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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 12/09/24 through 12/11/24. Additional information was obtained offsite 12/12/24 through 12/18/24; therefore, the exit date was changed to 12/18/24. The following intake was investigated NC00224814 and resulted in immediate jeopardy. 2 of the 3 complaint allegations resulted in deficiencies. Immediate Jeopardy was identified at: CFR 483.10 at tag F578 at a scope and severity (J) CFR 483.25 at tag F684 at a scope and severity (J) Tag F684 constituted Substandard Quality of Care. Immediate Jeopardy began on 12/01/24 and was removed on 12/15/24. A partial extended survey was conducted.	F 000		
F 578 SS=J	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578		12/28/24

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

Electronically Signed | 01/03/2025

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F 578	Continued From page 1 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record reviews, and staff and Responsible Party (RP) interviews, the facility failed to update an advanced directive to reflect the wishes of the resident and his RP for the resident not to be intubated (insertion of a tube into the airway to support breathing) for mechanical ventilation (helps move air in and out of the lungs) for 1 of 3 residents reviewed for advanced directives (Resident #1). This failure	F 578	1. It is the intention of Myers Park Nursing Center to ensure residents Most forms are updated following hospitalizations, quarterly, or annually as indicated or discussed with the responsible party. 2. This alleged deficient practice has the potential to affect all residents who reside in the facility. Resident #1 expired on	

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F 578	Continued From page 2 resulted in Resident #1 who had a history of Alzheimer's disease and had a change in condition of unresponsiveness on 12/02/24 being intubated during an Emergency Department evaluation on 12/02/24. This intubation was against Resident #1's and the RP's documented wishes due to being transferred with an outdated Medical Orders for Scope of Treatment (MOST) form. Resident #1 remained intubated for 6 days until the RP was asked to make the decision to extubate (removal of the tube in the airway used for mechanical ventilation) the resident on 12/08/24. Immediate Jeopardy began on 12/01/24 when the facility sent an outdated MOST form with Resident #1 to the emergency department which resulted in intubation for mechanical ventilation. The immediate jeopardy was removed for Resident #1 on 12/15/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of a D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective. The findings included: Review of the facility's Advance Directive policy and procedure last updated 12/2016 under Policy Interpretation and Implementation read in part: 3. If the resident is incapacitated and unable to receive information about his or her right to formulate an advanced directive, the information may be provided to the resident's legal representative. 12. Depending on State requirements, the legal	F 578	12/11/2024. An audit of MOST forms was completed by the administrator/designee on12/14/24. Discrepant findings were addressed immediately, and all needed actions were completed on 12/14/24. 3. The Administrator re- educated the Social Services Director, Medical Records Director, and clinical staff on 12/14/2024, regarding the requirements of completing and maintaining an accurate MOST form at least annually and following hospitalizations, quarterly, or annually as indicated or discussed with the responsible party. No staff will have worked after 12/14/24 without having had this education. Facility Administrator/designee educated all licensed nurses on the requirement to send the MOST form with EMS at the time of discharge on 12/14/2024. Staff who have not received this education will be removed from the schedule as of 12/14/2024, until education is received.This educational content will be provided to all new hires licensed nurses and/or agency upon orientation as of 12/14/2024. 4. Facility Director of Nursing or designee will perform 5 random medical record audits for a accurately completed and maintained MOST form, of new admissions, readmissions, and/or those residents on the MDS assessments schedule, weekly for four weeks. Following this audit, the Director of Nursing or designee will perform 3 random medical record audits for accurately completed and maintained MOST form, weekly for one month. All	

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representative may also have the right to refuse or forego treatment.
18. The Interdisciplinary Team will review annually with the resident his or her advanced directives to ensure that such directives are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded on the resident assessment instrument (MDS).
21. The Nurse Supervisor will be required to inform emergency medical personnel of a resident's advanced directive regarding treatment options and provide such personnel with a copy of such directive when transfer from the facility via ambulance or other means is made.

Resident #1 was admitted to the facility on 04/06/21 with diagnoses including Alzheimer's disease. Resident #1 was readmitted on 05/11/24 and 08/27/24 and transferred out to an acute care hospital on 12/02/24.

A review of Resident #1's electronic medical record revealed a physician's order written on 04/06/21 for Do Not Resuscitate.

A review of Resident #1's Medical Orders for Scope of Treatment (MOST) form initiated on 06/03/2021 and last updated on 10/20/23 revealed the resident was DNR (do not attempt resuscitation) with full scope of treatment which included: use intubation, advanced airway interventions, mechanical ventilation, cardioversion as indicated, medical treatment, Intravenous (IV) fluids, etc.; also provide comfort measures. In addition, the following were checked on the MOST form: Transfer to hospital if indicated. Antibiotics if indicated. IV fluids if indicated. No feeding tube.

findings will be reported to QAPI committee and additional interventions implemented as indicated to maintain ongoing compliance.

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A review of Resident #1's electronic medical record (EMR) revealed a discharge summary dated 05/11/24 from an acute hospitalization which read in part, "spoke to patient's family member and he (Resident #1) was made Do Not Resuscitate (DNR)/Do Not Intubate (DNI) as per the family member's wishes."

A review of Resident #1's EMR revealed on 05/11/24 at 1:14 PM a progress note written by the former Unit Manager for 3rd floor that Resident #1 was readmitted to the facility via wheelchair by hospital transportation. There was no documentation noting the change in Resident #1's MOST form to reflect Resident #1 and the RP's wishes for him to be Do Not Intubate (DNI).

An attempt was made to contact Unit Manager #3 without success due to a discontinued phone number.

A review of Resident #1's hard chart in medical records revealed a golden rod dated 05/11/24 checked for no expiration with an order for Do Not Resuscitate.

Review of the record also revealed a physician order written on 05/11/24 for Do Not Resuscitate.

Several attempts were made to contact Nurse #4 who was assigned to Resident #1 during the 7:00 AM to 3:00 PM shift on 05/11/24 with voicemails left for return call with no response.

A review of Resident #1's quarterly Minimum Data Set assessment dated 11/01/24 revealed he was severely cognitively impaired.

A review of a Care Conference Progress Note

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written by the facility Social Worker (SW) dated 11/06/24 at 12:32 PM revealed a quarterly care plan meeting had been held with the interdisciplinary team (IDT) and the resident's Responsible Party (RP) (via phone). The purpose of the quarterly care plan meeting was to update the RP on the resident's care at the facility and address any questions or concerns. The SW reviewed the resident's face sheet and code status with the RP and the RP confirmed the resident remained Do Not Resuscitate (DNR). According to the RP the resident was to continue to be at the facility for long term. The RP didn't have any concerns about the resident's care but had a question for Unit Manager #2 which was answered. The resident's plan of care remained the same with no changes made. The documentation did not indicate Resident #1's MOST form was discussed during the meeting with the RP, just the Do Not Resuscitate (DNR) status.

An interview on 12/11/24 at 2:09 PM with the facility Social Worker revealed she had attended the care conference meeting with Resident #1's RP via phone and the IDT. She stated they had discussed that Resident #1 would remain a DNR but said the RP had not mentioned that the resident was to be a Do Not Intubate (DNI) or that he wanted any changes made to the MOST form. The SW further stated she had not asked the RP specifically if he wanted any changes made to the MOST form and said they had not discussed any specifics about the MOST form the facility had on file just that the resident was to remain a DNR. The SW indicated she was not aware of the RP's request that Resident #1 be made a DNI and said she was not aware of the discharge summary dated 05/11/24 that indicated the RP's wishes for

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Resident #1 to be DNI. She further indicated she was not aware she was supposed to discuss the specifics of the MOST form with the RP and thought this was done by the providers.

A nursing progress note written by Nurse #3 revealed on 12/01/24 around 8:30 PM the resident had an unwitnessed fall in the dining room. The resident was found lying on his right side in the dining room with no outward signs of injury. Resident #1 was assessed by Nurse #1 and Nurse #2 and vital signs were taken and his assessment and vital signs were documented as being within normal limits for the resident. The resident was assisted back in his wheelchair and taken to his room and assisted into bed. On 12/02/24 sometime between 5:00 AM and 5:30 AM, NA #4 went into Resident #1's room to do her last round and found him unresponsive. NA #4 immediately notified Nurse #3 who assessed the resident and found him unresponsive to verbal and tactile stimulation. She contacted the on-call provider at 5:31 AM and sent the resident out to the hospital Emergency Department (ED) for evaluation and treatment. The resident was sent to the hospital with a Skilled Nursing Facility (SNF)/Nursing Facility (NF) to Hospital Transfer Form and a copy of his MOST form on file at the facility.

A telephone interview with Nurse #3 on 12/10/24 at 10:45 AM revealed she had been alerted by NA #4 on 12/02/24 around 5:20 AM that Resident #1 was not responding to his name and did not rouse when NA #4 touched his arm. Nurse #3 stated she went in and assessed the resident, and he was not responding to verbal or tactile stimulation, so she contacted the on-call provider who ordered Resident #1 to be sent out to the

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Emergency Department for evaluation and treatment. Nurse #3 further stated she sent the resident out with the Skilled Nursing Facility (SNF)/Nursing Facility (NF) Transfer to Hospital Form and Resident #1's MOST form on file. Nurse #3 indicated there was only one MOST form on file for Resident #1and she was not aware the resident was supposed to have a MOST form that indicated Resident #1 and the RP did not want the resident to be intubated. She further indicated the MOST form that went with Resident #1 via Emergency Medical Services (EMS) was the one on file at the facility that was last updated on 10/20/23.

A telephone interview on 12/09/24 at 9:38 AM with the Responsible Party (RP) for Resident #1 revealed the resident was still hospitalized and had been intubated upon arrival to the Emergency Department (ED) because the facility had sent the MOST form on file at the facility with the resident to the hospital. The RP stated he had been asked by the hospital to make the decision to discontinue the resident from life support on 12/08/24 even though the resident was not supposed to have been intubated, and that had been a difficult decision for him. He stated Resident #1 had been extubated and moved out of the intensive care unit and would be transferred to Hospice for comfort care.

A review of Resident #1's medical records from the hospital Emergency Department (ED) dated 12/02/24 revealed a note written by the emergency department physician that read as follows: "On review of the patient's true chart, his last reported code status was DNR, with limited scope including all interventions, did not wish for endotracheal intubation; however, on the patient's

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arrival he had a MOST from with him which indicated full scope of treatment including intubation and this was used to proceed with decision for intubation."

Further review of the medical record from the hospital revealed on the discharge summary dated 12/09/24, the resident had been evaluated by neurosurgery who felt the resident was a poor candidate for craniotomy (removing part of the bone from the skull to expose the brain). The critical care team discussed goals of care with the resident's RP who made the decision to transition resident to comfort care measures so palliative extubation was done on 12/08/24. The resident was transferred out of intensive care unit (ICU) on 12/09/24 and the Hospitalist team assumed primary care. The Hospice team was consulted, and the resident was discharged to the inpatient Hospice House on 12/09/24.

A telephone interview was attempted several times with the ED physician with voicemail left for return call with no response.

A telephone interview was attempted with the Hospitalist with no response.

A telephone interview with the Administrator and Director of Nursing (DON) on 12/11/24 at 12:29 PM revealed they were both unaware of the code status change requested by Resident #1's RP on his discharge summary dated 05/11/24. The Administrator nor the DON were aware of the information in the discharge summary or that the providers were not aware of the information in the resident's discharge summary. The DON stated she was a part of the interdisciplinary team that had attended Resident #1's care conference

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meeting on 11/06/24 and said she did not recall discussing the specifics of his MOST form just that the RP wanted the resident to remain DNR. She further stated it was the responsibility of the Unit Manager and receiving nurse to review the discharge summary and orders to ensure all orders were completed when the resident returned to the facility. The DON indicated Unit Manager #3 and Nurse #4 who were assigned to the resident on his return from the hospital on 05/11/24 were no longer working at the facility and she could not answer why the requested change to the MOST form had been missed. She further indicated she could not answer why the medical providers had not seen the documentation in the discharge summary but said they should have reviewed it and signed it as being reviewed.

Several attempts were made to contact the Medical Director and voicemails left with no response. The Administrator was aware of the need to interview the Medical Director and had provided his contact information.

The Administrator was notified of the Immediate Jeopardy via telephone on 12/12/24 at 6:10 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 as a result of the noncompliance.
" The facility failed to update the Medical Order for Scope of Treatment (MOST) with the hospital information from Resident #1's readmission on 05/11/24 that indicated Resident #1's family requested DNR/Do Not Intubate (DNI) and failed

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to review and update MOST form during the quarterly care plan meeting in November 2024 to discuss any changes to the scope of treatment for Resident #1.

" Resident #1 sustained an unwitnessed fall on 12/1/24. Ongoing neurological assessment following the unwitnessed fall, was not completed per policy. The resident was found to be unresponsive with trace amounts of vomit in bed on 12/2/24. Resident #1 was sent to the hospital. The resident was intubated upon admission to the hospital requiring the resident's family to make a decision to remove the resident from the ventilator. Resident was transferred to Hospice House from the hospital on 12/9/2024 and expired on 12/11/2024.

" Resident #1 MOST form was not updated and reviewed after a readmission.

" A full review of all resident MOST forms was conducted by the Administrator or designee on 12/14/2024 with the responsible party, for compliance with the MOST form accurately reflecting the resident's wishes. There are two residents identified as at risk for serious adverse outcomes requiring the MOST form to be updated with the responsible party on 12/14/2024 by the Administrator.

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.

" A review of Advance Directives policy procedure will be completed by the Administrator or designee, and changes, as needed, will be made by the QAA committee by 12/14/24.

" The administrator or designee will educate the interdisciplinary care plan team and all licensed professional nurses on the requirements of completing and maintaining an accurate MOST

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form at least annually and following hospitalizations, quarterly, or annually, as indicated or discussed with the responsible party before the staff's next worked shift. If staff have not received education, they will be removed from the schedule on 12/14/2024, until education is received.

" In the event that the information on the MOST form is updated, the previous MOST form will be placed into archived documents within the medical record by the Medical Records staff or designee. This verbal education was completed by the Administrator or designee with the Medical Records staff on 12/14/2024. If staff have not received education, they will be removed from the schedule on 12/14/2024, until education is received.

" Current and accurate MOST forms will be provided to EMS staff and sent with the transferring resident, by the licensed nurse or designee, at the time of transfer from the facility. This verbal education was completed by the DON or designee on 12/14/2024 to all licensed nursing staff. If staff have not received education, they will be removed from the schedule on 12/14/2024, until education is received.

" The Administrator or designee will track the completion of all education provided to ensure the staff completes it before they work.

The facility administrator assumes responsibility for the immediate jeopardy removal plan. The date of the immediate jeopardy removal is 12/15/24.

Alleged date of IJ removal: 12/15/24.

On 12/18/24, the credible allegation of Immediate Jeopardy removal date of 12/15/24 was validated by onsite verification through staff interviews and

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F 578	Continued From page 12 record reviews. The staff interviewed included members of administration, Social Services, Medical Records, and Licensed Nurses. The staff interviews related to Advanced Directives policy and procedure revealed they had received in-services and education regarding the requirements for completion of the Medical Orders for Scope of Treatment (MOST) form, what to do when a MOST form is updated, and sending the MOST form with the resident when they are sent out of the facility via Emergency Medical Services (EMS). The IJ removal date of 12/15/24 was validated.	F 578		
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 review, and responsible party, facility staff, and on-call Nurse Practitioner (NP) interviews, the facility staff failed to complete ongoing neurological assessments after an unwitnessed fall for a resident with severely impaired cognition. On 12/01/24 at 8:30 PM Nurse Aide (NA) #1 heard a loud boom in the dining room, she and NA #3 discovered Resident #1 on the floor in the dining room with his hands behind his head, and his wheelchair beside him.	F 684	1. It is the intention of Myers Park Nursing Center to ensure neurological assessments follow an unwitnessed fall per policy. 2. The alleged deficient practice has the potential to affect any resident who experiences an unwitnessed fall. Resident #1 expired on 12/11/2024. A full review by the DON/designee was completed by 12/14/2024 to review	12/28/24

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F 684	Continued From page 13 Resident #1 was assessed by Nurse #1 who noted the resident was within his normal limits for range of motion, he denied any pain, and told her he had not hit his head. Nurse #1 Resident #1 was assisted back into his wheelchair and then assisted to bed. A head-to-toe assessment completed by the weekend Nursing Supervisor conducted at 8:45 PM revealed no abnormal results. There were no other documented neurological checks located in the medical record after the initial note following the incident. During the night of 12/01/24 into the morning of 12/02/24, the resident was checked for incontinence every 2 to 3 hours by NA #4 and she stated he was snoring but roused easily until her last round at between 5:00 AM and 5:30 AM. Resident #1 was assessed by Nurse #3 and was noted to be unresponsive to tactile and verbal stimuli. Emergency Medical Services (EMS) was dispatched and Resident #1 was taken to the hospital for evaluation. Resident #1 was intubated (insertion of a tube into the airway to support breathing) for mechanical ventilation (helps move air in and out of the lungs) in the Emergency Department and a Computed Tomography (CT) (a noninvasive medical imaging procedure that uses x-rays to create detailed images of the inside of the body) scan was completed which revealed a life threatening subdural hematoma (collection of blood that forms between the brains surface and the tough outer layer of the brain caused by head injury) of the right frontotemporal (front and sides of the brain) and parietal lobes (large uppermost portion of the brain) measuring 1.7 centimeters (cm) thickness and approximately 15 cm diameter with a 1.5 cm right to left shift (brain shifted off center). Resident #1's Responsible Party (RP) made the decision to extubate (removal of tube from the	F 684	residents with unwitnessed falls to review progress notes and neurological assessment for 11/13/2024 through 12/13/2024. Residents without completed neuro checks were reviewed/assessed and no adverse effects were noted. The resident□s MD was notified of each assessment. 3. Facility Administrator/designee will educate all licensed nurses regarding the requirements of completing ongoing neurological assessments following any unwitnessed fall. No licensed nursing staff will work after 12/14/2024 without having this education. Facility Administrator/designee will educate all licensed nurses with verbal education to complete a head-to-toe assessment on any identified resident who is at risk for an adverse outcome. Following the assessment, the licensed nurse is required to notify the resident□s physician of the findings. Any licensed professional nurses not having had this education by 12/14/24 will be removed from the schedule until education is received. Facility Administrator/designee will educate all certified nursing assistants will on symptoms to look for after an unwitnessed fall and the reporting process if any of the symptoms are identified. Certified Nursing Assistants will be notified by the licensed nurse or designee, that an unwitnessed fall with ongoing neurological assessment is actively being completed on a specified resident. All certified nursing assistants not having had this education by 12/14/24 will be removed from the schedule until education is	

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F 684	Continued From page 14 airway used for mechanical ventilation) the resident on 12/08/24. The resident was moved out of intensive care unit on 12/09/24, discharged to Hospice on 12/09/24, and died on 12/11/24. This deficient practice occurred for 1 of 3 sampled residents reviewed for quality of care (Resident #1). Immediate Jeopardy began on 12/01/24 when Resident #1 had an unwitnessed fall and the facility staff failed to complete ongoing comprehensive neurological assessments, routine monitoring, and recognize symptoms indicating the need for urgent medical attention for a resident following an unwitnessed fall to determine if a higher level of care was needed. The immediate jeopardy was removed for Resident #1 on 12/15/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective. The findings included: Resident #1 was admitted to the facility on 04/06/21. Resident #1's diagnoses included Alzheimer's disease, repeat falls, and unspecified head injury related to fall. A review of Resident #1's quarterly Minimum Data Set assessment dated 11/01/24 revealed he was severely cognitively impaired. Resident #1 was coded as requiring substantial to maximal assistance with most activities of daily living except eating. He was coded as using a	F 684	received. All new hires and/or agency staff will receive respective aforementioned education based on licensure and certification at the time of facility orientation. This education will begin 12/14/2024. 4. Facility Director of Nursing or designee will perform audit on any unwitnessed fall for compliance of documented ongoing neurological assessment weekly for four weeks and once monthly for 3 months. All findings will be reported to QAPI committee and additional interventions implemented as indicated to maintain ongoing compliance.	

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wheelchair for mobility and was documented as having two or more falls since admission.

A review of Resident #1's care plan last updated on 09/24/24 revealed a focus area for the resident being at risk for falls related to confusion and a history of falls. The goal was for the resident not to sustain serious injury through the review date. The listed interventions included to follow the facility fall protocol.

A review of Resident #1's Medication Administration Record (MAR) and medical orders dated 12/01/24 revealed an order for aspirin Low Dose Tablet 81 milligrams (mg) 1 tablet by mouth one time a day related to cerebral infarction. Review for the MAR for the period of 11/01/24 through 12/01/24 revealed the resident received the aspirin daily as ordered.

On 12/09/24 at 12:11 PM an interview was conducted with NA #1 who worked 3:00 to 11:00 PM on 12/01/24. NA #1 stated she was in the hallway charting on her residents when she heard a "boom" in the dining room. She stated NA #3 was coming down the hallway and she followed her, and they found Resident #1 lying on his right side on the floor beside his wheelchair. She further stated he had his hands behind his head and said, "I'm not hurt, just get me up." NA #1 said Nurse #1 assessed him and there were no outward signs of injury, so they assisted him back into his wheelchair and NA #3 took him to his room and put him in the bed.

On 12/09/24 at 4:33 PM a telephone interview was conducted with NA #3 who was assigned to care for Resident #1 during the 3:00 to 11:00 PM shift on 12/01/24. NA #3 stated dinner was over,

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and she asked Resident #1 if he was ready to go to bed and he told her no that he wanted to watch TV for a little while before going to bed. She said she assisted two other residents to bed, going back and forth from the dining room to resident rooms. NA #3 stated she was coming up the hallway and saw Resident #1 lying on the floor in the dining room and she and NA #1 got to him and called for the nurse who was in the nurses' station. Both Nurse #2 and Nurse #1 responded and assessed the resident for injuries, completed vital signs, an initial neurological check, they assisted him up off the floor, and back into his wheelchair. NA #3 explained she then took the resident to his room and put him to bed for the night. NA #3 stated after she had put the resident to bed, she had checked the resident one time during her incontinence rounds for any injuries and the resident was sleepy but roused when she was in the room. She indicated she did not witness the fall and did not see any outward signs of injury on the resident during her shift which ended at 11:00 PM.

A nursing progress note written by Nurse #1 dated 12/01/24 at 8:55 PM revealed Resident #1 was found on the floor in the dining room at 8:30 PM. He stated he was trying to self-transfer, stood and fell. After an initial assessment for injuries, he was assisted up in his wheelchair and put to bed. Neurological check was completed and within his normal range, pupils were equal, round and reactive to light, his range of motion was within his normal limits, denied pain, no change in his normal cognition of alert with confusion/dementia as his baseline. Resident #1's vital signs were documented as temperature of 97.7, pulse 62, respirations 19, blood pressure 174/89 and oxygen saturation of 93% on room

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air. The weekend Nursing Supervisor, Director of Nursing, and resident's Responsible Party were all made aware of the fall.

On 12/09/24 at 11:58 AM a telephone interview was conducted with Nurse #1. Nurse #1 stated she worked 3:00 PM to 11:00 PM on 12/01/24 and was assigned to care for Resident #1. She further stated she was in the nurse's station charting when she heard Nurse Aide (NA) #3 and NA #1 call for the nurse. She said she and Nurse #2 were both in the nurse's station and both got up and went to the dining room. Nurse #1 indicated they found Resident #1 lying on the floor on his right side and he had attempted to get up and ambulate and fell. She said they examined the resident and saw no signs of injury, completed vital signs, assessment, and an initial neurological check on the resident and all results were within the resident's normal range. Nurse #1 further indicated they assisted the resident up off the floor and into his wheelchair and NA #3 took him and put him to bed. She stated she notified the weekend Nursing Supervisor of the fall, and she came up and the weekend Nursing Supervisor assessed the resident from head to toe and determined there were no outward signs of injury, and since he was not on a blood thinner, they would monitor him closely through the night during incontinent rounds. According to Nurse #1 the Nursing Supervisor contacted the on-call provider and the decision was made by the on-call provider not to send Resident #1 out since there were no changes, no outward signs of injury, and he was not on an anticoagulant. Nurse #1 indicated she had not witnessed Resident #1's fall and said she had been charting in the nurse's station and had her back turned towards the dining room. She further indicated

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she had not done an assessment or neuro check on the resident after the initial one she had done right after the resident fell. Nurse #1 said neuro checks had to be initiated in the electronic medical record to alert staff to do the neuro checks and that had not been done by the weekend Nursing Supervisor. Nurse #1 indicated she knew as a nurse that residents who had an unwitnessed fall should be monitored and assessed with neuro checks and said she assumed once she reported the fall to the weekend Nursing Supervisor that she had taken over with assessments of the resident.

On 12/09/24 at 1:12 PM a telephone interview was conducted with Nurse #2. Nurse #2 worked on 12/01/24 on the 3:00 to 11:00 PM shift. She stated she had been in the nurses' station charting on 12/01/24 when she heard NA #3 and NA #1 call for a nurse. She stated she immediately got up and went into the dining room and saw Resident #1 had fallen onto his right side beside his wheelchair. Nurse #2 further stated she made sure the resident was ok, and Nurse #1 took over and she left the dining room and went back into the nurses' station to finish her charting. She further stated she had been sitting down in the nurses' station charting on her computer and had not witnessed Resident #1's fall.

A late entry nursing progress note written by the weekend Nursing Supervisor on 12/03/24 at 1:13 PM for 12/01/24 at 8:40 PM revealed Resident #1 had a fall in the dining room and upon arrival to the floor was notified by NA #3 that the resident was now in his room lying in the bed, so the Nursing Supervisor went to Resident #1's room to assess the resident. Resident #1 was lying in

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bed on his left side, awake, and alert with bilateral pupils equal and reactive to light, denied headache, dizziness, blurred vision, nausea and had no vomiting, no increased confusion noted, equal hand grips bilaterally, no shortness of breath or dyspnea noted, denied pain or aches to body when assessed, no edema noted to upper or lower extremities, positive pedal pulses, head to toe assessment completed. Resident #1 was able to converse with nurse regarding fall, stated he was trying to stand up from his wheelchair, denied hitting his head, no acute changed noted neurologically. No acute distress noted, vital signs taken by nurse were within normal limits, on-call provider notified of fall and no injury noted and no new orders received. Director of Nursing (DON) notified, Resident #1's Responsible Party (RP) made aware of resident fall and no injury noted.

On 12/09/24 at 12:54 PM a telephone interview was conducted with the weekend Nursing Supervisor. She stated she worked 8:00 AM to 12:00 midnight on 12/01/24. The Nursing Supervisor stated she was notified of Resident #1's fall and asked to come and assess the resident who was now in his room in the bed. She further stated she did a head-to-toe assessment of the resident, and he denied dizziness, headache, blurred vision, nausea, and had not had any vomiting. Resident #1 told the Nursing Supervisor he had not hit his head when he fell, and she examined his head and did not feel any bumps or lumps and said he was able to move all his limbs as per his usual and his initial neurological check was normal. The Nursing Supervisor indicated after her assessment she had contacted the on-call provider, and the decision was made to monitor the resident closely

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and not send him out to the hospital since he was not taking an anticoagulant. She further indicated she did not see any outward signs of injury on the resident. The Nursing Supervisor stated she had done a neurological check on the resident during her head-to-toe assessment but had not continued doing them because the resident had no outward signs of injury and said she had not instructed NA #3 or Nurse #1 to continue with neurological checks on the resident but to monitor him during medication and incontinence rounds.

A review of Resident #1's medical record revealed the only documented vital signs and neurological check were included in Nurse #1's progress note written on 12/01/24 at 8:55 PM. Resident #1's vital signs were documented as temperature of 97.7 (normal range 97.8 to 99.1 degrees Fahrenheit), pulse 62 (normal range 60 to 100 beats per minute), respirations 19 (normal range 12 to 18 breaths per minute), blood pressure 174/89 (normal range 90/60 to 120/80) and oxygen saturation of 93% (normal range 95% to 100%) on room air. The neurological checks work sheet had been initiated in the electronic medical record, but it was blank.

On 12/09/24 at 4:48 PM a telephone interview was conducted with NA #4 who had cared for Resident #1 during the 11:00 PM to 7:00 AM shift on 12/01/24 leading into 12/02/24. NA #4 stated she had checked Resident #1 about every 2 to 3 hours during the night and said he was "snoring" but was rousable until her last round on him at 5:00 AM or 5:30 AM. She further stated during this round she was unable to elicit a response from him and noticed he had something coming from his mouth and there was a small amount of

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vomit on his sheet. NA #4 indicated she immediately notified Nurse #3 who assessed him, notified the on-call provider and sent the resident out to the hospital. NA #4 further indicated she had not noticed any signs of injury to his head or any swelling on his head or any marks on him from his fall and was aware he had a fall on 12/01/24 around 8:30 PM. NA #4 indicated the resident sometimes slept through the night and sometimes was up during the night and said he sometimes snored, so she had not paid much attention when he was snoring that night.

A late entry nursing progress note written by Nurse #3 on 12/09/24 at 12:08 PM for 12/02/24 at 6:00 AM revealed Resident #1's skin was warm and dry, and the patient was unresponsive to tactile and verbal stimuli. Patient was breathing and noted to have a small amount of vomit in his bed. The on-call provider was made aware and gave orders to send the resident out to the emergency room (ER).

On 12/09/24 at 1:58 PM a telephone interview was conducted with Nurse #3 who was assigned to care for Resident #1 on the 11:00 PM to 7:00 AM shift on 12/01/24 leading into 12/02/24. Nurse #3 stated Resident #1 had not complained of headache, dizziness, or blurred vision throughout the night. Nurse #3 further stated NA #4 had checked on him about every 2 to 3 hours throughout the night and when NA #3 checked him during the night for incontinence care stated he had roused until NA #3 checked him between 5:00 and 5:30 AM at which time he did not rouse. NA #4 notified Nurse #3 immediately and when Nurse #3 went into Resident #1's room to assess him he did not rouse to verbal or tactile stimulation. It was also noted that he had

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vomited a small amount in his bed, so Nurse #3 called the on-call provider and received orders to send him out to the hospital for evaluation and treatment. Nurse #3 further stated she never noticed any outward signs of injury, any marks or any swelling on the resident and stated she had not completed neuro checks on the resident during her shift. Nurse #3 indicated Resident #1 sometimes slept through the night and sometimes he would wake during the night but said they had not noticed anything out of the ordinary for him until they were unable to rouse him at 5:30 AM.

A review of the facility's Situation, Background, Appearance, and Review and Notify (SBAR) form dated 12/02/24 completed by Nurse #3 revealed under Situation - Resident #1 was found unresponsive at 5:00 to 5:30 AM on 12/02/24. Under Background it was documented he was long-term care and was on a platelet inhibitor of Aspirin 81 mg by mouth daily. Vital signs were documented as blood pressure of 120/68, pulse of 60, respiration of 18, temperature of 97.0, weight of 148 pounds, mental status was documented as unresponsive, functional status was documented as general weakness, respirations were documented as other respiratory changes - snoring respirations, neurological evaluation was documented as altered level of consciousness - unresponsive and code status was documented as Do Not Resuscitate. Appearance was documented as patient unresponsive to verbal and tactile stimuli, pupils dilated and non-reactive to light. Review and notify was documented as on call provider notified at 6:00 AM on 12/02/24 and orders received to send to emergency room.

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A review of the facility's Hospital Transfer Form dated 12/02/24 completed by Nurse #3 revealed the resident's vital signs were 102/68, pulse 60, respiration 18, temperature 97 and oxygen saturation 99% on room air. Resident #1's pain level was scored at 0 on scale of 0-10. Code status was documented as Do Not Resuscitate (DNR). The resident's functional status was coded as independent for eating and needs assistance with toileting and transfers and the resident was incontinent. The resident was coded as not alert, unresponsive and it was documented the Responsible Party (RP) and provider were notified of the transfer. Risk factors for Resident #1 were listed as anticoagulation (Aspirin), aspiration, needs medications crushed and swallowing precautions. The resident's face sheet and Medical Orders for Scope of Treatment (MOST) form were attached with the transfer form.

On 12/12/24 at 11:35 AM an interview was conducted with the on-call Nurse Practitioner (NP). The on-call NP stated he had been notified at on 12/01/24 at 8:39 PM that Resident #1 had an unwitnessed fall in the dining room but had no injury and vitals and assessment were within normal limits for the resident. The NP stated the Nursing Supervisor had reported to him the resident had no outward signs of injury and no change in his mentation. The NP stated he advised they monitor the resident closely through the night and call with any change in condition for further orders. He further stated at 5:31 AM on 12/02/24 he was contacted again by the facility, and it was reported the resident was now unresponsive and he gave orders for the resident to be transferred to the hospital for evaluation and treatment. The NP indicated he was the on-call

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provider and had never seen the resident and was not familiar with the resident's normal state except as reported by the facility staff.

Review of the Emergency Medical Services dispatch revealed they were dispatched on 12/02/24 at 5:34 AM and arrived on scene at 5:47 AM to find Resident #1 lying in bed unresponsive with vital signs of blood pressure 205/110 (out of normal range), blood glucose level of 103 (normal range), oxygen saturation of 98% on room air (normal range), snoring respirations with heavy accessory muscle use, weak radial pulses, strong rapid carotid pulses, pupils 5 millimeters (mm) equal round and non-reactive to light. Skin color was mottled pale with capillary refill less than 2 seconds, poor skin turgor and lungs equal with increased respiratory effort bilaterally. In route to the hospital Resident #1 had a blood pressure of 220/125 (out of normal range), pulse of 120 (out of normal range), respirations of 10 (out of normal range) and oxygen saturation of 99%. A nasopharyngeal tube (tube inserted through the nasal passage down into the throat) was inserted to provide an airway, and a bag valve mask (BVM) was used to provide positive pressure ventilation (delivery of pressurized oxygen into the lungs) to the resident because he was not breathing adequately on his own. An intravenous (IV) access was attempted but not successful. The resident was transported with lights and siren to the acute care hospital within 3 minutes and care transferred to the Emergency Department physician and nurse.

Hospital records dated 12/02/24 through 12/09/24 revealed Resident #1 arrived via EMS from the facility unresponsive after a fall the night before. Resident was being ventilated by the paramedic

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on arrival to the emergency department and the decision was made based on the MOST form to intubate the resident. A computed tomography (CT) scan of the head was performed which revealed a life-threatening subdural hematoma of the right frontotemporal and parietal lobes measuring 1.7 centimeters (cm) thickness and approximately 15 cm diameter with 1.5 cm right to left shift. The resident was admitted to the Intensive Care Unit and neurosurgery consulted and felt the patient would be a poor candidate for craniotomy (removing part of the bone from the skull to expose the brain) and critical care team discussed goals with the resident's Responsible Party (RP) and the decision was made to transition to comfort care measures and palliative extubation was done on 12/08/24. The resident was moved from the intensive care unit on 12/09/24 and later that evening was transferred to inpatient Hospice on 12/09/24 and the resident expired at Hospice on 12/11/24.

Several attempts were made to contact the emergency department physician and voicemail left with no return calls.

An attempt was made on 12/11/24 at 10:34 AM to contact the hospitalist but the hospitalist was unable to interviewed.

On 12/10/24 at 3:50 PM an interview was conducted with the Director of Nursing (DON). The DON stated the process when they have a resident with a fall was the nurse assesses the resident before they were moved and that assessment included vital signs, and assessment for any injuries to ensure they were safe to be moved. After it was determined it was safe to move the resident and their assessment was

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completed with any injuries noted, calls were made to the DON, family or representative of the resident, and if needed the provider. If it was determined the resident needed medical attention the nurse would stay with the resident and others would make the calls. The Medical Director or Nurse Practitioner, family, DON and Administrator would all be notified of the fall. Based on the findings of the nursing assessment and medications the resident was prescribed the responsible nurse, Nursing Supervisor or Unit Manager or their designee would consult with providers and potentially send the resident out if the provider ordered to do so. Documentation would be completed in the progress notes, SBAR would be completed and if the resident was sent out a transfer form was completed. For unwitnessed falls the responsible nurse, Nursing Supervisor or Unit Manager or their designee would do neurological checks in addition to vital signs and assessments and if the findings were out of the normal range for the resident, the provider would be called to obtain orders to send the resident out to the hospital for evaluation and treatment. For witnessed falls the responsible nurse, Nursing Supervisor, or Unit Manager or their designee would do an assessment and monitor the resident more frequently for signs of injury and pain. The DON stated she was initially notified that Resident #1's fall had been witnessed and he had not hit his head and that was probably why he had not been sent out to the hospital after the fall and why his vital signs, neuro checks, and assessments had not continued. She further stated she learned later that the fall had not been witnessed but the resident had not had any change in his mental status and there were no outward signs of injury. The DON indicated Resident #1's vital signs,

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neuro checks, and assessments should have been continued since his fall was unwitnessed. The DON explained there must have been miscommunication between Nurse #1, who was assigned to care for the resident, and the weekend Nursing Supervisor as to who was going to continue with assessing the resident.

The Medical Director was unavailable for interview

The Administrator was notified of the Immediate Jeopardy on 12/13/24 at 9:33 AM.

The facility implemented the following Credible Allegation of immediate jeopardy removal.

- Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance;
o The facility's noncompliance of not providing ongoing neurological assessment after an unwitnessed fall had a high likelihood of a significant decline in physical function and/or life-threatening condition.

o The facility failed to have and implement effective systems to ensure that the staff are continuously assessing residents who sustain unwitnessed falls.

o Resident #1 sustained an unwitnessed fall on 12/1/24. Ongoing neurological assessment following the unwitnessed fall, was not completed per policy. The resident was found to be unresponsive with trace amounts of vomit in bed on 12/2/24. Resident #1 was sent to the hospital. Resident was transferred to Hospice House from the hospital on 12/9/2024 and expired on

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12/11/2024.

o A full review by the DON or designee of all unwitnessed falls incident reports, documented neurological assessments and progress notes in the last 30 days, 11/13/24 through 12/13/24, will be completed. The facility has identified 4 residents who are at risk for an adverse outcome because the facility has not provided ongoing neurological assessment after an unwitnessed fall, with a high likelihood of a significant decline in physical function and/or life-threatening conditions. The director of nursing will complete this review by 12/14/24. On 12/14/2024, the DON or designee instructed all licensed nurses with verbal education to complete a head-to-toe assessment on any identified resident who is at risk for an adverse outcome. Following the assessment, the licensed nurse is required to notify the resident's physician of the findings.

- 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.
o A review of the Fall policy and procedure and the Neurological Assessment policy and procedure will be completed and communicated to the QAA committee by the Administrator or designee, and changes, if needed, will be made as identified by the QAA committee by 12/14/24.

o All licensed professional nurses will receive education from the Administrator or designee on the policy and procedure regarding neurological assessment completion after an unwitnessed fall before their next shift via verbal education. Any licensed professional nurses not having had this education by 12/14/24 will be removed from the

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schedule until education is received.

o On 12/14/2024, the DON or designee instructed all licensed nurses with verbal education to complete a head-to-toe assessment on any identified resident who is at risk for an adverse outcome. Following the assessment, the licensed nurse is required to notify the resident's physician of the findings. Any licensed professional nurses not having had this education by 12/14/24 will be removed from the schedule until education is received.

o All certified nursing assistants will receive education from Administrator or designee on symptoms to look for after an unwitnessed fall and the reporting process if any of the symptoms are identified. Certified Nursing Assistants will be notified by the licensed nurse or designee, that an unwitnessed fall with ongoing neurological assessment is actively being completed on a specified resident. All certified nursing assistants not having had this education by 12/14/24 will be removed from the schedule until education is received.

o For all education provided, the administrator or designee will track completion to ensure the education is completed before the staff working. Staff will complete a written quiz to validate competency of all licensed nursing staff and certified nursing assistants. The quiz will be administered and reviewed by the administrator or designee.

The facility administrator assumes responsibility for the immediate jeopardy removal plan.

Alleged date of immediate jeopardy removal:

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F 684	Continued From page 30 12/15/24. On 12/18/24, the credible allegation of immediate jeopardy removal with a removal date of 12/15/24 was validated by onsite verification through staff interviews, record review, and education review. The interviewed staff included members of administration, licensed nurses, and nursing assistants. Staff interviews were conducted with administration, licensed nurses and nurse aides related to the facility's policy and procedures for falls and neurological checks. The interviewed staff revealed they had received in-service training regarding what steps to take when a witnessed and unwitnessed fall occurred. The interviewed staff provided further answers and detailed when to initiate neurological checks, and the initiation of the worksheet in the electronic medical record which identifies the timeline. Additional interviews with nursing assistants indicated they had received education related to reporting any changes post fall. In-service records of education and quizzes provided to staff were reviewed and were ongoing. Head-to-toe assessments were reviewed for high-risk residents identified. The immediate jeopardy removal date of 12/15/24 was validated.	F 684		