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F 000	INITIAL COMMENTS A complaint investigation was conducted onsite from 6/17/24 through 6/18/24. Additional information was obtained remotely on 6/19/24 through 6/21/24. Therefore, the exit date was 6/21/24. The following intake was investigated: NC00218075. 1 of the 1 complaint allegation did not result in deficiency. Past non-compliance was identified at: was identified at: CFR 483.25 at tag F684 at a scope and severity (J) The tag F684 constituted Substandard Quality of Care. Non-compliance began on 5/16/24. Immediate jeopardy was removed on 5/24/24. The facility came back in compliance effective 5/24/24. A partial extended survey was conducted.	F 000		
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	F 684		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/06/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 684	Continued From page 1 by: Based on record reviews and interviews with family, staff, Physician Assistant, and Physician the facility failed to monitor and assess a resident's neurological status (an assessment of motor and sensory response to determine if the nervous system is impaired) after an unwitnessed fall for a resident on an anticoagulant (Coumadin) and to recognize the seriousness of a change in condition and immediately seek emergent medical care. On 5/16/24 at approximately 9:30 AM Resident #1 was found in her room sitting on the floor and was unable to report what happened. At approximately 1:55 PM the resident was identified with lethargy, a change in mental status, and later developed unclear speech. The resident's family requested a transfer to the Emergency Room (ER) and 911 was called at 5:28 PM. A computerized tomography (CT) revealed multiple abnormalities including a large (9.4 centimeter [cm]) hemorrhagic contusion (bleeding within the skull) and a subdural hematoma (buildup of blood on the surface of the brain) with a 9-millimeter (mm) left-to-right midline shift (displacement of brain tissue along the center of the brain). Resident #1's injury was a life ending event, she was changed to comfort care, and expired on 5/20/24. This deficient practice was for 1 of 3 residents reviewed for falls (Resident #1). The findings included: Resident #1 was admitted into the facility on 1/10/23 with diagnoses of hypertension, non-Alzheimer's dementia, disorder of bone density and structure, anxiety disorder, long term use of anticoagulant, fracture of the superior rim (upper end) of the left pubis (one of the three	F 684	Past noncompliance: no plan of correction required.	

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smaller bones that make up the hip bone), and presence of a prosthetic heart valve.

A review of Resident #1's quarterly Minimum Data Set dated 3/21/24 included that Resident #1 was severely cognitively impaired, had clear speech, was able to express ideas and wants, and was able to understand verbal content. She received both scheduled and as needed pain medication and her pain assessment indicated she was frequently in pain with pain rating a 7 on a scale of 0 to 10 with 0 meaning no pain at all and 10 meaning very severe pain. It also included that she was taking an anticoagulant medication.

A physician order dated 4/29/24 indicated to keep the order for Coumadin 2.5 milligrams (mg) daily for an International Normalized Ratio (INR) (a test that determines how long it takes blood to clot) of 3.1 and to recheck the INR in 2 weeks. The normal range INR range for a person with atrial fibrillation is 2.0-3.0. An increased INR makes a person more prone to bleeding.

Resident #1's medical record indicated on 5/13/24 Resident #1's INR was 4.4 and orders were received to decrease the dose of her anticoagulant medication to 2.0 mg and to draw the next lab on 5/16/24.

A physician order dated 5/13/24 indicated that Resident #1's order for Coumadin was decreased from 2.5 mg to 2 mg.

An interview conducted on 6/17/24 at 3:15 PM with Nurse #3 indicated that the normal protocol for neurological checks were to complete as follows: every 15 minutes x 1 hour, every 30 minutes x 1 hour, every hour for 4 hours and then

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every 4 hours for 24 hours.

An incident report dated 5/16/24 at 9:30 AM by Nurse #3 indicated that the nurse was called to the room and noted Resident #1 sitting on the floor. Resident #1 was alert, verbal and was assisted to the chair. Resident #1 stated she did not know what to do. There were no injuries observed at the time of the incident and Resident #1's mental status was confused. There were no witnesses to the fall.

A progress note by Nurse #1 on 5/16/24 at 9:30 AM indicated Resident #1 had an unwitnessed fall and Nurse #1 was called to the room and noted the resident was sitting on the floor, was alert and verbal, was assisted to the chair, and stated she did not know what to do.

During a telephone interview with Nurse #1 on 6/18/24 at 10:45 AM she indicated she completed an initial neurological check on Resident #1 when she assessed her after the fall on 5/16/24. The results were within normal range except for limited movement to hips which was not abnormal for the resident due to her fractured pubis.

A neurological assessment was documented by Nurse #1 on 5/16/24 at 9:35 AM and was within normal range except for extremity movement indicated limited range of motion to hips.

During a telephone interview with Nurse #1 on 6/18/24 at 10:45 AM she was asked about the timing of the neurological assessments since she had documented one at 9:35 AM which was 5 minutes after the time of her first neurological assessment. She was unable to explain the time

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F 684	Continued From page 4 but stated that she completed this neurological assessment per protocol. Additional progress notes for Resident #1 dated 5/16/24 completed by Nurse #1 indicated the following: - At 10:00 AM the neurological assessment was within normal range except for extremity movement of limited range of motion to her bilateral hips. - At 10:15 AM the neurological assessment was within normal range. - At 11:09 AM the neurological assessment was within normal range except for extremity movement: limited range of motion to hips. - At 12:10 PM the neurological assessment was within normal range except for extremity movement was limited range of motion to hips. - At 1:51 PM Nurse #1 documented she had given Resident #1 Oxycodone hydrochloride (opioid pain medication) 2.5 milligrams by mouth for complaints of pain to her hips (this order had been in place since 4/16/24). - At 1:55 PM Nurse #1 documented Resident #1 was noted to be lethargic with altered mental status, she was assisted to bed, peri care provided, and noted to be complaining of pain, as needed pain medication was given orally. - At 2:05 PM Nurse #1 documented she had called the Physician Assistant and informed her that Resident #1 was lethargic and complained of pain to her hips. The Physician Assistant stated that the Physician should be there soon and to make sure he sees her. - At 2:47 PM Nurse #1 documented Resident #1 was resting in bed with both eyes closed, bed in lowest position and call bell in reach. A review of Nurse #1's witness statement	F 684		

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obtained 5/20/24 revealed on 5/16/24 around 9:15 AM an aide hollered that Resident #1 was on the floor and she went and assessed her. Resident #1 stated she didn't know what she was doing, she was alert and verbal and stated she was fine. The nursing assistants put Resident #1 back to bed and Nurse #1 initiated neurological checks which were normal until 1:55 PM. Resident #1 was up in the chair, and she had given Oxycodone, Resident #1 appeared lethargic, and she completed the neurological checks. Resident #1 was able to squeeze Nurse #1's hands equally and Resident #1's pupils were equal and reactive to light. She called the Physician Assistant. Nurse #1 indicated she thought Resident #1 was just sleepy since she was leaning and slow to respond but after incontinence care she seemed better, but she called the Physician Assistant anyway. The Physician Assistant stated that the physician would be there shortly and would assess her (Resident #1) when he got there. The nursing assistants put her (Resident #1) to bed and Nurse #1 reported the events of the day to the next shift. She stopped and checked on Resident #1 on her way off the unit at 3:00 PM and she was in bed with her eyes closed.

A telephone interview was conducted on 6/18/24 with Nurse #1 at 10:45 AM. She stated that she had assessed Resident #1 after the fall and had started neurological assessments which were normal. She then notified the Physician Assistant of the fall and anticoagulant medication and also notified the responsible party of the fall. She stated that later around 2:00 PM Resident #1 had been in the dining room, and she was sleepy and in pain so herself, the therapist, and Nursing Assistant #2 put her bed and provided

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incontinence care. She then gave Resident #1 pain medication, Oxycodone 2.5 mg, for pain in her hips and notified the Physician Assistant of her findings. She stated that it wasn't unusual for Resident #1 to receive a pain pill due to her fractured pubis and there were times the medication made Resident #1 tired. The Physician Assistant told her the physician would be in later to see Resident #1. She gave a report to the oncoming shift and when she left her shift Resident #1 was resting quietly in her bed with her eyes closed. Nurse #1 indicated that the normal procedure for an unwitnessed fall was to complete neurological checks per protocol.

A review of Nurse Assistant #2's witness statement obtained on 5/20/24 indicated on 5/16/24 around 9:15 AM he responded to a fall and saw Resident #1 on the floor, sitting on her buttocks with her legs out in front of her. She was alert and verbal and just saying her hips hurt like she always does. Her head was not anywhere near anything she could have hit her head on. The nurse assessed her (Resident #1) and Nurse Assistant #2, Nurse Assistant #1, and Nurse #1 assisted her off the floor and back in bed. Around lunch time, Resident #1 seemed to be a little out of it like she was tired, and Nurse Assistant #2 told Nurse #1 when touching her (Resident #1) leg she (Resident #1) acted like she was in pain and wasn't acting right. The other aide and Nurse Assistant #2 took her (Resident #1) to her room via wheelchair and assisted her to bed. When he (Nurse Assistant #2) left at 3:00 PM, Resident #1 was still in bed with her eyes closed and appeared to be sleeping.

A telephone interview was conducted on 6/18/24

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with Nursing Assistant #2 at 10:15 AM he stated couldn't remember a lot about Resident #1 on 5/16/24, but knew at lunch she seemed tired and out of it so she was put into bed.

A telephone interview was conducted on 6/18/24 with the Physician Assistant at 2:28 PM. She revealed that she was aware of the fall on 5/16/24 and that Resident #1 was on an anticoagulant medication. She stated that the standard with a fall was that if the resident was at baseline and neurological checks were normal then the resident was monitored, with the expectation that the neurological checks were continued per facility policy. She further revealed that she was under the impression when Nurse #1 had called regarding lethargy that Resident #1 was lethargic related to the pain medication being given, she was not aware that Resident #1 was lethargic prior to receiving the pain medication. She stated that all the conversations with Nurse #1 left her feeling that the resident was at baseline and just tired due to receiving pain medication.

Resident #1's progress notes dated 5/16/24 completed by Nurse #2 indicated the following:
- At 3:22 PM Nurse #2 documented she received in report that Resident #1 was lethargic today and that the resident had a fall this morning. The 7AM-3PM nurse reported she contacted the Physician Assistant and made her aware and the Physician Assistant stated that the Physician will see her today. The resident was noted resting in bed, eyes closed, respirations even and non-labored.
- At 4:30 PM Nurse #2 documented Resident #1's speech was noted unclear at times. Vital signs were normal except her blood pressure was 145/81 (normal is top number less than 120 and

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bottom number less than 80). Her respirations were even and non-labored, no signs or symptoms or complaints of pain or discomfort noted status post fall. The Physician was made aware and reported he would come and assess.
- At 5:30 PM Nurse #2 documented the Physician was in to assess Resident #1, her family was at bedside requesting resident to be sent to the emergency room. The Assistant Director of Nursing called 911 and the writer called and gave report to the emergency room nurse.

An interview was conducted on 6/18/24 at 10:57 AM with Nurse #2. Nurse #2 worked the 3PM-11PM shift on 5/16/24. She indicated that she was told by Nurse #1 in report that Resident #1 was lethargic (which was not normal for Resident #1), she had a fall that morning, and she had received a pain pill which wasn't unusual due to her fractured pubis. She was also told by Nurse #1 that the Physician Assistant had been notified twice and the physician would see her that evening. Nurse #2 stated she had seen her at the beginning of the shift and Resident #1 was resting quietly with no signs of pain, in bed with her eyes closed. At 4:30 PM she was checking on Resident #1 and noticed her speech was unclear/slurred at times which was not normal for her. The Physician was in the building at the time so she and the Medication Aide went and told him of the change, and he stated he would be over to see Resident #1. At 5:30 PM Nurse #2 was notified by the Medication Aide that the family of Resident #1 was at the facility and wanted Resident #1 to be sent to the emergency department. Nurse #2 and the Physician went to the room where the family was waiting, and the Physician said to send her to the emergency department. Emergency medical services were

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F 684	Continued From page 9 called. A review of Nurse Assistant #3's witness statement obtained on 5/20/24 indicated that around 3 PM on 5/16/24 the Medication Aide brought to his attention that Resident #1 did not seem right. He (NA #3) went to Resident #1, she was incoherent, she was babbling and not making much sense, and she (Resident #1) was alert but seemed drowsy. He believed that the Medication Aide told the Nurse because the Medication Aide was in the room. An interview was conducted on 6/18/24 at 3:45 PM with Nursing Assistant #3 who was assigned to Resident #1 on 5/16/24 for the 3PM-11PM shift. He stated that he was told by the Medication Aide that Resident #1 had fallen that day. He stated that the Medication Aide was in Resident #1's room around 4:00 PM and had him come in. He reported he noted Resident #1 was pale and her speech was muffled which wasn't normal for her (Resident #1). The Medication Aide notified Nurse #2 and they notified the physician. An interview was conducted on 6/18/24 at 3:29 PM with the Medication Aide who was assigned to Resident #1 on 5/16/24 for the 3PM-11 PM shift. She indicated that during report, it was told that Resident #1 had fallen and was sleeping soundly. She stated that around 4-4:30 PM something told her to go check on Resident #1 and she noted her (Resident #1) color was bad she was very pale, her mouth was "weird" (she couldn't explain it other than using the term weird), and she was not talking right. She indicated by then the family was there and a staff member (unable to recall who) had gone to get the Physician. The family member was upset because of the way Resident	F 684		

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F 684	Continued From page 10 #1 looked and was acting which was not normal for Resident #1 and the physician had not been there yet. When the physician came around 5:30 PM Resident #1 was sent to the Emergency Room. A telephone interview was conducted on 6/18/24 at 9:11 AM with Resident #1's family member, Family Member #1. She stated that when she and another family member (Family Member #2) walked into the door of the facility on 5/16/24 around 4:15-4:30 PM they could hear someone groaning and realized it was Resident #1. When they walked into Resident #1's room there was no staff present and Resident #1's head and her body was contorted on her right side, and it appeared Resident #1 was about to fall out of bed. Family Member #2 went to Resident #1 to keep her from falling and spoke to Resident #1, but she did not give any acknowledgement. Family Member #1 stated that Resident #1 was staring straight ahead with her right eye wide open but blank and the left eye shut. She revealed that Resident #1 was pulling on her clothes and exposing her top half which the resident would never do especially in front of Family Member #2 (male relative). The resident wouldn't or couldn't talk to her or Family Member #2. Family Member #1 stated that while Family Member #2 was holding Resident #1, she (Family Member #1) went down the hall saying, "call 911 call 911". Family Member #1 stated she looked at the Medication Aide and said, "call 911, [Resident #1] isn't right" and the Medication Aide told her she was going to go get the physician. Family Member #1 stated that she believed about 20 minutes passed, the physician had not appeared, so she went to Nurse Assistant #3 and said to call 911. Nurse Assistant #3 told her the Medication	F 684		

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F 684	Continued From page 11 Aide went to go get the physician. The family told Nurse Assistant #3 "I know this, but something is very wrong with [Resident #1] and you need to call 911." Family Member #1 stated she then went back into Resident #1's room and finally the physician came, took one step into the room and said call 911 and she never saw the physician again. Family Member #1 stated that when the facility had called her at 11:00 AM they told her Resident #1 was fine but babbling which was unusual for the resident to do and if she had known the extent of the change, she would have told them then to send the resident to the emergency department. The Emergency Medical Service (EMS) record dated 5/16/24 revealed the call to 911 was received at 5:28 PM. When they arrived at the facility at 5:36 PM Resident #1 was not alert with uneven pupils and "non-responsive to verbal only painful stimuli." EMS was informed Resident #1 had fallen earlier around 9:00 AM and had had altered mental status since then. The physician came to check on Resident #1 when the family insisted Resident #1 be taken and seen at the emergency department. Resident #1's hospital record dated 5/18/24 revealed Resident #1 presented to the emergency department on 5/16/24 after she was found unresponsive at her skilled nursing facility. Earlier in the day the resident was found on the floor noted to have an unwitnessed fall. After this the resident spent the majority of the time in bed, however later in the day she was found to be difficult to arouse and unresponsive. A computerized tomography of the head was performed which demonstrated multiple abnormalities including multicompartment	F 684		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 12 intracranial hemorrhages most notable for a 9.4 centimeter (cm) x 5.2 cm x 4.3 cm hemorrhagic contusion in the left temporal lobe (area in the brain near temples and ears) with a 9-millimeter left-to-right midline shift in the brain and trace subfalcine (brain tissue is displaced to the other side) and left uncal (occurs from rising pressure in the brain causing brain tissue to move from one compartment to another) herniations, subdural hematoma. It was also revealed that during the physical examination of Resident #1 a parietal scalp contusion. This was discussed with neurosurgery and trauma surgery at tertiary center (higher level of care) and deemed a life altering/ending event. Resident #1 was made comfort care at this time. After approximately 48 hours she was pronounced deceased. An interview was conducted on 6/17/24 with the Physician at 4:12 PM. He indicated that Resident #1 could have been sent out earlier on 5/16/24, but it would not have made a difference in the outcome. He thought that there was nothing the facility could have done differently and with her comorbidities of micro abrasions (tiny blood vessel damage) in her frontal lobe (the area of the brain behind the forehead), microvascular ischemic changes (narrowing of small blood vessels in the brain) and parenchymal atrophy (pathological loss of brain functional tissue in the brain) and infarction of the left thalamus (ischemic strokes [a blood clot blocks an artery leading to the brain] that affect the subcortical grey matter [play an essential role in cognitive and motor function]) not to mention anticoagulant therapy that the bleed would have happened regardless of when she was sent to the hospital resulting in the same outcome. An interview was conducted on 6/18/24 at 2:42	F 684		

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	345215	A. BUILDING ______ B. WING ______	C 06/21/2024

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PM with the Director of Nursing. She stated that from her investigation related to the fall that occurred on 5/16/24 involving Resident #1 that the nurses may have a different perspective regarding urgency or seriousness when a change is noted in a resident's condition. She further stated that the nurses had contacted the Physician Assistant or the Physician and followed orders.

The Administrator was notified of Immediate Jeopardy on 6/17/24 at 5:25 PM.

The facility presented the following corrective action plan:

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

Resident #1 has a diagnosis of acute kidney failure, chronic atrial fibrillation (abnormal heart rhythm), edema, gastroesophageal reflux disease, long-term use of anticoagulants (medications to prevent blood clots), fracture of the right ulna (right lower arm), disorders of bone density and structure, malignant neoplasm (cancer) of the large intestine, thrombocytopenia (low level of platelets that help blood to clot), vitamin D deficiency, allergic rhinitis (inflammation of the lining of the nose), cognitive social or emotional deficit following cerebrovascular disease (stroke), left hip fracture, anxiety disorder, insomnia (difficulty sleeping), muscle weakness, presence of prosthetic heart valve, and severe dementia without behavioral disturbances. The resident was receiving warfarin sodium 2mg to prevent blood clots. On 5/16/24 at approximately 9:15 am, Resident #1

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F 684	Continued From page 14 was observed in the room on the floor next to the bed. The resident was noted to be alert and verbal. Neurological checks were initiated and within normal limits with no signs of head injury at the time of the incident. The physician's assistant was initially contacted by the nurse and notified of the fall and the resident's condition which was at baseline. There were no new orders received. The family was contacted and notified of the fall. At 9:15 am, 9:35 am, 9:55am, 10 am, 10:15am, 11am, and 12:10pm, neurological checks were completed and within normal limits for the resident. At approximately 1:55pm, Resident #1 was up in the chair and noted by the nurse to be lethargic (a state of tiredness or sleepiness) and leaning to the side. The nurse completed a neurological assessment. The resident was able to squeeze the nurse's hands equally and pupils were equal and reactive to light. The physician's assistant was notified of the resident's change in condition. Due to the resident receiving narcotic pain medication, the physician assistant stated to the nurse, the physician was enroute to the facility and would assess the resident upon arrival to determine the course of action. At approximately 3:15 pm, Resident #1 was observed in the room with incoherent speech and appeared drowsy. At approximately 4 pm, vital signs were stable. The resident appeared lethargic but was responsive to tactile and verbal stimuli. The resident did not appear to be in any distress or pain. Pupils were equal, round, and reactive to light/accommodation. The nurse made the physician aware of Resident #1's change of condition. At approximately 5 pm, the physician assessed Resident #1. The resident's family was in the room with the resident at that time and requested the resident be sent out to the hospital for evaluation. The resident was transferred out	F 684		

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of the facility via emergency medical services. A hospital CT scan revealed multicompartment intracranial hemorrhages most notable for a 9.4 cm x 5.2 cm x 4.3 cm hemorrhagic contusion in the left temporal lobe, associated mass effects were notable for a 9 mm left-to-right midline shift and trace subfalcine and left uncal herniations. The resident was changed to comfort care and expired on 5/20/24. A root cause analysis was completed on 5/23/24 by the Director of Nursing and determined that the nurse failed to continue neuro checks and identify an emergent acute change after a resident displayed lethargy, altered mental status, and unclear speech following a fall.

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

On 5/22/24, the Assistant Director of Nursing initiated a head-to-toe assessment of all residents including residents with recent falls who are on blood thinners for signs and symptoms of acute change in condition. This audit is to ensure the resident was assessed, interventions initiated as appropriate to include neuro checks or emergent medical treatment, the physician notified for further recommendations, and the resident representative notified with documentation in the electronic record. There were no additional concerns identified during the audit. The audit was completed by 5/23/24.

On 5/22/24, the Assistant Director of Nursing reviewed all progress notes for the past 30 days to identify any resident with an acute change including residents with recent falls who are on

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blood thinners. The purpose of the audit is to ensure the resident was assessed, interventions initiated as appropriate to include neuro checks or emergent medical treatment, the physician was notified for further recommendations and the resident representative was notified with documentation in the electronic record. The Assistant Director of Nursing will address all concerns identified during the audit. The audit was completed by 5/23/24.

On 5/22/24, the Assistant Director of Nursing reviewed the past 30 days of fall incident reports to include residents on blood thinners. This audit is to ensure the resident was assessed, interventions initiated as appropriate to include neuro checks or emergent medical treatment, the physician notified for further recommendations, and the resident representative notified with documentation in the electronic record. If the acute change continued, the resident did not improve or the physician was not on-site during an emergency situation, the physician was notified again for further recommendations, or the resident was sent out to the hospital for further evaluation. There were no additional concerns identified during the audit. The audit was completed by 5/23/24.

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

On 5/22/24, the Assistant Director of Nursing initiated an in-service with all nurses to include the agency regarding Acute change with emphasis on 1) assessing changes in condition to include neurological checks, obtaining vital signs, initiating interventions for the acute

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change, notification of the physician for further recommendations and notifying the resident representative with documentation in the electronic record. 2) If acute change continues, the resident does not improve or the physician is not on-site during an emergent event, the resident should be sent to the emergency room for further evaluation and treatment with notification of the physician and resident representative with documentation in the electronic record. The in-services will be completed by 5/23/24. After 5/23/24, the Director of Nursing monitored staff completion and any nurse who has not worked or received the in-service will complete it before the next scheduled work shift. All newly hired nurses will be educated during orientation by the Director of Nursing regarding Acute Changes. The Administrator confirmed this responsibility with the Director of Nursing on 5/23/24.

On 5/22/24, the Assistant Director of Nursing initiated an in-service with all CNAs to include agency staff regarding Notification of Acute Changes with emphasis on immediately reporting to the nurse any change in condition to include but not limited to a decreased level of consciousness. The in-service will be completed by 5/23/24. After 5/23/24, the Director of Nursing monitored staff completion and any nursing assistant who has not worked or received the in-service will complete it before the next scheduled work shift. All newly hired nursing assistants will be educated during orientation. All newly hired nursing assistants will be educated during orientation by the Director of Nursing regarding Notification of Acute Changes. The Administrator confirmed this responsibility with the Director of Nursing on 5/23/24.

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On 5/23/24, the ADON initiated an in-service with all nurses regarding Incidents with emphasis on investigating all incidents thoroughly including obtaining statements and completion of investigative folder, assessment of the resident to include neuro checks for suspected head trauma to include residents prescribed blood thinners, initiating intervention based on root cause, updating care plans for new safety interventions and notification of MD/RR. The in-services will be completed by 5/23/24. After 5/23/24, the Director of Nursing monitored staff completion and any nurse who has not worked or received the in-service will complete it before the next scheduled work shift. All newly hired nurses will be educated during orientation by the Director of Nursing regarding Incidents. The Administrator confirmed this responsibility with the Director of Nursing on 5/23/24.

" Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and

The decision to monitor the system for residents with acute changes through review of incident reports and progress notes was made on 5/23/24 by the Administrator and Director of Nursing and presented to the Quality Assurance (QA) Committee on 5/23/24.

The facility's interdisciplinary team (IDT) including the Administrator, Director of Nursing, Assistant Director of Nursing, and Unit Managers will review progress notes and incident reports 5 times per week x 4 weeks to identify residents with an acute change including residents with falls prescribed blood thinners utilizing the Acute

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F 684	Continued From page 19 Change Audit Tool. This audit is to ensure the resident was assessed, interventions initiated as appropriate to include neuro checks or emergent medical treatment, the physician notified for further recommendations, and the resident representative notified with documentation in the electronic record. If the acute change continued, the resident did not improve or the physician was not on-site during an emergent situation, the physician should be notified again for further recommendations and notify the resident representative with documentation in the electronic record. The unit managers will address all concerns identified during the audit including but not limited to an assessment of the resident, initiating interventions as appropriate to include neuro checks or emergent medical treatment, notification of the physician for further recommendations, notification of the resident representative with documentation in the electronic record, and/or re-training of staff. The Director of Nursing or Assistant Director of Nursing will review the Change in Condition audits weekly x 4 weeks to ensure all areas of concern were addressed appropriately. The Administrator or Director of Nursing will present the findings of the Acute Change Audit Tools to the Quality Assurance Performance Improvement (QAPI) committee monthly for 1 month to review and to determine trends and/or issues that may need further interventions and the need for additional monitoring. Alleged date of immeidate jeopardy removal and corrective action completion: 5/24/24 The corrective action plan was validated on 6/18/24 by reviewing the audit tools used by the facility for all residents who were on	F 684		

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F 684	Continued From page 20 anticoagulants and had falls were assessed for acute changes in condition, progress notes were reviewed for the past 30 days for any residents with acute changes to ensure the resident was assessed, interventions initiated as appropriate to include neuro checks or emergent medical treatment, the physician was notified for further recommendations and the resident representative was notified with documentation in the electronic record, and the past 30 days of fall incident reports to include residents on blood thinners. This audit is to ensure the resident was assessed, interventions initiated as appropriate to include neuro checks or emergent medical treatment, the physician notified for further recommendations, and the resident representative notified with documentation in the electronic record. All audits were completed 5/23/24. The nursing staff were educated on regarding Acute change with emphasis on 1) assessing changes in condition to include neurological checks, obtaining vital signs, initiating interventions for the acute change, notification of the physician for further recommendations and notifying the resident representative with documentation in the electronic record. 2) If acute change continues, the resident does not improve or the physician is not on-site during an emergent event, the resident should be sent to the emergency room for further evaluation and treatment with notification of the physician and resident representative with documentation in the electronic record. The nursing staff was also educated on Incidents with emphasis on investigating all incidents thoroughly including obtaining statements and completion of investigative folder, assessment of the resident to include neuro checks for suspected head trauma	F 684		

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F 684	Continued From page 21 to include residents prescribed blood thinners, initiating intervention based on root cause, updating care plans for new safety interventions and notification of MD/RR The nursing assistants were educated on immediately reporting to the nurse any change in condition to include but not limited to a decreased level of consciousness. The nursing staff licensed and unlicensed were able to verbalize the education that was given to them upon questioning on 6/18/24. The facility's immediate jeopardy removal date and corrective action plan completion date of 5/24/24 was validated.	F 684		