:15 PM and reported Resident # 2 had no signs of injury on 12/5/19 following the fall.

On 1/8/20 at 9:15 AM the facility's 12/5/19 investigation was reviewed with the DON. According to the investigative report and DON interview the incident had occurred at 8:15 AM on 12/5/19 and had been documented at 4:26 PM. The DON stated the new intervention was to toilet the resident after all meals and staff were directed to do so.

On 12/7/19 at 6:40 PM Nurse # 4 documented in the medical record the following. An overhead page was heard at 5:55 PM noting a Code Green (the facility's code to signify a resident has fallen). The nurse responded and found Resident # 2 lying in the hallway near another resident's room. There were moderate amounts of blood on the floor and the resident had a deep laceration above his right eye and two small cuts to the top of his head and back of his head. The resident could not state what had occurred. The physician was notified and emergency services was called at 6:05 PM. The resident was transferred to the hospital.

Review of the 12/7/19 assignment sheet for the 3:00 to 11:00 PM shift revealed NA # 11 was assigned to care for all of the residents who resided on the 800 hall and all of the residents who resided on the 200 hall with the exception of residents who resided in of the two rooms on this hallway. The assignment sheet indicated NA # 11 was assigned to Resident # 2 on this shift.

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Nurse Aide (NA) # 11 had been assigned to care for Resident # 2 on the 3:00 PM to 11:00 PM shift of 12/7/19. Nurse Aide # 11 was interviewed on 1/8/20 at 9:50 PM via phone and reported the following regarding the evening of 12/7/19. Resident # 2 had been "steady-steady trying to get up." She checked on him often and had to redirect him four or five times before supper. She offered to toilet him, but he kept trying to get up. The resident did not want her to touch him in anyway, and would say "stop" if she tried to help him. He was very active. On that evening, she was assigned residents on the 200 hall, where Resident # 2 resided, and on the 800 hall also. She was not on the 200 hall when Resident # 2 fell. She was on the 800 hall helping with dinner trays and was not able to see that he had tried to get up out of bed or what had happened to him.

Nurse # 4 was interviewed on 1/9/20 at 3:03 PM and reported the following. Nurse #4 stated she was assigned to care for Resident #2 on 12/07/19 during the 3:00 PM to 11:00 PM shift. The nurse stated at the first of the evening shift on 12/7/19 she had been told in report Resident # 2 had been trying to get up and taking him to the rest room would help. That evening the resident was constantly trying to get up and they did try toileting him, but that did not help. She was on the 800 hall busy with medication administration when she heard the page he had fallen. She was not sure who had found him but thought it had been a housekeeper or dietary aide. After the page, she arrived to find him in the hallway with blood around his head. She assessed him and paged EMS (Emergency Medical Services) from the hallway phone to transfer the resident to the hospital. She felt the resident had needed one on one supervision that evening prior to the fall but

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she did not have enough staff to assign someone to watch him one on one. It had also been difficult for her to watch him because she was assigned to residents on the 800 hall and he was on the 200 hall. The 200 hall could not be observed while she was doing her duties on the 800 hall. Therefore, there were periods of time when she nor the resident's assigned NA were able to see what he was doing on the evening of 12/7/19.

Observations on 1/7/20 at 9:22 AM revealed the 200 hall was adjacent to the 800 hall, but the rooms on the 200 hallway could not be observed if you were on the 800 hallway.

Nurse # 5 was interviewed on 1/9/20 at 5:20 PM and reported he had heard the page while working on the 100 hall signifying the resident had fallen on 12/7/19. He had been busy on the 100 hall and had not witnessed the resident fall. He did respond and assisted with the transfer to the hospital. Nurse # 5 did not know who had found the resident on the floor.

A medical records employee was interviewed on 1/9/20 at 5:22 PM. She reported she had been seated at Nursing Station # 1, which was situated at the end of the 200 hall. She recalled someone had called out to page Code Green (indicating a fall) but she had not seen the resident until she stood up from the nursing desk and did not know what had occurred or recalled who had found the resident. She was able to see the resident when she stood up from the desk.

According to hospital records Resident # 2 was hospitalized from 12/7/19 to 12/11/19. Upon admission a head CT showed a right subdural fluid accumulation which was likely a subacute or

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early chronic hematoma. According to hospital records a neurosurgical consult was obtained due to the subdural hematoma. For the consult, the resident was evaluated by a neurosurgeon's physician assistant (PA). The PA noted the neurosurgeon was in agreement with the PA's assessment and plan. The family was given an option to have the subdural hematoma drained or to consider comfort care. The family opted for comfort care measures. On Resident # 2's discharge summary, "subacute/chronic right subdural hematoma" was listed as one of the resident's diagnoses. Also on the 12/11/19 hospital discharge summary it was noted that the 12/7/19 fall was suspected to have been due to a mechanical fall and not to seizure activity. The hospital discharge summary noted the resident's Depakote (medication for seizures and mood disorder) level was therapeutic and he had not had seizures while hospitalized; thereby making it less likely that seizures had caused him to fall on 12/7/19.

On 1/8/20 at 9:15 AM the facility's 12/7/19 investigation was reviewed with the DON and the DON was interviewed. There was no notation in the investigation file regarding who had found the resident and what had occurred prior to him being found. There was no mention in the investigation file in regards to the facility assessing if the staff had been able to supervise the resident on 12/7/19 and complete their other job tasks. According to the investigation, the resident had been found in the hallway approximately four rooms down from his room. There was a notation under "intervention put into place post-incident" which noted "sent to ER-Admission-(hospital) added Zyprexa 5 mg (milligrams) on tongue nightly-questionable fall versus seizure." The

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DON did not know who had found the resident on the evening of the 12/7/19 incident. According to the interview with the DON, the Zyprexa (an antipsychotic medication) had been added to the resident's drug regimen while he was hospitalized following the 12/7/19 fall, and it was being tapered down in the facility in an effort to discontinue it because the resident did not have a supporting diagnosis for an antipsychotic medication. In a follow up interview with the DON on 1/9/20 at 11:00 AM the DON stated the resident had come to the end of his Zyprexa taper during the current week and the geriatric Nurse Practitioner was evaluating the resident for other medication that might help the resident as an alternative to the Zyprexa. The DON also stated it was her understanding the resident had never suffered any further brain injury while residing at the facility.

A follow up interview was conducted with the DON on 1/14/20 at 4:37 PM via phone. The DON reported the following. Although she was not aware a new subdural hematoma had formed while the resident resided in the facility, she did not think this would have changed what they did. Their goal remained that they would try to prevent injury because they could not keep him from always falling. The DON stated on multiple occasions their inventions had worked to keep the resident safe. Since the date of 1/9/20 she had been trying to find out more about who had found Resident # 2 on the night of 12/7/19 when he went out to the hospital with the head injury. She had validated it was not a nursing staff member, and she did not know who had found him. According to the DON and a review of the 12/7/19 assignment sheets, there was another NA who was assigned mainly rooms on the 100

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hall and two rooms on the 200 hall on the 3:00 to 11:00 PM shift on 12/7/19. According to the DON, this second NA had not found the resident and did not know what had happened. The DON stated the medical records employee, who had been seated at the Nursing Station 1 desk, just recalled someone alerting her that the resident had fallen and a Code Green needed to be called. The DON was interviewed regarding what staff are directed to do when they have a resident who is repeatedly trying to get up and toileting and redirection are not helping. The DON stated the staff could have called her and she would have seen if there had been someone on another unit on 12/7/19 who might have assisted with supervising the resident or the family could have been contacted for assistance as well in supervising the resident. According to the DON, the 200 hall mainly consisted of rehab residents and the facility's rehab census had been low that night on the 200 hall. Therefore, they were not short staffed, but because their census was lower Nurse # 4 and NA # 11 had assigned residents on two halls. The DON stated no staff member had called her on the evening of 12/7/19 to alert her that they felt more supervision was needed than they could provide that evening. According to the DON, the facility investigation had not revealed a lack of supervision on the night of 12/7/19 had contributed to the problem and the staff had not shared the concern with her.

On 1/9/20 at 1:18 PM Resident # 2's Nurse Practitioner (NP) was interviewed. According to the NP she had not identified from reviewing the hospital records that the resident had experienced any new subdural hematoma which had originated in the resident's head while he had resided at the facility.

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The Physician's Assistant (PA) who conducted the neurological consult at the hospital on 12/7/19 was interviewed on 1/14/20 at 3:57 PM via phone. The PA reported the following. Based on the comparison of a CT that was done during the resident's hospitalization of 11/14/19 and a CT that was done on 12/7/19, the resident had developed a new subdural hematoma sometime between these two interval dates. It was located in the right parietal area. A small part of the subdural hematoma was considered to be new and due to the fall of 12/7/19, but most of it had occurred sometime between the interval of 11/14/19 to 12/7/19. The 12/7/19 fall probably worsened the hematoma that was there. In his opinion the most likely reason for the subdural hematoma was the resident's falls but he could not definitively rule out spontaneous development was the cause. According to the PA, the resident was more at risk for head injury due to his age and vascular changes. There was more room in his skull for his brain to move around and shift.

On 12/11/19 Resident # 2 was discharged from the hospital back to the facility for care.

On 12/15/19 at 7:45 AM Nurse # 6 documented in the medical record she was called to Resident # 2's room at 7:45 AM because he was sitting on the floor mat beside his bed. The nurse noted no injuries.
An investigation summary into the 12/15/19 incident revealed the fall mat had effectively prevented injury and no new intervention was needed.

On 12/24/19 at 3:22 PM Nurse # 7 documented in the medical record that Resident # 2 was on the

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floor and found to be without injuries. An investigation summary into the 12/24/19 incident revealed the fall mat had effectively prevented injury and the resident was in the process of going through a discontinuation of his Zyprexa medication.

The resident's facility physician was interviewed on 1/9/20 at 4:05 PM and again on 1/14/20 at 5:19 PM. According to the physician, the resident could have possibly not shown any symptoms of the chronic subdural hematoma he developed because chronic subdural hematomas develop over time and do not always present with symptoms as they start to form. They do not have as high as a mortality rate when compared to acute subdural hematomas and do not present as much of an emergency when compared to acute subdural hematomas. According to the physician, since the neurologist thought the subdural hematoma identified on 12/7/19 was considered chronic/subacute in nature, it was possible that the incident which precipitated the development of this was when he fell on 11/14/19 (at which time he was in a supervised area and the maintenance staff member did not get to him quickly enough). The initial CT of 11/14/19 would not have necessarily shown the slow bleed that started to form. He did feel the staff were working to keep the resident safe and the DON could better address specific interventions.

The resident was observed on 1/9/20 at 9:35 AM in his room on a bed which was very close to the ground. A mattress was by the floor. The resident was awake and alert but appeared confused and would not converse or seem to understand questions. His responsible party (RP) was at the bedside and indicated she visited often.

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F 689	Continued From page 19 According to the RP the resident had been calmer in the past few weeks and she felt his calmer behavior had led to less falls	F 689		
F 725 SS=G	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and nurse practitioner interviews and physician interview the facility failed to allocate sufficient	F 725	On 1/30/20, the Administrator reviewed the daily staff sheet and determined there was sufficient staffing to meet resident	2/15/20

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F 725	Continued From page 20 staff to supervise one (Resident # 2) of three sampled residents reviewed for falls when his individualized needs indicated more staff were needed to keep him safe. Resident #2, suffered a laceration to his head and was identified to have a worsening of a subdural hematoma which was deemed subacute or chronic in nature. The facility also failed to allocate sufficient staff to assure ambulation services were provided for two (Residents # 7 and #9) of two sampled residents reviewed for range of motion. The findings included: This tag is cross referenced to: 1. F-689: Based on observation, record review, staff interview, family interview, nurse practitioner interview, neurological physician assistant interview, and physician interview the facility failed to provide supervision to prevent falls for one (Resident # 2) of three sampled residents who were reviewed for falls. Resident #2, suffered a laceration to his head and was identified to have a worsening of a subdural hematoma which was deemed subacute or chronic in nature. An interview was conducted with the Director of Nursing on 1/9/20 at 3:42 PM who indicated she was responsible for developing the facility's nursing staffing schedule. She reported that the schedule was based on the resident census and she felt staffing was enough for the number of residents in the facility. She indicated she had not been made aware by residents or staff that the number of staff members being scheduled were not adequate to meet resident needs.	F 725	needs to include sufficient staff to supervise residents at risk for falls to include resident #2 and sufficient staff to ensure ambulation services were provided to include resident #7 and resident #9. All residents with the potential of being affected, the 200 hall nurses station was relocated to Nurse Station 1 to ensure a clear line of sight and increased visibility. On 1/30/20, the Administrator and Director of Nursing (DON) reviewed the clinical staffing schedule for the next 7 days. This review is to ensure sufficient staff were scheduled to meet the care needs of the residents to include sufficient staff to supervise residents at risk for falls to include resident #2 and sufficient staff to ensure ambulation services were provided to include resident #7 and resident #9. On 1/29/20, the Facility Nurse Consultant in-serviced the Administrator, DON and Scheduler in regards to Sufficient Staff. The Administrator and DON must ensure sufficient staff based on the staff s ability to provide needed care to residents that enable them to reach their highest practicable physical, mental, and psychosocial well-being. On 1/29/20 the Director of Nursing initiated in-service with nursing staff in regards to (1) Incidents to include assessment of resident, obtaining statements, determining the root cause and initiation of appropriate intervention based on root cause, completion of incident report in electronic record, notification of physician and RR, and updating care plan/care guide (2) Root Cause Analysis to include definition of root	

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F 725	Continued From page 21 2. F-688: Based on record review, resident and staff interviews the facility failed to provide ambulation as specified in the plan of care for 2 of 2 residents reviewed for range of motion (Resident #7 and Resident # 9). During an interview with Restorative Aide #2 on 1/9/20 at 2:50 PM, the Restorative Aide stated she was pulled to the floor most of her time that she was scheduled to work as a nurse aide rather than do restorative services. She stated when she was pulled to work the floor the other nurse aides were to provide restorative services to their assigned residents. An interview was conducted with the Director of Nursing (DON) on 1/9/20 at 3:42 PM who indicated she was responsible for developing the facility's nursing staffing schedule. She reported that the schedule was based on the resident census and she felt staffing was enough for the number of residents in the facility. She further stated she was aware that restorative aides were being pulled to work the floor based on the census. She stated she was not aware that resident ambulation was not being done by the nurse aides. The DON stated each aide was trained on how to provide restorative services.	F 725	cause, steps to determine root cause and presenting investigative findings to the Quality Assurance Performance Improvement Team to review all possible actions that can prevent reoccurrence. (3) Restorative program, (4) completing tasks per plan of care and (5) documentation to include completion of task or resident refusal. In-service will be completed by 02/15/20. The Administrator, DON, and/or scheduling coordinator will audit staffing schedule in a daily staffing meeting include nights and weekends, 5 times a week for two (2) weeks, then twice weekly for two (2) weeks, then weekly for four (4) weeks then monthly for one (1) month utilizing the Sufficient Staff Audit Tool. This audit is to ensure facility has sufficient staff to meet the needs of the residents. The DON/Administrator will immediately address all areas of concern. The Administrator will initial the Sufficient Staff Audit Tool to assure the staffing patterns are appropriate to meet the needs of the residents. The Director of Nursing will present the results of the Sufficient Staff Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee Meeting monthly for three (3) months. The QAPI Committee will meet and review the Sufficient Staff Audit Tool monthly for three (3) months to determine trends and / or issues that may need further interventions are place and to determine the need for further and / or frequency of monitoring	