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	345560	A. BUILDING _____ B. WING _____	C 01/13/2025

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F 000	INITIAL COMMENTS A complaint investigation was conducted onsite from 1/07/25 through 1/08/25 with additional information obtained remotely on 1/09/25 through 1/10/25. Onsite validation of the immediate jeopardy removal plans was conducted on 1/13/25. Therefore, the exit date was 1/13/25. Event ID# 6YI511. The following intake was investigated: NC00225640. Intake NC00225640 resulted in immediate jeopardy. 1 of the 1 complaint allegation resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity J CFR 483.25 at tag F684 at a scope and severity J The tag F684 constituted Substandard Quality of Care. Immediate Jeopardy began on 11/23/24 and was removed on 1/11/25. A partial extended survey was conducted.	F 000		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which	F 580		1/31/25

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

Electronically Signed | 01/27/2025

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results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct

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F 580	Continued From page 2 part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews with facility staff, physician's office staff, Nurse Practitioner (NP), and Medical Director, the facility failed to notify the physician or nurse practitioner (NP) immediately of an unwitnessed fall with head injury for a resident prescribed an anticoagulant (blood thinner) in order for the physician to determine the necessary treatment plan. The resident fell on Saturday 11/23/24 and the physician was not notified until Monday 11/25/24. Resident #1 continued to receive his anticoagulant medication. On 11/27/24, Resident #1 had an acute change in condition and was sent to the hospital. Resident #1's Glasgow Coma Scale (used to objectively describe the extent of impaired consciousness in all types of acute medical and trauma patients) in the hospital indicated he sustained a severe traumatic brain injury. He received treatment to reverse the effects of Eliquis (a blood thinner) and attempt to slow the bleeding. He was placed on a ventilator (a medical device that helps people breathe by moving air into and out of their lungs) and was transferred to a different hospital for a higher level of care. A computerized tomography (CT) scan revealed multiple abnormalities including a large subdural hematoma (brain bleed) measuring 3.7 centimeters (cm) with a 9 millimeter (mm) midline shift (displacement of brain tissue across the center line of the brain) and a small subfalcine and uncal herniation (types of brain herniations that are life threatening and occur when increased pressure inside the skull causes brain tissue to push through openings in the brain). The	F 580	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #1 passed away on 11/30/2024. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The Director of Nursing completed an audit of all falls from 11/1/25 to 11/30/25 with head injury to include falls with head injury and prescribed an anticoagulant. The audit also included timely notification of responsible representative and physician and physician extender. The audit was completed 12/3/24 by the Director of Nursing. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Director of Health Services or Clinical Competency Coordinator will educate all licensed nursing staff to immediately notify the physician or physician extender in person or by phone of a fall with head injury for a resident on an anticoagulant for the physician or physician extender to make an informed decision regarding	

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F 580	Continued From page 3 CT scan also found he had a fracture of the L1 vertebrae (a broken first lumbar bone in the spine). He died on 11/30/24 and the death certificate indicated the immediate cause of death was complications from a right side subdural hematoma with midline shift. The underlying cause was listed as blunt force injury of head and brain. This deficient practice was for 1 of 4 residents reviewed for notification of the physician (Resident #1). Immediate jeopardy began on 11/23/24 when Resident #1, who was prescribed an anticoagulant, had a fall with obvious signs of head injury and the physician was not notified. Immediate jeopardy was removed on 1/11/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D to ensure education is completed and monitoring systems put in place are effective. The findings included: Resident #1 was admitted to the facility on 10/21/24 with diagnoses including atrial fibrillation (irregular heart beat), congestive heart failure, cognitive communication deficit, and hypertension (high blood pressure). Resident #1's medical record face sheet (a document that summarizes a patient's important information in a patient's medical record) indicated his code status was full code requesting full medical interventions in an emergency. Resident #1's admission Minimum Data Set (MDS) dated 10/28/24 indicated he had severe	F 580	continued use anticoagulant or need to transfer the resident to an acute care facility. The physician or physician extender should be notified immediately in person or by phone if any significant change in condition, to include falls with head injury, for residents prescribed an anticoagulant. Licensed nurses will be educated regarding health risk for residents on anticoagulants and the importance of notification of physician or physician extender in person or by phone. Staff education will be completed on 1/10/25 or prior to the staff working their next scheduled shift. The education will be added to the licensed nurse written orientation program. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Beginning 1/10/25, the Director of Health Services, Performance Improvement Nurse or the Nurse Supervisor will use the Fall/Anticoagulant/Discharge Audit Tool for review of all fall events during the morning clinical meeting to verify licensed nursing staff immediately notified the physician or physician extender in person or by phone of a fall with head injury for a resident on an anticoagulant for the physician or physician extender to make an informed decision regarding continued use anticoagulant or need to transfer the resident to an acute care facility. The Director of Health Services, Performance Improvement Nurse or the	

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F 580	Continued From page 4 cognitive impairment and was taking an anticoagulant medication. Resident #1's physician orders dated 11/8/24 noted he was prescribed Eliquis (an anticoagulant) 2.5 milligrams (mg) twice a day. An event incident report written by Nurse #1 dated 11/23/24 indicated Resident #1 had an unwitnessed fall in his room. The report noted he was found by staff on the floor. Upon assessment, it was found he hit his head and had an abrasion to top left side of his head with an indentation. His vital signs were stable and he was able to move his arms and legs. He was placed back into his wheelchair. Nurse #1 noted he was alert and oriented. Nurse #1 asked if he needed or wanted to go to the hospital and he stated he did not. He stated his head hurt and he was given Tylenol per his request. Nurse #1 noted his neurological checks were within normal limits. Resident #1's nursing progress notes dated 11/23/24 at 2:00 PM written by Nurse #3 indicated Nurse #3 was alerted by a Nursing Assistant (NA) that Resident #1 was on the floor. When Nurse #3 entered his room, he was in the corner on the floor near the television. Resident #1 complained of having a headache and Nurse #3 noted Tylenol was given and no other issues were noted. Nurse #3 noted the physician communication log was updated on 11/23/24. The Facility/Provider Communication Log documented an entry by Nurse #3 on 11/23/24 which noted Resident #1 had an unwitnessed fall with an indentation on top of his head. The NP wrote for staff to monitor Resident #1.	F 580	Nurse Supervisor will use the Fall/Anticoagulant/Discharge Audit Tool weekly x eight weeks. The results of the weekly audits will be presented to the Quality Assurance team weekly x 4 weeks, then no less than monthly until compliance is achieved Compliance will be achieved by 1/31/25.	

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In an interview on 1/8/25 at 11:08 AM, Nurse #3 said she was called to the room by NA #1. When she came to the room, Resident #1 was on the floor between the television cabinet and the wall. Nurse #3 said she assessed him and NA #1 assisted her with moving him into his wheelchair. She said Resident #1 had a small indentation that looked "like when someone would press down into a soft mattress" approximately the size of a nickel in his head where it had hit something. She said she knew Resident #1 was taking a blood thinner at the time of the fall. Nurse #3 said the nurse supervisor normally called the physician to notify them of a fall incident but that she wrote about the fall in the physician communication book kept at the nurses' station.

A nursing progress note dated 11/23/24 at 2:04 PM written by Nurse #1 indicated Resident #1 had an unwitnessed fall and hit his head. She noted Resident #1 had an abrasion to the top left side of his head with a visible indentation. His vital signs were stable and he was able to move all of his extremities. Resident #1 was placed back in his wheelchair and was alert and oriented. Nurse #1 called the Director of Nursing (DON) and Resident #1 was asked if he needed or wanted to go to the hospital and Resident #1 stated no. Resident #1 stated his head hurt but for Nurse #1 to give him some Tylenol and he would be fine. Nurse #1 documented Tylenol was administered. Neurological checks were within normal limits.

In an interview on 1/7/25 at 4:04 PM, Nurse #1 said she was notified by Nurse #3 that Resident #1 was found on the floor in his room. Nurse #1, who was the nurse supervisor that day, went to

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the unit and found Resident #1 was up in his wheelchair. Nurse #1 assessed Resident #1 neurologically and physically and all of his assessments were within normal limits. Nurse #1 said she called the Director of Nurses (DON), who told her to ask Resident #1 if he would like to go to the hospital and he said no, he "ain't going to no hospital." Nurse #1 stated she knew he was on blood thinners and that hitting his head while on blood thinners could lead to uncontrolled bleeding and a brain bleed. She stated the physician or NP was usually notified of falls through the medical practice telemedicine program. She said she did not notify the telemedicine program about the fall and that notification was done by Nurse #3.

In a phone interview on 1/8/25 at 2:42 PM, the Medical Records Coordinator at the medical practice said when she reviewed the notification records, there was no record of the facility notifying the medical practice regarding the fall on 11/23/24.

Resident #1's November 2024 Medication Administration Record documented he continued to receive Eliquis twice a day.

Resident #1's Nurse Practitioner (NP) progress note dated 11/25/24 indicated he had two falls in the past week with the last one on 11/23/24. Resident #1 complained of pain from the fall but said he did not hit his head and was doing well. The NP noted that staff had no acute concerns or requests at the time of the visit.

In a phone interview on 1/7/25 at 4:07 PM, the NP said she came to the facility full-time Monday through Friday, but on the weekends the staff

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were to call the medical practice telemedicine service with any incidents or changes of condition. She remembered that Resident #1 was cognitively impaired and was not a reliable historian. She said when she came into the facility on 11/25/24, she learned about Resident #1's fall on 11/23/24. She said Resident #1 reported he did not hit his head and appeared to be acting normally and at baseline. The NP said she found out later that visit (unrecalled when) that he had a small abrasion on the top of his head. She said she did not recall if she had assessed the abrasion that day. She said she was not aware of the fall on 11/23/24 until 11/25/24 when she reviewed the physician communication log. During the interview, she reviewed the telemedicine notification log on her phone and said the practice had not received a notification from the facility about Resident #1 on 11/23/24 or 11/24/25. She said if she had known of the fall on 11/23/24 and that Resident #1 had a head injury, she would have reviewed the nursing assessments and weighed the risks and benefits of hospitalization or withholding his Eliquis to prevent bleeding.

Resident #1's nursing progress notes dated 11/27/24 at 11:15 AM written by Nurse #3 documented she notified the nurse supervisor, Nurse #1, and informed her that Resident #1 was not opening his eyes and waking up. She noted Resident #1 responded to touch and would mumble but he would not open his eyes.

In her interview on 1/8/25 at 11:08 AM, Nurse #3 said that after the fall on 11/23/24, Resident #1 was acting normally. On the morning of 11/27/24, she attempted to give him his morning medications and he would mumble for her to not

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bother him. She said that was not unusual for Resident #1 and she frequently had to attempt several times throughout the morning for him to take all of his medications. She had been told by NA #1 that Resident #1 had yelled at her that morning, which was not normal since he usually liked working with NA #1. NA #1 also came to get her at approximately 10:30-11:30 AM that morning saying Resident #1 wouldn't wake up. She went to Resident #1's room and saw he was significantly less responsive than normal when she called his name. He would move a little and moan but did not open his eyes. She said this was when she first noticed a change in his condition. She called for Nurse #1, who was the nurse supervisor that day, and told her of her concerns. Nurse #3 said she went back into Resident #1's room to monitor him and take his vitals. Nurse #1 came to the unit immediately and brought Nurse #2 with her. Nurse #3 said she stayed in the room for a few minutes during Nurse #1 and Nurse #2's assessments, but when they said he needed to go to the hospital, she left the room to get the hospital transfer paperwork done.

Resident #1's nursing progress notes dated 11/27/24 at 12 noon written by Nurse #1 noted she went to assess Resident #1 after receiving a call from Nurse #3 that he was unresponsive. Nurse #1 noted she performed a sternal rub and Resident #1 would moan. Nurse #1 also noted Resident #1 had a temperature of 101.7 Fahrenheit (F). Nurse #1 noted she called the NP with her findings. The nurses repositioned him in bed and his blood pressure went up from 94/48 to 153/67. Resident #1 was still unresponsive but responded to pain. Nurse #1 noted she received an order from the NP to send Resident #1 to the

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Emergency Room (ER) for altered mental status and fever.

In her interview by phone on 1/7/25 at 3:25 PM, Nurse #1 said she was called by Nurse #3 to go see Resident #1 because he was not waking up on 11/27/24 at approximately 11:00 AM. When she arrived on the unit with Nurse #2, Resident #1 would respond only to painful stimuli. She said she performed a sternal rub, which caused him to moan and move his arms a little, but not verbally respond or open his eyes. She said she called the NP directly on the NP's cell phone, described how the resident was responding, and the NP ordered him to be sent to the ER.

Resident #1's Emergency Medical Services (EMS) Call Detail Report dated 11/27/24 noted they received a call for services for Resident #1 at 11:35 AM due to complaint of altered mental status and that Resident #1 was unconscious.

Resident #1's hospital #1's ER report dated 11/27/24 noted he had fallen approximately four days prior and hit his head. He had a contusion (bruise) in the occipital area (back) of his head. The ER note documented that morning when he was woken up at approximately 7:30 AM and "cussing out" the staff and wanted to go back to sleep. He was later found at approximately noon unresponsive. The ER noted he was unresponsive with semi-purposeful movements where he would squeeze the hand. If he was given painful stimulus he would say nonsensible words but was in general not responding. The physician noted Resident #1 was given the two medications Andexxa and Tranexamic acid (TXA) to reverse the effects of Eliquis. He was intubated and assessed as scoring 3-8 on the Glasgow

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Coma Scale, which indicated he was comatose. He was placed on a ventilator to assist with his breathing and was transferred to a different hospital for a higher level of care.

Resident #1's hospital #2's report dated 11/30/24 included results from a CT scan which revealed multiple abnormalities including a large subdural hematoma measuring 3.7 cm with a 9 mm midline shift and a small subfalcine and uncal herniation. The CT scan also found he had an acute fracture of the L1 vertebrae. The report noted he was evaluated by neurology and it was determined he was not a candidate for neurosurgery due to no expectation of a meaningful recovery. Resident #1 was placed on comfort care and expired on 11/30/24.

Resident #1's death certificate dated 12/4/24 indicated Resident #1 expired on 11/30/24 and noted the immediate cause of death was due to complications from right side subdural hematoma with midline shift. The underlying cause of death was listed as blunt force injury of head and brain.

In an interview on 1/8/25 at 11:55 AM, the Medical Director, who was also Resident #1's physician, said Resident #1's death was preventable if the resident had gone to the hospital, but the facility couldn't force him to go, even if he didn't understand the risks versus benefits due to his cognitive impairment. She said the industry practice was to no longer immediately send a resident to the hospital after a fall, even if the resident hit their head, that the decision would depend on the severity of the head injury, the medical history of that particular resident, and the subsequent clinical assessments. She said she would not have

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stopped the Eliquis if she had received the fall report on 11/23/24. She said because the Eliquis as a stroke prevention medication was new for him, she said he was at an increased risk of stroke if the Eliquis was held. She said because the neurological checks had been done appropriately, and there was no change in him medically until 11/27/24, she would not have done anything other than to monitor him during that time. She said she reviewed the physician communication log and the documentation written by the NP, and the facility did not notify the practice or providers on 11/23/24 or 11/24/24. She said Resident #1's brain bleed wouldn't have shown symptoms until days later when it grew big enough to affect him which was why he appeared at baseline until 11/27/24.

In an interview on 1/8/25 at 5:55 PM, the DON said Nurse #3 updated the physician communication log after the fall on 11/23/24. She said any nurse, including Nurse #3, should notify the physician either through the physician communication log or through the practice telemedicine notification system when there was a fall. She said the nursing staff determine which method to use to communicate with the physician, depending on if the resident had a change of condition. She said Resident #1 remained at his baseline after the fall, which was why Nurse #3 used the physician communication log to notify the provider. The NP came to the facility Monday through Friday and the physician did not regularly work on the weekends. The medical practice had on-call physicians for the weekends. When the DON was asked if staff should have notified the physician via the telemedicine notification system in order for the notification to be received on Saturday rather than

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using the communication log that would be viewed on Monday, she indicated the communication log notification was appropriate.

The Administrator was notified of Immediate Jeopardy on 1/8/24 at 6:06 PM.

The facility provided the following credible allegation of immediate jeopardy removal:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome

The facility failed to notify the physician immediately of a fall with head injury for a resident on an anticoagulant for the physician to determine the necessary treatment plan. The resident fell on 11/23/24 and the physician was not notified until 11/25/24. Failure to notify the physician of the resident's fall with head injury while taking anticoagulant resulted in the resident being discharged to an acute care facility on 11/27/24 with a severe traumatic brain injury.

Licensed nurses failed to understand the risk related to a resident having the potential for a severe injury while taking anticoagulants. Licensed nurses failed to understand that the physician or physician extender need to be notified when a resident has had a fall with a head injury and is being administered anticoagulants.

Resident #1 passed away on 11/30/24.

All residents receiving anticoagulants are at risk of suffering a serious outcome.

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Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

Beginning 1/10/25, the Director of Health Services or the Nurse Supervisor will review all events during the morning clinical meeting to verify the physician or the physician extender has been notified of changes in condition to include falls with head injury for residents on anticoagulants.

The Director of Health Services or Clinical Competency Coordinator will educate all licensed nursing staff to immediately notify the physician or physician extender in person or by phone of a fall with head injury for a resident on an anticoagulant for the physician or physician extender to make an informed decision regarding continued use anticoagulant or need to transfer the resident to an acute care facility. The physician or physician extender should be notified immediately in person or by phone if any significant change in condition, to include falls with head injury, for residents prescribed an anticoagulant. Licensed nurses will be educated regarding health risk for residents on anticoagulants and the importance of notification of physician or physician extender in person or by phone. Staff education will be completed on 1/10/25 or prior to the staff working their next scheduled shift. The education will be added to the licensed nurse written orientation program.

The immediate jeopardy was removed on 1/11/25.

Onsite validation of the immediate jeopardy removal plan was completed on 1/13/25.

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F 580	Continued From page 14 Interviews with licensed nurses confirmed all licensed nurses were educated to immediately notify the physician or physician extender in person or by phone of a fall with head injury for a resident on an anticoagulant in order for the physician or physician extender to make the decision regarding continued use of anticoagulant or the need to transfer the resident to an acute care facility. Education included health risks for residents on anticoagulants and the importance of notification of the physician or extender in person or by phone. The immediate jeopardy removal date of 1/11/25 was validated.	F 580		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews with the Responsible Party (RP), staff, Nurse Practitioner (NP), and Medical Director, the facility failed to: explain to the resident and RP the risk of life threatening consequences and the importance of hospital evaluation when a severely cognitively impaired resident who was prescribed an anticoagulant (blood thinner) had an unwitnessed	F 684	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #1 passed away on 11/30/2024. All residents on anticoagulants are at serious risk of suffering a serious	1/31/25

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F 684	Continued From page 15 fall with obvious signs of head injury and refused hospital evaluation; and to recognize the seriousness of a change in condition and immediately seek emergent medical care. On 11/23/24 Resident #1 had an unwitnessed fall and was assessed as having an abrasion with a small indentation on the top of his head described by Nurse #3 "like when someone would press down into a soft mattress". The resident stated he "ain't going to no hospital." The RP was notified of the fall by Nurse #3 who did not mention that the resident refused the hospital or explain the potential consequences of a serious head injury. The RP stated they did not understand the seriousness of the injury. Resident #1 continued to receive his anticoagulant medication. On 11/27/24, Resident #1 was noted with a change in behaviors at approximately 8:00 AM and between approximately 10:00 AM and 10:15 AM Nurse Aide (NA) #1 tried to wake the resident but he wouldn't open his eyes and his only response was grunting and mumbling incoherent words. Resident #1 was not assessed by a nurse until approximately 11:00 AM. Nurse #1 performed a sternal rub (a painful stimulus used to assess a patient's neurological status and responsiveness) to which the resident was only responsive to painful stimuli. The NP was contacted at 11:20 AM to report the change in condition and Emergency Medical Services (EMS) were contacted at 11:35 AM. Resident #1's Glasgow Coma Scale (used to objectively describe the extent of impaired consciousness in all types of acute medical and trauma patients) in the hospital indicated he sustained a severe traumatic brain injury. He received treatment to reverse the effects of Eliquis (anticoagulant) and attempt to slow the bleeding. He was placed on a ventilator (a medical device that helps people breathe by	F 684	outcome. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The Director of Nursing completed an audit of all falls from 11/1/25 to 11/30/25 with head injury to include falls with head injury and prescribed an anticoagulant. The audit also included timely notification of responsible representative and physician and physician extender. The audit was completed 12/3/24 by the Director of Nursing. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Education began 1/9/24 by the Director of Health Services to all licensed staff on identification of change in condition and what constitutes a change in condition. The education will include the use of the Interact Change in condition tool. Nurses will be educated regarding notification of physician when a change in resident condition occurs. The education will be added to the licensed nurse orientation. Licensed staff will be educated regarding a resident with any cognition level that refuses hospital transport once a physician and/or physician extender order has been received, that the physician and/or physician extender and resident representative must be notified of the	

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F 684	Continued From page 16 moving air into and out of their lungs) and was transferred to a different hospital for a higher level of care. A computerized tomography (CT) scan revealed multiple abnormalities including a large subdural hematoma (brain bleed) measuring 3.7 centimeters (cm) with a 9 millimeter (mm) midline shift (displacement of brain tissue across the center line of the brain) and a small subfalcine and uncal herniation (types of brain herniations that are life threatening and occur when increased pressure inside the skull causes brain tissue to push through openings in the brain). The CT scan also found he had a fracture of the L1 vertebrae (a broken first lumbar bone in the spine).He died on 11/30/24 and the death certificate indicated the immediate cause of death was complications from a right side subdural hematoma with midline shift. The underlying cause was listed as blunt force injury of head and brain. This deficient practice was for 1 of 4 residents reviewed for falls (Resident #1). Immediate jeopardy began on 11/23/24 when Resident #1, who was severely cognitively impaired and prescribed an anticoagulant, refused hospital evaluation following an unwitnessed fall with obvious signs of head injury and the facility failed to explain to the resident and RP the life-threatening consequences that could occur and the importance of hospital evaluation. Immediate jeopardy was removed on 1/11/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D to ensure education is completed and monitoring systems put in place are effective. The findings included:	F 684	refusal. Staff education will be complete by 1/10/25 or prior to the staff working their next scheduled shift. The education will be added to the licensed nurse orientation. Licensed staff will be educated in their responsibility to educate the resident and the resident representative regarding refusal of follow-up at an acute care facility to ensure the resident and resident representative are making an informed decision. The resident and resident representative education will be documented by the licensed nurse in the medical record. The Director of Health Services and the Administrator will be notified when a resident refuses an ordered transport to an acute care facility. Staff education will be complete by 1/10/25 or prior to the staff working their next scheduled shift. The education will be added to the licensed nurse orientation. Certified Nursing Assistants and the Therapy Department staff will be educated by the Director of Health Service or the Clinical Competency Coordinator on reporting to the licensed nurse, any changes they notice in a resident they feel are outside of the resident□s usual behavior, physical appearance or vital signs. Staff education will be completed by 1/10/25 or prior to the staff working their next scheduled shift. The education will be added to the certified nursing assistant and Therapy Department orientation.	

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F 684	Continued From page 17 Resident #1 was admitted to the facility on 10/21/24 with diagnoses including atrial fibrillation (irregular heart beat), congestive heart failure, cognitive communication deficit, and hypertension (high blood pressure). Resident #1's medical record face sheet (a document that summarizes a patient's important information in a patient's medical record) indicated his code status was full code requesting full medical interventions in an emergency. Resident #1's comprehensive care plan dated 10/21/24 revealed he would refuse care, was at risk for falls, and was taking an anticoagulant medication. Interventions for his anticoagulant use was to educate the resident and representative on risk and benefits of anticoagulation use. Resident #1's admission Minimum Data Set (MDS) dated 10/28/24 indicated he had severe cognitive impairment, would refuse care, and needed partial or moderate assistance from staff for his activities of daily living (ADLs). The MDS indicated he had not had any falls since his admission and was taking an anticoagulant medication. Resident #1's physician orders dated 11/8/24 noted he was prescribed Eliquis (an anticoagulant) 2.5 milligrams (mg) twice a day. An event incident report written by Nurse #1 dated 11/23/24 indicated Resident #1 had an unwitnessed fall in his room. The report noted he was found by staff on the floor. Upon assessment, it was found he hit his head and had	F 684	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Beginning 1/10/25, the Director of Health Services, Performance Improvement Nurse or the Nurse Supervisor will use the Fall/Anticoagulant/Discharge Audit Tool for review of all fall events during the morning clinical meeting to verify licensed nursing staff immediately notified the physician or physician extender in person or by phone of a fall with head injury for a resident on an anticoagulant for the physician or physician extender to make an informed decision regarding continued use anticoagulant or need to transfer the resident to an acute care facility. The audit tool also reflects if the licensed staff made a progress note that reflects notification of the physician/physician extender and to the resident and responsible party regarding risk versus benefit of resident choosing not to go to the hospital if the licensed staff determines condition warrants being sent out to an acute care facility. The Director of Health Services, Performance Improvement Nurse or the Nurse Supervisor will use the Fall/Anticoagulant/Discharge Audit Tool weekly x eight weeks. The results of the weekly audits will be presented to the Quality Assurance team weekly x 4 weeks, then no less than monthly until compliance is achieved	

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an abrasion to top left side of his head with an indentation. His vital signs were stable and he was able to move his arms and legs. He was placed back into his wheelchair. Nurse #1 noted he was alert and oriented. Nurse #1 asked if he needed or wanted to go to the hospital and he stated he did not. He stated his head hurt and he was given Tylenol per his request. Nurse #1 noted his neurological checks were within normal limits. Nurse #1 noted she asked Resident #1 several times if he would like to go to the hospital and he continued to refuse.

Resident #1's nursing progress notes dated 11/23/24 at 2:00 PM written by Nurse #3 indicated Nurse #3 was alerted by a Nursing Assistant (NA) that Resident #1 was on the floor. When Nurse #3 entered his room, he was in the corner on the floor near the television. Resident #1 complained of having a headache and Nurse #3 noted Tylenol was given and no other issues were noted. Nurse #3 noted the physician notification communication book was updated and she notified Resident #1's RP.

A nursing progress note dated 11/23/24 at 2:04 PM written by Nurse #1 indicated staff called for a fall huddle, a meeting of all staff on the unit and the nurse supervisor to review a fall to discuss the fall and any possible contributing factors, due to Resident #1 being found on the floor. Nurse #1 noted he had an unwitnessed fall and hit his head. She noted Resident #1 had an abrasion to the top left side of his head with a visible indentation. His vital signs were stable and he was able to move all of his extremities. Resident #1 was placed back in his wheelchair and was alert and oriented. Nurse #1 called the Director of Nursing (DON) and Resident #1 was asked if he

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needed or wanted to go to the hospital and Resident #1 stated no. Resident #1 stated his head hurt but for Nurse #1 to give him some Tylenol and he would be fine. Nurse #1 documented Tylenol was administered. Neurological checks were within normal limits. Nurse #1 documented she asked him several times if would he like to go to the hospital and he continued to refuse.

In an interview on 1/7/25 at 4:04 PM, Nurse #1 said she was notified by Nurse #3 that Resident #1 was found on the floor in his room. Nurse #1, who was the nurse supervisor that day, went to the unit and found Resident #1 was up in his wheelchair. Nurse #1 assessed Resident #1 neurologically and physically and all of his assessments were within normal limits. Nurse #1 said she called the Director of Nurses (DON), who told her to ask Resident #1 if he would like to go to the hospital and he said no, he "ain't going to no hospital." Nurse #1 stated she knew he was on blood thinners and that hitting his head while on blood thinners could lead to uncontrolled bleeding and a brain bleed. She stated she explained to him about how the blood thinners he was taking could affect him by causing uncontrolled bleeding, but he continued to say he was not going to the hospital.

In an interview on 1/8/25 at 11:08 AM, Nurse #3 said she was called to the room by NA #1. When she came to the room, Resident #1 was on the floor between the television cabinet and the wall. Nurse #3 said she assessed him and NA #1 assisted her with moving him into his wheelchair. She said Resident #1 had a small indentation that looked "like when someone would press down into a soft mattress" approximately the size of a

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nickel in his head where it had hit something. Nurse #3 said she called for a fall huddle and the staff did not identify any concerns. Nurse #3 said she was in the room when Nurse #1 called the DON and heard Resident #1 say he did not want to go to the hospital. He complained of having a headache and was given Tylenol. She said she brought Resident #1 out to the common area to better monitor him and to continue to perform neurological checks. She said she knew Resident #1 was taking a blood thinner at the time of the fall. Nurse #3 said she called Resident #1's RP to notify her of the fall and that he hit his head. Nurse #3 said she did not tell the RP that he had refused to go to the hospital or about the potential complications he could have due to being on a blood thinner. She said she could not think why she did not tell the RP.

In an interview on 1/8/25 at 11:22 AM, NA #1 said when she found Resident #1 on the floor, he had hit his head on a sharp corner of his television cabinet. She said there was a dent in his head. After Nurse #3 assessed him, NA #1 helped her move Resident #1 back into his wheelchair. NA #1 said when she worked with him again later that shift, she told him he had a dent in his head and he should get it checked out. He told NA #1 he had hit his head harder than that and he was fine.

In a phone interview on 1/8/25 at 10:13 AM, Resident #1's RP said Nurse #3 had notified her of the fall on 11/23/24. She thought she remembered Nurse #3 saying Resident #1 did not want to go to the hospital, but also said she did not understand the potential risks of him falling and hitting his head while taking a blood thinner. She said she would have wanted him to go to the

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hospital if she had understood how serious the risks were from the fall. She said Resident #1 may have listened to her and gone to the hospital if she (the RP) was clearer about the seriousness of the situation.

Resident #1's November 2024 Medication Administration Record documented he continued to receive Eliquis twice a day.

Resident #1's Nurse Practitioner (NP) progress note dated 11/25/24 indicated he had two falls in the past week with the last one on 11/23/24. Resident #1 complained of pain from the fall but said he did not hit his head and was doing well. The NP noted that staff had no acute concerns or requests at the time of the visit.

In a phone interview on 1/7/25 at 4:07 PM, the NP remembered that Resident #1 was cognitively impaired and was not a reliable historian. She said he was able to make simple daily decisions but needed assistance otherwise. She said when she came into the facility on 11/25/24, she learned about Resident #1's fall on 11/23/24. She said Resident #1 reported he did not hit his head and appeared to be acting normally and at baseline. The NP said she found out later that visit (unrecalled when) that he had a small abrasion on the top of his head. She said she did not recall if she had assessed the abrasion that day. She said she had reviewed the nurses' documentation of neurological checks and the results were normal. She said if she had known of the fall on 11/23/24 and that Resident #1 had a head injury, she would have reviewed the nursing assessments and weighed the risks and benefits of hospitalization or withholding his Eliquis to prevent bleeding.

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Resident #1's clinical documentation from 11/25/24-11/26/24 revealed he participated in physical and speech therapy and had vital signs and neurological checks that were within normal limits.

In her interview on 1/8/25 at 11:22 AM, NA #1 said when she came into work on 11/27/24, she went and checked on Resident #1 at approximately 8:00 AM. She said she worked with Resident #1 regularly and had a good rapport with him. NA #1 said he would be agitated in the mornings and liked to sleep in. She said she was able to wake him in a way that would not agitate him and he was always nice to her. She said that morning, when she went to check on him, she attempted to wake him and he became immediately agitated and yelled at her. She said he had never acted like that with her prior to that morning and it was a change for him. She said at approximately 9:30-10:00 AM, the RP asked for assistance. The RP told her Resident #1 must have had a hard night and was still really sleepy. NA #1 said she went to the room and tried to wake him up. He hadn't eaten his breakfast that morning, which wasn't unusual as some days he would sleep through breakfast and eat later. When she tried to wake him, he wouldn't open his eyes and would just grunt and mumble incoherent words, which was abnormal, as he would usually wake easily and talk to the staff immediately when woken up. She said she went and notified Nurse #3 that Resident #1 was difficult to arouse and not responding at approximately 10:00-10:15 AM.

In her phone interview on 1/8/25 at 10:13 AM, the RP said she arrived at the facility at

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approximately 9:00-9:30 AM on 11/27/24. She said Resident #1 was asleep in bed. She said she was told by staff (name not recalled) that Resident #1 had "cussed" out one of the staff that morning. The RP said there were some staff members he was not as patient with, so he may have talked sharply to them. She said he had seemed the same since his fall on 11/23/24 and she had not noticed any changes in him. That morning she thought he was more sleepy than normal.

Resident #1's progress notes dated 11/27/24 at 10:03 AM documented the Registered Dietitian (RD) noted she had attempted to visit with Resident #1 twice that morning but he had been sleeping.

In an interview on 1/8/25 at 9:41 AM, the RD said Resident #1 was sleeping deeply when she tried to see him that morning, but the RP came to visit the resident during that time. She could not recall anything else about Resident #1's condition.

Resident #1's nursing progress notes dated 11/27/24 at 11:15 AM written by Nurse #3 documented she notified the nurse supervisor, Nurse #1, and informed her that Resident #1 was not opening his eyes and waking up. She noted Resident #1 responded to touch and would mumble but he would not open his eyes.

In her interview on 1/8/25 at 11:08 AM, Nurse #3 said that after the fall on 11/23/24, Resident #1 was acting normally. On the morning of 11/27/24, she attempted to give him his morning medications and he would mumble for her to not bother him. She said that was not unusual for Resident #1 and she frequently had to attempt

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several times throughout the morning for him to take all of his medications. She had been told by NA #1 that Resident #1 had yelled at her that morning, which was not normal since he usually liked working with NA #1. NA #1 also came to get her at approximately 10:30-11:30 AM that morning saying Resident #1 wouldn't wake up. She went to Resident #1's room and saw he was significantly less responsive than normal when she called his name. He would move a little and moan but did not open his eyes. She said this was when she first noticed a change in his condition. She called for Nurse #1, who was the nurse supervisor that day, and told her of her concerns. Nurse #3 said she went back into Resident #1's room to monitor him and take his vitals. Nurse #1 came to the unit immediately and brought Nurse #2 with her. Nurse #3 said she stayed in the room for a few minutes during Nurse #1 and Nurse #2's assessments, but when they said he needed to go to the hospital, she left the room to get the hospital transfer paperwork done.

Resident #1's nursing progress notes dated 11/27/24 at 12 noon written by Nurse #1 noted she went to assess Resident #1 after receiving a call from Nurse #3 that he was unresponsive. Nurse #1 noted she performed a sternal rub and Resident #1 would moan. Nurse #1 also noted Resident #1 had a temperature of 101.7 Fahrenheit (F). Nurse #1 noted she called the NP with her findings. The nurses repositioned him in bed and his blood pressure went up from 94/48 to 153/67. Resident #1 was still unresponsive but responded to pain. Nurse #1 noted she received an order from the NP to send Resident #1 to the Emergency Room (ER) for altered mental status and fever.

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In her interview by phone on 1/7/25 at 3:25 PM, Nurse #1 said she was called by Nurse #3 to go see Resident #1 because he was not waking up on 11/27/24 at approximately 11:00 AM. When she arrived on the unit with Nurse #2, Resident #1 would respond only to painful stimuli. She said the RP was in the room and had commented on how they thought he was sleeping really deeply, as had the RD and other staff who had worked with Resident #1 that day. She said she performed a sternal rub, which caused him to moan and move his arms a little, but not verbally respond or open his eyes. She said she called the NP, described how the resident was responding, and the NP ordered him to be sent to the ER.

In an interview on 1/8/25 at 11:49 AM, Nurse #2 said Nurse #1 asked her to go see Resident #1 with her due to a reported change of condition on 11/27/24 at approximately 11:00 AM. Nurse #2 said she asked the RP what was going on and she said she was having a hard time getting Resident #1 up. When Nurse #1 and Nurse #2 tried to wake him, he would just moan. She knew he had fallen a few days prior to 11/27/24 but did not recall when the falls were. Nurse #2 did not remember if Resident #1 taking blood thinners was mentioned at any time.

In her phone interview on 1/7/25 at 4:07 PM, the NP said she received a phone call from Nurse #1 on 11/27/24 at 11:20 AM (time indicated in the call log) reporting that Resident #1 had a change in status. The NP said Nurse #1 described how she assessed Resident #1 and the NP said she was going to order a full clinical work-up including laboratory tests until Nurse #1 told her Resident #1 would only respond to the sternal rub. The NP

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said she then ordered that Resident #1 be sent out immediately to the ER.

Resident #1's Emergency Medical Services (EMS) Call Detail Report dated 11/27/24 noted they received a call for services for Resident #1 at 11:35 AM due to complaint of altered mental status and that Resident #1 was unconscious.

Resident #1's hospital #1's ER report dated 11/27/24 noted he had fallen approximately four days prior and hit his head. He had a contusion (bruise) in the occipital area (back) of his head. The ER note documented that morning when he was woken up at approximately 7:30 AM and "cussing out" the staff and wanted to go back to sleep. He was later found at approximately noon unresponsive. The ER noted he was unresponsive with semi-purposeful movements where he would squeeze the hand. If he was given painful stimulus he would say nonsensible words but was in general not responding. The physician noted Resident #1 was given the two medications Andexxa and Tranexamic acid (TXA) to reverse the effects of Eliquis. He was intubated and assessed as scoring 3-8 on the Glasgow Coma Scale, which indicated he was comatose. He was placed on a ventilator to assist with his breathing and was transferred to a different hospital for a higher level of care.

Resident #1's hospital #2's report dated 11/30/24 included results from a CT scan which revealed multiple abnormalities including a large subdural hematoma measuring 3.7 cm with a 9 mm midline shift and a small subfalcine and uncal herniation. The CT scan also found he had an acute fracture of the L1 vertebrae. The report noted he was evaluated by neurology and it was

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determined he was not a candidate for neurosurgery due to no expectation of a meaningful recovery. Resident #1 was placed on comfort care and expired on 11/30/24.

Resident #1's death certificate dated 12/4/24 indicated Resident #1 expired on 11/30/24 and noted the immediate cause of death was due to complications from right side subdural hematoma with midline shift. The underlying cause of death was listed as blunt force injury of head and brain.

In an interview on 1/8/25 at 11:55 AM, the Medical Director (MD), who was also Resident #1's physician, said Resident #1's death was preventable if the resident had gone to the hospital, but the facility couldn't force him to go, even if he didn't understand the risks versus benefits due to his cognitive impairment. She said the industry practice was to no longer immediately send a resident to the hospital after a fall, even if the resident hit their head, that the decision would depend on the severity of the head injury, the medical history of that particular resident, and the subsequent clinical assessments. She said she would not have stopped the Eliquis if she had received the fall report. She said because the Eliquis as a stroke prevention medication was new for him, she said he was at an increased risk of stroke if the Eliquis was held. She said because the neurological checks had been done appropriately, and there was no change in him medically until 11/27/24, she would not have done anything other than to monitor him during that time. The MD said she spoke with therapy, who told her that they had worked with him on 11/26/24 and he was at his baseline. She said Resident #1's brain bleed wouldn't have shown symptoms until days later

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when it grew big enough to affect him which was why he appeared at baseline until 11/27/24.

In an interview on 1/8/25 at 5:55 PM, the DON said Resident #1 did not show any changes from his baseline after the fall on 11/23/24 until 11/27/24. She said Resident #1 had refused to go to the hospital after the fall when the nurse asked him.

In an interview on 1/8/25 at 6:00 PM, the Administrator said the facility had monitored Resident #1 and he had no changes after the fall on 11/23/24. She said when the staff noticed the changes of condition on 11/27/24, he was sent to the hospital immediately.

The Administrator was notified of Immediate Jeopardy on 1/8/24 at 6:06 PM.

The facility provided the following credible allegation of immediate jeopardy removal:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome

The facility failed to explain to the resident and the responsible party the life-threatening consequences that could occur and the importance of hospital evaluation when a severely cognitively impaired resident who was on a blood thinner had an unwitnessed fall with obvious signs of head injury and refused hospital evaluation on 11/23/24. The resident's blood thinner continued to be administered.

Staff did not recognize the seriousness of a significant change in condition and identify the need for urgent medical attention when resident

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was first identified with a change in condition on 11/27/24 at 8 AM.

Resident #1 expired on 11/30/2024. All residents receiving anticoagulants are at risk of suffering a serious outcome.
Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

Education began 1/9/24 by the Director of Health Services to all licensed staff on identification of change in condition and what constitutes a change in condition. The education will include the use of the Interact Change in condition tool. Nurses will be educated regarding notification of physician when a change in resident condition occurs. The education will be added to the licensed nurse orientation.

Licensed staff will be educated regarding a resident with any cognition level that refuses hospital transport once a physician and/or physician extender order has been received, that the physician and/or physician extender and resident representative must be notified of the refusal. Staff education will be complete by 1/10/25 or prior to the staff working their next scheduled shift. The education will be added to the licensed nurse orientation.

Licensed staff will be educated in their responsibility to educate the resident and the resident representative regarding refusal of follow-up at an acute care facility to ensure the resident and resident representative are making an informed decision. The resident and resident representative education will be documented by

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the licensed nurse in the medical record. The Director of Health Services and the Administrator will be notified when a resident refuses an ordered transport to an acute care facility. Staff education will be complete by 1/10/25 or prior to the staff working their next scheduled shift. The education will be added to the licensed nurse orientation.

Certified Nursing Assistants and the Therapy Department staff will be educated by the Director of Health Service or the Clinical Competency Coordinator on reporting to the licensed nurse, any changes they notice in a resident they feel are outside of the resident's usual behavior, physical appearance or vital signs. Staff education will be completed by 1/10/25 or prior to the staff working their next scheduled shift. The education will be added to the certified nursing assistant and Therapy Department orientation.

The Supervisor and/or Director of Health Services will review events during morning meetings to ensure significant changes in condition are recognized by nursing staff, the need for urgent medical attention is recognized and physician and/or physician extender and family were notified of change of condition and/or refusal of transfer.

The immediate jeopardy was removed on 1/11/2025.

Onsite validation of the immediate jeopardy removal plan was completed on 1/13/25.

Interviews with licensed nurses confirmed all licensed nurses were educated on identification of a change in condition and what constitutes a

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change in condition. Education included use of the facility's Interact Change in Condition tool. Licensed nursing staff were also educated to notify a physician when a change in resident's condition occurs. Additional education was received regarding a resident with any cognition level that refuses hospital transport once an order is received. The physician or physician extender and resident representative must be notified of the refusal. Licensed nursing staff were also educated about their responsibility to educate the resident and the resident representative regarding the risk of refusal to ensure the resident and resident representative are making an informed decision. During interviews licensed nurses identified the Interact Change in Condition tool and its location.

Interviews confirmed all therapy staff and nurse aides were educated on reporting to a licensed nurse any changes they notice in a resident they feel are outside of the resident's usual behavior, physical appearance or vital signs. Education included the key points of a change of condition which included: sudden changes in vital signs (like blood pressure, heart rate), altered mental status (confusion, lethargy), difficulty breathing, unusual pain, changes in appetite or fluid intake, new or worsening skin conditions, unexpected weight loss, falls, changes in bowel habits. Also included was the process for utilizing the facility's notification tool, Stop and Watch. Therapy staff and nurse aides were able to locate the tool and the procedure to complete the tool.

The immediate jeopardy removal date of 1/11/25 was validated.