STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CHERRYDALE HEALTH AND REHABILITATION CENTER	3710 LEE HIGHWAY ARLINGTON, VA 22207

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 2/15/2022 through 2/17/2022. Six complaints were investigated during the survey. Complaint # VA00048863 was unsubstantiated with no deficient practice. Complaint # VA00049322 was unsubstantiated with no deficient practice. Complaint # VA00052756 was unsubstantiated with no deficient practice. Complaint # VA00054111 was substantiated with no deficient practice. Complaint # VA00054274 was substantiated with deficient practices cited. Complaint # VA00054352 was unsubstantiated with no deficient practice. The facility was not in compliance with 42 CFR Part 482 Federal Long Term Care requirements. The census in this 180 certified bed facility was 158 at the time of the survey. The survey sample consisted of four current Resident reviews and five closed record reviews.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);	F 580		3/21/22

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

Electronically Signed | 03/08/2022

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F 580	Continued From page 1 (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on family interview, staff interview, clinical record review, facility document review, and in the course of a complaint investigation, the facility	F 580	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with	

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F 580	Continued From page 2 staff failed notify the physician of a change in condition for one of nine residents, Resident #1. Resident #1 had an unwitnessed fall on 01/07/22 that resulted in injury. The resident's physician and RP (responsible party) were not notified until two days later on 01/09/22. Findings include: Resident #1 was admitted to the facility on 06/29/18, with the most current readmission on 12/24/21. The resident was discharged from the facility on 01/14/22 and did not return. Diagnoses for Resident #1 included, but were not limited to: Atrial fibrillation with long term anticoagulant therapy (Xalrelto 15 mg/milligrams daily), history of a stroke with right sided hemiparesis/hemiplegia, dysphagia, constipation, dementia, anxiety and depression. The most recent full MDS (minimum data set) was an admission (5 day/annual) assessment dated 01/10/22. This MDS assessed the resident with long and short term memory impairment and severe impairment in daily decision making skills. Resident #1 was also assessed as requiring total assistance from at least one staff person for bed mobility, transfers, dressing, toileting, and extensive assistance for eating and hygiene. This MDS documented that the resident did not ambulate in room or corridor during the look back period. In Section G 0300. "Balance during transitions and walking" Resident #1 was assessed as "activity did not occur" for the following: moving from seated to standing position, walking, turning around, and/or moving on and off the toilet. This MDS assessed the resident as having one fall since readmission (12/24/21), not major in injury.	F 580	the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F580 1. Resident #1 is no longer a resident in the center. 2. Falls from the last 30 days will be reviewed to ensure RP/MD was notified timely. 3. The SDC will in-service the nursing staff on the center□s policy for notification of MD/NP for unusual incidents including the policy for falls. 4. DON/UM will review unusual incidents including falls daily during clinical meeting 5x weekly to ensure the RP/MD notification was completed and notification documented in the medical record. 5. The results of the review will be discussed at the quarterly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be conducted on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction.	

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F 580	Continued From page 3 Resident #1's clinical records were reviewed and included the following: A physician's progress note dated 01/07/22 at 3:01 PM documented, "...to be seen...for positive COVID...generalized weakness...cognitive impairment, advanced age, frail...muscle weakness...signed by nurse practitioner (NP)." There was no information regarding a fall in the NP's note. A progress note dated 01/09/22 at 1:58 AM documented, "Patient grimacing and moaning, Tylenol...given, well tolerated...continue to monitor for changes..." A post fall assessment dated 01/09/22 and timed 2:46 PM documented, "...date and time of fall: 01/09/22 1:00 AM...date and time physician notified: 01/09/22 1:00 AM...date and time RP notified 01/09/22 1:15 AM...two person assist...chair bound, requires assistance to transfer...pain management/assessment...patient assisted back to bed...staff members assisted...2...signed LPN (licensed practical nurse) #1." There was no other information on the post fall assessment. No documentation was found in Resident #1's progress notes regarding a fall or any type of injury sustained by Resident #1 until 01/09/22 at 3:33 PM, which documented, "Patient observed lying on the floor beside her bed face down, hematoma observed on right side of the head close to the forehead VS (vital signs)...ROM (range of motion) within normal limit (sic)...MD (medical doctor) and RP notified...signature of LPN#1.	F 580	Date of compliance: 03/21/2022	

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A progress note dated 01/09/22 at 3:54 PM documented, "Patient observed lying on the floor beside her bed face down, hematoma observed on right side of the head close to the forehead VS...ROM within normal limit (sic)...MD and RP notified...signature of LPN #1.

A physician's progress note dated 01/09/22 at 5:17 PM documented, "...S/P (status post) fall and right anterior forehead hematoma...generalized weakness...Vital Signs: (Resident #1's blood pressure, pulse and respiration were dated from 12/24/21 on this progress note, and were not current as of the date of 01/09/22 note) cognitive impairment, advanced age, frail...muscle weakness...fall precautions...forehead hematoma start apply ice to hematoma TID (three times daily) Start Tylenol 650 mg for pain...signed by NP."

A progress note dated 01/09/22 at 10:18 PM documented, "Situation: Post fall 3-11...history of...A-Fib...right hemiparesis. Assessment (RN)/Appearance (LPN): Head to toe assessment done heamatoma (sic) noted on right side of the head close to the forehead, NP and supervisor aware, ROM within normal limit, remain afebrile...continue to monitor...educate resident to call for help, bed in the lowest position...signature of LPN #1."

No other documentation was located in Resident #1's clinical record regarding the details of this fall. According to the documentation in the resident's clinical records the resident sustained a fall with injury on 01/09/22.

On 02/15/22 at approximately 10:00 AM, the

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administrator, DON (director of nursing) and the corporate nurse were made aware of a complaint regarding Resident #1 and were asked for any information or investigation regarding a fall with injury for Resident #1 in January 2022. The administrator stated that the investigation was currently underway and that it would be completed on 02/16/22. The administrator stated they were made aware that Resident #1 had a fall on 01/09/22 by the Unit Manager (LPN #2) in a "morning meeting" on 01/10/22. The administrator stated that it wasn't until an investigator called and came to the facility on 02/08/22 that they were made aware of concerns regarding alleged significant injuries. The administrator stated that was when the investigation was initiated and that this information was what prompted the investigation. The administrator stated that there had not been any other investigation regarding Resident #1.

On 02/15/22 at approximately 2:30 PM, the hospital medical records obtained by the facility were presented for review. The corporate nurse stated that the facility had obtained hospital records for Resident #1 (discharged from the facility on 01/14/22 and admitted to the hospital on 01/14/22) after being notified by the investigator of concerns with injuries that were alleged to have occurred at the facility prior Resident #1's discharge.

The ED (emergency department) provider note dated 01/14/22 at 11:22 AM documented, "Sent to the ER for evaluation of lethargy and mental status change since yesterday...Patient is on Xalrelto. It is reported that patient has been lethargic and sleeping all day since yesterday...report of a fall that occurred last

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week...Altered mental status, lethargy...patient non verbal, not following commands, lying on stretcher with eyes closed...Ecchymosis (bruises) to forehead and orbital left eye...A-fib at 100 bpm (beats per minute)...Trauma and CNS (central nervous system) failure or compromise...C1 anterior tubercle fracture, right and left posterior arch fracture of C1 with moderate distraction of fracture fragments, non-displaced fracture C3 left facet...left superior articular facet fracture of C2 extending into L (left) vertebral foramen, right impacted fracture of proximal femur...1:20 PM...awake, not following commands...opens eyes on own, pushes away noxious stimuli, moans, makes unintelligible sounds...Right forehead/scalp hematoma...Left peri-orbital ecchymosis...right forearm ecchymosis...HIP, LEG, FOOT: left withdrawals to pain...right...deformity right foot, right leg shortened, yellowing ecchymosis right knee, healing abrasions to right upper thigh...right hip fracture...trauma consulted...hold Xalrelto...C1-C3 fractures...right proximal femur displaced impacted fracture..."

There were no other assessments, information regarding how the fall occurred, or specific details regarding the size, shape, color of the hematoma, or the extent of bruising sustained. There was no documentation or information concerning the fall, the head injury, or that the resident was currently on and had been on long term anticoagulant therapy (Xalrelto 15 mg daily since June 2020).

Resident #1's current CCP (comprehensive care plan) at the time of the fall documented, "...The resident is at risk for falls related to gait/balance problems/poor safety awareness...assist bars for bed mobility, wheelchair for locomotion, pommel

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cushion for w/c positioning...call light in reach...encourage resident to use it for assistance as needed...educate caregivers about safety reminders and what to do if a fall occurs...rounding and close monitoring, and anticipate to meet the resident's needs...environment free of hazards...is on anticoagulant therapy related to Atrial Fibrillation (created on 05/12/2020)...Lab work as ordered...meds as ordered...Monitor for bleeding such as unusual bruising, bloody or black tarry stool, red or dark brown urine, abdominal pain...swelling...bleeding from eyes, gums, nose...report symptoms to MD...Observe for any signs/symptoms of bleeding related to anticoagulation therapy...SKIN: bruises to bilateral forearms, right head hematoma (revised on 01/09/22)..."

On 02/16/22 at approximately 9:00 AM, the administrator and corporate nurse presented their final investigation for review.

The investigation had an incident report dated, 01/09/22 which documented, "...UN-witnessed: (Name of patient)...Nursing Description: observed lying on the floor beside her bed on the floor face down. Patient Description: cannot explain due to dementia...Immediate Action Taken: Head to Toe assessment done, hematoma observed on right side of the head close to forehead, pt (patient) assisted back to bed by two staff...Hematoma top of scalp...alert...oriented to person...Level of consciousness: (blank)...No witness found."

Also included in the investigation was LPN #1's statement which documented, "...date of incident: 7-3 (shift) 01/07/22...On 01/07/22 I was the only

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nurse for 7-3 shift on that day, when my manager (Name of LPN #2/Unit Manager) called me in room (number) with urgency...I was in middle of doing patient care (in another room) but I have to run to him due to the urgency from him...upon getting into the room (number) I saw resident (Name of Resident #1) lying on the floor with my manager in the room told me she fell...manager was suppose (sic) to do the necessary documentation...In report out going nurse reported about (Resident #1) huge swelling on patient head...signed on 02/11/22 by LPN #1."

There was no statement from LPN #2 who was the Unit Manager.

On 02/16/22 at 10:25 AM, Resident #1's daughter was interviewed via phone. The daughter stated that she was notified of the fall on Sunday 01/09/22; she was unsure of the time, but stated it was later in the day. The daughter stated that a female nurse called her and told her that her mother had a fall and had a bump on her head. The daughter stated that she asked the nurse how it happened and the nurse told her that it happened on the 5th floor and she didn't know. The daughter stated that was the first she had been notified of her mother having a fall was on 01/09/22.

On 02/16/22 at 1:35 PM, Resident #1's attending physician was interviewed. The physician stated that he did not see Resident #1 after the fall. The physician stated that NP saw Resident #1 and completed an assessment. The physician stated that he was notified, but was unsure of when, and stated, "I get so many calls." The physician stated that he was unsure of the details and did not see Resident #1 during this time.

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On 02/16/22 at 1:55 PM, the NP was interviewed regarding Resident #1's fall. The NP was made aware of the investigation and the statement by LPN #1 that Resident #1's fall occurred on 01/07/22. The NP stated that she was notified of the fall on the 9th and that when she saw Resident #1 she had a hematoma and she was fully assessed. The NP was asked if Resident #1 should have been sent out at that time for an evaluation, as the resident had sustained a head injury and was on Xalrelto 15 mg daily at the time of the fall. The NP stated, "In most cases yes, the placement (of the hematoma), I figured it would go away, and based on my assessment didn't show any distress, but probably should have sent her out." The NP stated that she was not sure why staff did not notify her of the resident's fall on the day it occurred (on 01/07/22).

On 02/16/22 at 2:20 PM, LPN #1 was interviewed via phone. LPN #1 stated, "It happened on Friday (01/07/22); I was the only nurse on the floor and around at that time and Resident #1 tested positive and was sent to the COVID positive floor (5th floor). I was in the middle of care and my manager was calling me with urgency to come. I get into the room, patient is lying on the floor face down, he (LPN #2) asked me to help get the patient back to bed." LPN #1 stated that he was not in the room when it happened and that he did not know what happened. LPN #1 stated that LPN #2 didn't say what happened to Resident #1 but it did happen on the 7th (not the 9th as documented). LPN #1 stated that Resident #1 was on the 3rd floor, tested positive and was moved to the 5th floor, it was in the afternoon, and that he worked the 7-3 shift and he wasn't

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there much longer before he left for the day. LPN #1 stated that he passed it on in report to the oncoming nurse that the resident fell, but did not report it to the physician. LPN #1 stated that LPN #2 was the one who found Resident #1 and was supposed to do all that and the paperwork. LPN #1 stated that the only people in the room were the patient, LPN #1 and LPN #2, and that Resident #1 was put back in bed. LPN #1 stated, "I just noticed swelling on the face." LPN #1 stated that he didn't notice any bruising at that time. LPN #1 stated, "I did not witness the fall that was on Friday." LPN #1 stated that he was off on Saturday and picked up another shift on Sunday. When he came in on Sunday he noticed there was no documentation regarding the fall, so he called LPN #2 and asked why he didn't document the fall and report for Resident #1. LPN #1 stated that LPN #2 told him that since he wasn't in the facility that LPN #1 needed to do it. LPN #1 then stated that is when he documented the fall on 01/09/22, but it happened on 01/07/22. LPN #1 stated that he texted the NP and informed her of the fall on 01/09/22. LPN #1 was asked if Resident #1 was assessed. LPN #1 stated that he did not assess Resident #1 or notify the physician, and that LPN #2 (the unit manager) must not have either.

A policy titled, "Documentation and Notification" documented, "...unit manager is responsible for ensuring that notifications by the charge nurses to physician's and responsible parties regarding a change...have properly occurred...Charge Nurse is responsible for notifying the physician (MD) and/or RP whenever there is a change...notification will occur when there is a: ...change in patient's condition...change medication, room change,, fall, new

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order...notification of the MD/RP is not limited to the above...considered a sample...Whenever there is a notification of the MD/RP...include this information in the shift report...document...The Unit Manager is ultimately responsible to ensure that notification of the MD/RP has occurred and has been documented accurately..."

A policy titled, "Falls Management Program" documented, "...Immediate responsibilities: ...do not move or reposition patient until a licensed nurse has completed a physical and mental assessment...Notify physician, responsible party..."

On 02/16/22 at 2:35 PM, the administrator, DON, and corporate nurse were made aware of the above information. The facility staff were made aware that according to their investigation and interviews with staff that were present, the fall had actually occurred on 01/07/22 not 01/09/22. The facility staff were made aware of the serious concerns regarding harm for Resident #1 due to the lack of immediate notification to the physician/NP and the RP, of an unwitnessed fall with a head injury. The facility staff were made aware that Resident #1 sustained a fall with injury on 01/07/22 and was not assessed until two days after, and the resident was not sent out for evaluation until 01/14/22 at 11:14 AM, at which time the resident was found to have a right femur fracture, fractures to the neck (C1 through C3) and a hematoma to the head, with bruising to the eyes and knees. The DON stated that she was on vacation when the fall occurred and she was made aware after (on 01/17/22 upon return to work). The administrator stated that she was made aware that the resident had a fall on 01/09/22 in a morning meeting on 01/10/22. The

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F 580	Continued From page 12 corporate nurse stated, "I see missteps in our process, unfortunately there is room for performance improvement." The corporate nurse stated, "No one can tell we saw this in this patient (sic)...we base on our own findings and our own review." No further information was presented prior to the exit conference on 02/17/22.	F 580		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, and in the course of a complaint investigation, the facility staff failed implement abuse policies and procedures for an injury of unknown origin for one of nine residents in the survey sample, Resident #1. Resident #1 had an unwitnessed fall with injury on 01/07/22 which not reported until 01/09/22; an investigation was not started until 02/08/22 and was not completed until during the survey. Findings include:	F 607	F607 1. Resident #1 is no longer a resident in the center. 2. A review of unusual incidents including falls will be reviewed from the last 30 days to ensure a thorough investigation was completed and outside agencies were notified if a Facility Reported Incident is required. 3. Facility staff will be educated by the SDC/Designee on the center□s policy on abuse and neglect. Nursing	3/21/22

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F 607	Continued From page 13 Resident #1 was admitted to the facility on 06/29/18, with the most current readmission on 12/24/21. The resident was discharged from the facility on 01/14/22 and did not return. Diagnoses for Resident #1 included, but were not limited to: Atrial fibrillation with long term anticoagulant therapy (Xalrelto 15 mg/milligrams daily), history of a stroke with right sided hemiparesis/hemiplegia, dysphagia, constipation, dementia, anxiety and depression. The most recent full MDS (minimum data set) was an admission (5 day/annual) assessment dated 01/10/22. This MDS assessed the resident with long and short term memory impairment and severe impairment in daily decision making skills. Resident #1 was also assessed as requiring total assistance from at least one staff person for bed mobility, transfers, dressing, toileting, and extensive assistance for eating and hygiene. This MDS documented that the resident did not ambulate in room or corridor during the look back period. In Section G 0300. "Balance during transitions and walking" Resident #1 was assessed as "activity did not occur" for the following: moving from seated to standing position, walking, turning around, and/or moving on and off the toilet. This MDS assessed the resident as having one fall since readmission (12/24/21), not major in injury. Resident #1's clinical records were reviewed and included the following: 01/09/22 at 3:33 PM, "Patient observed lying on the floor beside her bed face down, hematoma observed on right side of the head close to the forehead VS (vital signs)...ROM (range of motion)	F 607	Leadership/Administrator will be educated by the Regional Director of Clinical Services/designee on the process for conducting a thorough investigation for unwitnessed falls with injuries/injuries of unknown origin. 4. DON/UM will review unusual incidents including falls daily during clinical meeting 5x weekly to ensure a thorough investigation was completed for unwitnessed injuries/injuries of unknown origin. 5. The results of the review will be discussed at the quarterly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be conducted on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. Date of compliance: 03/21/2022	

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within normal limit (sic)...MD (medical doctor) and RP notified...signature of LPN (licensed practical nurse) #1.

A post fall assessment dated 01/09/22 and timed 2:46 PM documented, "...date and time of fall: 01/09/22 1:00 AM...date and time physician notified: 01/09/22 1:00 AM...date and time RP notified 01/09/22 1:15 AM...two person assist...chair bound, requires assistance to transfer...pain management/assessment...patient assisted back to bed...staff members assisted...2...signed LPN #1." There was no other information on the post fall assessment.

A progress note dated 01/09/22 at 3:54 PM documented, "Patient observed lying on the floor beside her bed face down, hematoma observed on right side of the head close to the forehead VS...ROM within normal limit (sic)...MD and RP notified...signature of LPN #1.

A progress note dated 01/09/22 at 10:18 PM documented, "Situation: Post fall 3-11...history of...A-Fib...right hemiparesis. Assessment (RN)/Appearance (LPN): Head to toe assessment done heamatoma (sic) noted on right side of the head close to the forehead, NP and supervisor aware, ROM within normal limit, remain afebrile...continue to monitor...educate resident to call for help, bed in the lowest position...signature of LPN #1."

A physician's progress note dated 01/09/22 at 5:17 PM documented, "...S/P (status post) fall and right anterior forehead hematoma...generalized weakness...Vital Signs: (Resident #1's blood pressure, pulse and respiration were dated from 12/24/21 on this

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progress note, and were not current as of the date of 01/09/22 note) cognitive impairment, advanced age, frail...muscle weakness...fall precautions...forehead hematoma start apply ice to hematoma TID (three times daily) Start Tylenol 650 mg for pain...signed by NP."

On 02/15/22 at approximately 10:00 AM, the administrator, DON (director of nursing) and the corporate nurse were made aware of a complaint regarding Resident #1 and were asked for any information or investigation regarding a fall with injury for Resident #1 in January 2022. The administrator stated that the investigation was currently underway and that it would be completed on 02/16/22. The administrator stated they were made aware that Resident #1 had a fall on 01/09/22 by the Unit Manager (LPN #2) in a "morning meeting" on 01/10/22. The administrator stated that it wasn't until an investigator called and came to the facility on 02/08/22 that they were made aware of concerns regarding alleged significant injuries. The administrator stated that was when the investigation was initiated and that this information was what prompted the investigation. The administrator stated that there had not been any other investigation regarding Resident #1.

On 02/16/22 at approximately 9:00 AM, the administrator and corporate nurse presented their final investigation for review.

The investigation had an incident report dated, 01/09/22 which documented, "...UN-witnessed: (Name of patient)...Nursing Description: observed lying on the floor beside her bed on the floor face down..Patient Description: cannot explain due to dementia...Immediate Action

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Taken: Head to Toe assessment done, hematoma observed on right side of the head close to forehead, pt (patient) assisted back to bed by two staff...Hematoma top of scalp...alert...oriented to person...Level of consciousness: (blank)...No witness found."

Also included in the investigation was LPN #1's statement which documented, "...date of incident: 7-3 (shift) 01/07/22...On 01/07/22 I was the only nurse for 7-3 shift on that day, when my manager (Name of LPN #2/Unit Manager) called me in room (number) with urgency...I was in middle of doing patient care (in another room) but I have to run to him due to the urgency from him...upon getting into the room (number) I saw resident (Name of Resident #1) lying on the floor with my manager in the room told me she fell...manager was suppose (sic) to do the necessary documentation...In report out going nurse reported about (Resident #1) huge swelling on patient head...signed on 02/11/22 by LPN #1."

There was no statement from LPN #2 who was the Unit Manager.

On 02/16/22 at 2:20 PM, LPN #1 was interviewed via phone. LPN #1 stated, "It (fall) happened on Friday (01/07/22); I was the only nurse on the floor and around at that time and Resident #1 tested positive and was sent to the COVID positive floor (5th floor). I was in the middle of care and my manager was calling me with urgency to come. I get into the room, patient is lying on the floor face down, he (LPN #2) asked me to help get the patient back to bed." LPN #1 stated that he was not in the room when it happened and that he did not know what happened. LPN #1 stated that LPN #2 didn't say

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what happened to Resident #1 but it did happen on the 7th (not the 9th as documented). LPN #1 stated that Resident #1 was on the 3rd floor, tested positive and was moved to the 5th floor, it was in the afternoon, and that he worked the 7-3 shift and he wasn't there much longer before he left for the day. LPN #1 stated that he passed it on in report to the oncoming nurse that the resident fell, but did not report it to the physician. LPN #1 stated that LPN #2 was the one who found Resident #1 and was supposed to do all that and the paperwork. LPN #1 stated that the only people in the room were the patient, LPN #1 and LPN #2, and that Resident #1 was put back in bed. LPN #1 stated, "I just noticed swelling on the face." LPN #1 stated that he didn't notice any bruising at that time. LPN #1 stated, "I did not witness the fall that was on Friday." LPN #1 stated that he was off on Saturday and picked up another shift on Sunday. When he came in on Sunday he noticed there was no documentation regarding the fall, so he called LPN #2 and asked why he didn't document the fall and report for Resident #1. LPN #1 stated that LPN #2 told him that since he wasn't in the facility that LPN #1 needed to do it. LPN #1 then stated that is when he documented the fall on 01/09/22, but it happened on 01/07/22. LPN #1 stated that he texted the NP and informed her of the fall on 01/09/22. LPN #1 was asked if Resident #1 was assessed. LPN #1 stated that he did not assess Resident #1 or notify the physician, and that LPN #2 (the unit manager) must not have either.

A policy titled, "Abuse/Neglect/Misappropriation/Crime" documented, "...All employees are responsible for immediately (no later than two hours after...if the incident involves abuse or bodily injury...no later

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than 24 hours if the incident does not involve abuse or bodily injury) reporting to the administrator, or in their absence, the director of nursing...upon notification of any alleged violations...including injuries of unknown source...the administrator will immediately report to the State Agency...no later than 24 hours if the events...do not involve abuse or do not result in serious bodily injury...injuries of unknown origin (injuries not witnessed or patient can't state what happened) should be handled the same as an allegation of mistreatment, neglect or abuse and must be reported to the state agency...All employees receive training...protecting patients from abuse and neglect and their responsibility to immediately report any cases of suspected or witnessed..."

On 02/16/22 at 2:35 PM, the administrator, DON, and corporate nurse were made aware of the above information. The facility staff were made aware that the Resident #1's fall with injury had occurred on 01/07/22 not 01/09/22, and it was not reported by staff as required in the facility's policy and procedures. The facility staff were made aware of the concerns with the delay of reporting and notification of an injury of unknown origin/unwitnessed fall with injury for Resident #1. The DON stated that she was on vacation when the fall occurred and she was made aware after (on 01/17/22 upon return to work). The administrator stated that she was made aware that the resident had a fall on 01/09/22 in a morning meeting on 01/10/22. The corporate nurse stated, "We've given you everything on this patient, we requested medical records and there was no indication of additional injury and we sent an FRI (facility reported incident). I see missteps in our process, unfortunately there is room for

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F 607	Continued From page 19 performance improvement." The corporate nurse stated, "No one can tell we saw this in this patient (sic)...we base on our own findings and our own review." No further information was presented prior to the exit conference on 02/27/22.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 609		3/21/22

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F 609	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review and in the course of a complaint investigation, the facility staff failed to report an injury of unknown origin/unwitnessed fall to the State Agency for one of 9 residents in the survey sample, Resident #1. Resident #1 was found in her room, face down on the floor on 01/07/22. There were no witnesses according to facility documentation and interviews. The incident was documented as occurring on 01/09/22, two days after the actual event. The incident was not reported to the State Agency until 02/10/22 (over a month later). Findings include: Resident #1 was admitted to the facility on 06/29/18, with the most current readmission on 12/24/21. The resident was discharged from the facility on 01/14/22 and did not return. Diagnoses for Resident #1 included, but were not limited to: Atrial fibrillation with long term anticoagulant therapy (Xalrelto 15 mg/milligrams daily), history of a stroke with right sided hemiparesis/hemiplegia, dysphagia, constipation, dementia, anxiety and depression. The most recent full MDS (minimum data set) was an admission (5 day/annual) assessment dated 01/10/22. This MDS assessed the resident with long and short term memory impairment and severe impairment in daily decision making skills. Resident #1 was also assessed as requiring total assistance from at least one staff person for bed mobility, transfers, dressing, toileting, and extensive assistance for eating and hygiene. This	F 609	F 609 1. Resident #1 is no longer a resident in the center. Once the center was made aware that there were additional injuries, the center submitted an FRI to the appropriate outside agencies and then the final report after the completion of a 5 day follow up 2. A review of unusual incidents including falls/injuries of unknown origin will be reviewed from the last 30 days to ensure a thorough investigation was completed and outside agencies were notified via Facility Reported Incident if required. 3. Facility staff will be educated by the SDC/Designee on the center□s policy on abuse and neglect. Nursing Leadership/Administrator will be educated by the Regional Director of Clinical Services/designee on the reporting requirements for unwitnessed falls with injuries/injuries of unknown origin. 4. DON/UM will review unusual incidents daily during clinical meeting 5x weekly to ensure incidents for unwitnessed falls with injuries/injuries of unknown origin are reported to the outside agencies as required. 5. The results of the review will be discussed at the quarterly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be conducted on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan	

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F 609	Continued From page 21 MDS assessed the resident as having one fall since readmission (12/24/21), not major in injury. Resident #1's clinical records were reviewed and included the following: 01/09/22 at 3:33 PM, "Patient observed lying on the floor beside her bed face down, hematoma observed on right side of the head close to the forehead VS (vital signs)...ROM (range of motion) within normal limit (sic)...MD (medical doctor) and RP notified...signature of LPN (licensed practical nurse) #1. A post fall assessment dated 01/09/22 and timed 2:46 PM documented, "...date and time of fall: 01/09/22 1:00 AM...date and time physician notified: 01/09/22 1:00 AM...date and time RP notified 01/09/22 1:15 AM...two person assist...chair bound, requires assistance to transfer...pain management/assessment...patient assisted back to bed...staff members assisted...2...signed LPN #1." There was no other information on the post fall assessment. A progress note dated 01/09/22 at 3:54 PM documented, "Patient observed lying on the floor beside her bed face down, hematoma observed on right side of the head close to the forehead VS...ROM within normal limit (sic)...MD and RP notified...signature of LPN #1. On 02/15/22 at approximately 10:00 AM, the administrator, DON (director of nursing) and the corporate nurse were made aware of a complaint regarding Resident #1 and were asked for any information or investigation regarding a fall with injury for Resident #1 in January 2022. The administrator stated that the investigation was	F 609	of correction. Date of compliance: 03/21/2022	

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currently underway and that it would be completed on 02/16/22. The administrator stated they were made aware that Resident #1 had a fall on 01/09/22 by the Unit Manager (LPN #2) in a "morning meeting" on 01/10/22. The administrator stated that it wasn't until an investigator called and came to the facility on 02/08/22 that they were made aware of concerns regarding alleged significant injuries. The administrator stated that was when the investigation was initiated and that this information was what prompted the investigation. The administrator stated that there had not been any other investigation regarding Resident #1.

On 02/16/22 at approximately 9:00 AM, the administrator and corporate nurse presented their final investigation for review.

The investigation had an incident report dated, 01/09/22 which documented, "...UN-witnessed: (Name of patient)...Nursing Description: observed lying on the floor beside her bed on the floor face down..Patient Description: cannot explain due to dementia...Immediate Action Taken: Head to Toe assessment done, hematoma observed on right side of the head close to forehead, pt (patient) assisted back to bed by two staff...Hematoma top of scalp...alert...oriented to person...Level of consciousness: (blank)...No witness found."

Also included in the investigation was LPN #1's statement which documented, "...date of incident: 7-3 (shift) 01/07/22...On 01/07/22 I was the only nurse for 7-3 shift on that day, when my manager (Name of LPN #2/Unit Manager) called me in room (number) with urgency...I was in middle of doing patient care (in another room) but I have to

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run to him due to the urgency from him...upon getting into the room (number) I saw resident (Name of Resident #1) lying on the floor with my manager in the room told me she fell...manager was suppose (sic) to do the necessary documentation...In report out going nurse reported about (Resident #1) huge swelling on patient head...signed on 02/11/22 by LPN #1."

On 02/16/22 at 1:55 PM, the NP was interviewed regarding Resident #1's fall. The NP was made aware of the investigation and the statement by LPN #1 that Resident #1's fall occurred on 01/07/22. The NP stated that she was notified of the fall on the 9th and that when she saw Resident #1 she had a hematoma and she was fully assessed. The NP was asked if Resident #1 should have been sent out at that time for an evaluation, as the resident had sustained a head injury and was on Xalrelto 15 mg daily at the time of the fall. The NP stated, "In most cases yes, the placement (of the hematoma), I figured it would go away, and based on my assessment didn't show any distress, but probably should have sent her out." The NP stated that she was not sure why staff did not notify her of the resident's fall on the day it occurred (on 01/07/22).

On 02/16/22 at 2:20 PM, LPN #1 was interviewed via phone. LPN #1 stated, "It (fall) happened on Friday (01/07/22); I was the only nurse on the floor and around at that time and Resident #1 tested positive and was sent to the COVID positive floor (5th floor). I was in the middle of care and my manager was calling me with urgency to come. I get into the room, patient is lying on the floor face down, he (LPN #2) asked me to help get the patient back to bed." LPN #1

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stated that he was not in the room when it happened and that he did not know what happened. LPN #1 stated that LPN #2 didn't say what happened to Resident #1 but it did happen on the 7th (not the 9th as documented). LPN #1 stated that Resident #1 was on the 3rd floor, tested positive and was moved to the 5th floor, it was in the afternoon, and that he worked the 7-3 shift and he wasn't there much longer before he left for the day. LPN #1 stated that he passed it on in report to the oncoming nurse that the resident fell, but did not report it to the physician. LPN #1 stated that LPN #2 was the one who found Resident #1 and was supposed to do all that and the paperwork. LPN #1 stated that the only people in the room were the patient, LPN #1 and LPN #2, and that Resident #1 was put back in bed. LPN #1 stated, "I just noticed swelling on the face." LPN #1 stated that he didn't notice any bruising at that time. LPN #1 stated, "I did not witness the fall that was on Friday." LPN #1 stated that he was off on Saturday and picked up another shift on Sunday. When he came in on Sunday he noticed there was no documentation regarding the fall, so he called LPN #2 and asked why he didn't document the fall and report for Resident #1. LPN #1 stated that LPN #2 told him that since he wasn't in the facility that LPN #1 needed to do it. LPN #1 then stated that is when he documented the fall on 01/09/22, but it happened on 01/07/22. LPN #1 stated that he texted the NP and informed her of the fall on 01/09/22. LPN #1 was asked if Resident #1 was assessed. LPN #1 stated that he did not assess Resident #1 or notify the physician, and that LPN #2 (the unit manager) must not have either.

A policy titled, "Falls Management Program" documented, "...the center considers all patients

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to be at risk for falls...fall is defined as unintentional change in position coming to rest on the ground or...next lower surface...Notify the physician, responsible party, and/or EMS (emergency medical services), as well as the Supervisor/Administrative personnel...evaluate, monitor and document patient response...include neurological assessment if the fall was unwitnessed and/or the patient hit his/her head..."

A policy titled, "Abuse/Neglect/Misappropriation/Crime" documented, "...All employees are responsible for immediately (no later than two hours after...if the incident involves abuse or bodily injury...no later than 24 hours if the incident does not involve abuse or bodily injury) reporting to the administrator, or in their absence, the director of nursing...upon notification of any alleged violations...including injuries of unknown source...the administrator will immediately report to the State Agency...no later than 24 hours if the events...do not involve abuse or do not result in serious bodily injury...injuries of unknown origin (injuries not witnessed or patient can't state what happened) should be handled the same as an allegation of mistreatment, neglect or abuse and must be reported to the state agency...All employees receive training...protecting patients from abuse and neglect and their responsibility to immediately report any cases of suspected or witnessed...Injuries of unknown origin (injuries not witnessed or patient can't state what happened) should be handled the same as an allegation of mistreatment, neglect or abuse and must be reported to the State Survey Agency...Centers are to report...any unusual incidents or occurrences..."

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F 609	Continued From page 26 On 02/16/22 at 2:35 PM, the administrator, DON , and corporate nurse were made aware of the concerns regarding this incident not being reported to the State Agency within the required time frame. The facility staff were made aware that the Resident #1's fall with injury had occurred on 01/07/22 not 01/09/22, and it was not reported by staff as required in the facility's policy and procedures. The DON stated that she was on vacation when the fall occurred and she was made aware after (on 01/17/22 upon return to work). The administrator stated that she was made aware that the resident had a fall on 01/09/22 in a morning meeting on 01/10/22. The corporate nurse stated, "We've given you everything on this patient, we [facility] requested medical records and there was no indication of additional injury [other than hematoma/bruising] and we sent an FRI [facility reported incident], I see missteps in our process, unfortunately there is room for performance improvement." The corporate nurse stated, "No one can tell we saw this in this patient (sic)...we base on our own findings and our own review." No further information and/or documentation was presented prior to the exit conference on 02/17/22.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.	F 610		3/21/22

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F 610	Continued From page 27 §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review and in the course of a complaint investigation, the facility staff failed to thoroughly investigate an injury of unknown origin/unwitnessed fall for one of 9 residents in the survey sample, Resident #1. Resident #1 was found in her room, face down on the floor on 01/07/22. There were no witnesses according to facility documentation and interviews. The incident was documented as occurring on 01/09/22, two days after the actual event. The incident was not investigated until 02/08/22 and not reported to the State Agency until 02/10/22 (over a month later). Findings include: Resident #1 was admitted to the facility on 06/29/18, with the most current readmission on 12/24/21. The resident was discharged from the facility on 01/14/22 and did not return. Diagnoses for Resident #1 included, but were not limited to: Atrial fibrillation with long term anticoagulant therapy (Xalrelto 15 mg/milligrams daily), history of a stroke with right sided hemiparesis/hemiplegia, dysphagia, constipation,	F 610	F610 1. Resident #1 is no longer a resident in the center. 2. A review of unusual incidents including falls will be reviewed from the last 30 days to ensure a thorough investigation was completed and outside agencies were notified if a Facility Reported Incident is required. 3. Facility staff will be educated by the SDC/Designee on the center□s policy on abuse and neglect. Nursing Leadership/Administrator will be educated by the Regional Director of Clinical Services/designee on the process for conducting a thorough investigation for unwitnessed falls with injuries/injuries of unknown origin. 4. DON/UM will review unusual incidents including falls daily during clinical meeting 5x weekly to ensure a thorough investigation was completed for unwitnessed injuries/injuries of unknown origin. 5. The results of the review will be discussed at the quarterly QAPI meeting.	

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F 610	Continued From page 28 dementia, anxiety and depression. The most recent full MDS (minimum data set) was an admission (5 day/annual) assessment dated 01/10/22. This MDS assessed the resident with long and short term memory impairment and severe impairment in daily decision making skills. Resident #1 was also assessed as requiring total assistance from at least one staff person for bed mobility, transfers, dressing, toileting, and extensive assistance for eating and hygiene. This MDS documented that the resident did not ambulate in room or corridor during the look back period. In Section G 0300. "Balance during transitions and walking" Resident #1 was assessed as "activity did not occur" for the following: moving from seated to standing position, walking, turning around, and/or moving on and off the toilet. This MDS assessed the resident as having one fall since readmission (12/24/21), not major in injury. Resident #1's clinical records were reviewed and included the following: 01/09/22 at 3:33 PM, "Patient observed lying on the floor beside her bed face down, hematoma observed on right side of the head close to the forehead VS (vital signs)...ROM (range of motion) within normal limit (sic)...MD (medical doctor) and RP notified...signature of LPN (licensed practical nurse) #1. A post fall assessment dated 01/09/22 and timed 2:46 PM documented, "...date and time of fall: 01/09/22 1:00 AM...date and time physician notified: 01/09/22 1:00 AM...date and time RP notified 01/09/22 1:15 AM...two person assist...chair bound, requires assistance to	F 610	Once the QAPI committee determines the problem no longer exists, the reviews will be conducted on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. Date of compliance: 03/21/2022	

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transfer...pain management/assessment...patient assisted back to bed...staff members assisted...2...signed LPN #1." There was no other information on the post fall assessment.

A progress note dated 01/09/22 at 3:54 PM documented, "Patient observed lying on the floor beside her bed face down, hematoma observed on right side of the head close to the forehead VS...ROM within normal limit (sic)...MD and RP notified...signature of LPN #1.

On 02/15/22 at approximately 10:00 AM, the administrator, DON [director of nursing] and the corporate nurse were made aware of the complaint investigation and were asked for any information and/or investigation regarding injuries sustained to Resident #1 in January 2022.

On 02/15/22 at approximately 10:00 AM, the administrator, DON (director of nursing) and the corporate nurse were made aware of a complaint regarding Resident #1 and were asked for any information or investigation regarding a fall with injury for Resident #1 in January 2022. The administrator stated that the investigation was currently underway and that it would be completed on 02/16/22. The administrator stated they were made aware that Resident #1 had a fall on 01/09/22 by the Unit Manager (LPN #2) in a "morning meeting" on 01/10/22. The administrator stated that it wasn't until an investigator called and came to the facility on 02/08/22 that they were made aware of concerns regarding alleged significant injuries. The administrator stated that was when the investigation was initiated and that this information was what prompted the investigation. The administrator stated that there had not been

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any other investigation regarding Resident #1.

On 02/16/22 at approximately 9:00 AM, the administrator and corporate nurse presented their final investigation for review.

The investigation had an incident report dated, 01/09/22 which documented, "...UN-witnessed: (Name of patient)...Nursing Description: observed lying on the floor beside her bed on the floor face down. Patient Description: cannot explain due to dementia...Immediate Action Taken: Head to Toe assessment done, hematoma observed on right side of the head close to forehead, pt (patient) assisted back to bed by two staff...Hematoma top of scalp...alert...oriented to person...Level of consciousness: (blank)...No witness found."

Also included in the investigation was LPN #1's statement which documented, "...date of incident: 7-3 (shift) 01/07/22...On 01/07/22 I was the only nurse for 7-3 shift on that day, when my manager (Name of LPN #2/Unit Manager) called me in room (number) with urgency...I was in middle of doing patient care (in another room) but I have to run to him due to the urgency from him...upon getting into the room (number) I saw resident (Name of Resident #1) lying on the floor with my manager in the room told me she fell...manager was suppose (sic) to do the necessary documentation...In report out going nurse reported about (Resident #1) huge swelling on patient head...signed on 02/11/22 by LPN #1."

There was no statement from LPN #2 who was the Unit Manager.

CNA (certified nursing assistant) #6's statement

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documented, "...I was not around when the accident happened, I came back to work I went to patient room to change patient and I saw bump and black eye on patient forehead (sic) and patient daughter came in the room and said patient in a bad condition and she asked me what happened to patient and I told her that I don't know what happened to patient because I was not around...signed on 02/10/22 by CNA #6." The statement by CNA #6 did not provide a date as to when the CNA "returned to work" or observed the "bump and black eye" on Resident #1.

RN #5's statement documented, "...Return to work on Monday (01/10/22). I was told resident had a fall over the weekend...signed RN #5 02/11/22."

CNA #8's statement documented, "I came to work on 3-11 shift patient was in bed I change her (sic) and seen she had bruises on both knees nurse was notified...signed CNA #8." The statement by CNA #8 did not provide a date as to when the CNA saw the bruising on Resident #1.

The remainder of the statements from staff documented that were on off, on vacation, off duty, or not assigned to Resident #1, and did not provide any information to the investigation.

On 02/16/22 at 1:35 PM, Resident #1's attending physician was interviewed. The physician stated that he did not see Resident #1 after the fall. The physician stated that NP saw Resident #1 and completed an assessment. The physician stated that he was notified, but was unsure of when, and stated, "I get so many calls." The physician stated that he was unsure of the details and did not see Resident #1 during this time. The

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physician stated that he has found out more about this incident after the fact than when it actually happened.

On 02/16/22 at 1:55 PM, the NP was interviewed regarding Resident #1's fall. The NP was made aware of the investigation and the statement by LPN #1 that Resident #1's fall occurred on 01/07/22. The NP stated that she was notified of the fall on the 9th and that when she saw Resident #1 she had a hematoma and she was fully assessed. The NP was asked if Resident #1 should have been sent out at that time for an evaluation, as the resident had sustained a head injury and was on Xalrelto 15 mg daily at the time of the fall. The NP stated, "In most cases yes, the placement (of the hematoma), I figured it would go away, and based on my assessment didn't show any distress, but probably should have sent her out." The NP stated that she was not sure why staff did not notify her of the resident's fall on the day it occurred (on 01/07/22).

On 02/16/22 at 2:20 PM, LPN #1 was interviewed via phone. LPN #1 stated, "It (fall) happened on Friday (01/07/22); I was the only nurse on the floor and around at that time and Resident #1 tested positive and was sent to the COVID positive floor (5th floor). I was in the middle of care and my manager was calling me with urgency to come. I get into the room, patient is lying on the floor face down, he (LPN #2) asked me to help get the patient back to bed." LPN #1 stated that he was not in the room when it happened and that he did not know what happened. LPN #1 stated that LPN #2 didn't say what happened to Resident #1 but it did happen on the 7th (not the 9th as documented). LPN #1

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stated that Resident #1 was on the 3rd floor, tested positive and was moved to the 5th floor, it was in the afternoon, and that he worked the 7-3 shift and he wasn't there much longer before he left for the day. LPN #1 stated that he passed it on in report to the oncoming nurse that the resident fell, but did not report it to the physician. LPN #1 stated that LPN #2 was the one who found Resident #1 and was supposed to do all that and the paperwork. LPN #1 stated that the only people in the room were the patient, LPN #1 and LPN #2, and that Resident #1 was put back in bed. LPN #1 stated, "I just noticed swelling on the face." LPN #1 stated that he didn't notice any bruising at that time. LPN #1 stated, "I did not witness the fall that was on Friday." LPN #1 stated that he was off on Saturday and picked up another shift on Sunday. When he came in on Sunday he noticed there was no documentation regarding the fall, so he called LPN #2 and asked why he didn't document the fall and report for Resident #1. LPN #1 stated that LPN #2 told him that since he wasn't in the facility that LPN #1 needed to do it. LPN #1 then stated that is when he documented the fall on 01/09/22, but it happened on 01/07/22. LPN #1 stated that he texted the NP and informed her of the fall on 01/09/22. LPN #1 was asked if Resident #1 was assessed. LPN #1 stated that he did not assess Resident #1 or notify the physician, and that LPN #2 (the unit manager) must not have either.

A policy titled, "Falls Management Program" documented, "...the center considers all patients to be at risk for falls...fall is defined as unintentional change in position coming to rest on the ground or...next lower surface...Notify the physician, responsible party, and/or EMS (emergency medical services), as well as the

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Supervisor/Administrative personnel...evaluate, monitor and document patient response...include neurological assessment if the fall was unwitnessed and/or the patient hit his/her head..."

A policy titled, "Abuse/Neglect/Misappropriation/Crime" documented, "...All employees are responsible for immediately (no later than two hours after...if the incident involves abuse or bodily injury...no later than 24 hours if the incident does not involve abuse or bodily injury) reporting to the administrator, or in their absence, the director of nursing...upon notification of any alleged violations...including injuries of unknown source...the administrator will immediately report to the State Agency...no later than 24 hours if the events...do not involve abuse or do not result in serious bodily injury...injuries of unknown origin (injuries not witnessed or patient can't state what happened) should be handled the same as an allegation of mistreatment, neglect or abuse and must be reported to the state agency...The administrator and/or director of nursing will immediately initiate a thorough internal investigation...will include, but not limited, collecting evidence, interviewing...victims...and involving other appropriate individuals, agents, or authorities to assist in the process...the administrator must thoroughly investigate and file a complete written report of the investigation of the submitted FRI to the state agency within 5 working days...investigative reporting document submitted must contain sufficient detail to demonstrate that a thorough investigation was conducted. It must include, but not limited to: Date of the occurrence...name of patient, staff, or individuals involved...location and description of occurrence...immediate action taken to

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F 610	Continued From page 35 protect...from further injury... " On 02/16/22 at 2:35 PM, the administrator, DON, and corporate nurse were made aware of the concerns that the investigation for Resident #1 was not a complete and thorough investigation. The facility staff were made aware that their investigation revealed discrepancies with dates or lack thereof, and that one employee statement revealed the injury to Resident #1 occurred on 01/07/22 not on 01/09/22, and was not followed up on by the facility. It was also documented multiple times and locations that the injury occurred on 01/9/22. The facility staff were made aware that some of the statements did not have dates to indicate when observations actually occurred. The staff were also informed that a statement or interview was not obtained for LPN #2 (unit manager) who was documented as the first person to find Resident #1 according to LPN #1. The corporate nurse stated, "We've given you everything on this patient, we requested medical records and there was no indication of additional injury and we sent an FRI (facility reported incident). I see missteps in our process, unfortunately there is room for performance improvement." The corporate nurse stated, "No one can tell we saw this in this patient (sic)...we base on our own findings and our own review." No further information and/or documentation was presented prior to the exit conference on 02/17/22.	F 610		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		3/21/22

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F 684	Continued From page 36 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 family interview, staff interview, clinical record review, facility document review, and in the course of a complaint investigation, the facility staff failed ensure care and treatment were provided in a timely manner for one of nine residents, Resident #1, resulting in harm. Resident #1 had an unwitnessed fall on 01/07/22, and was not assessed until two days later on 01/09/22. Resident #1's condition declined in the days after the unwitnessed fall and the resident was sent to the hospital on 01/14/22, and found to have a hematoma to the head with facial bruising, along with fractures to the cervical neck (C1-C3) and a right hip. Findings include: Resident #1 was admitted to the facility on 06/29/18, with the most current readmission on 12/24/21. The resident was discharged from the facility on 01/14/22 and did not return. Diagnoses for Resident #1 included, but were not limited to: Atrial fibrillation with long term anticoagulant therapy (Xalrelto 15 mg/milligrams daily), history of a stroke with right sided hemiparesis/hemiplegia, dysphagia, constipation, dementia, anxiety and depression. The most recent full MDS (minimum data set) was an admission (5 day/annual) assessment	F 684	F684 1. Resident is no longer a resident in the center. 2. A review of falls for the last 30 days will be conducted to ensure timely RP//MD notification was completed. In addition, the review will include checking whether there is a thorough assessment of the resident documented in the medical records at the time of the fall and appropriate interventions placed. 3. Licensed nurses will be educated by the SDC/designee on timely notification of the RP/MD when falls with injuries occur, falls management program, conducting head to toe assessments, documentation in the medical record and post fall ER transfer determination. 4. DON/ADON/UM will review unusual incidents daily during clinical meeting 5x weekly to ensure a thorough investigation was completed for unwitnessed falls with injuries/injuries of unknown origin, documented head to toe assessment was completed, and a post fall determination was made regarding transferring resident to ER for further evaluation. 5. The results of the review will be discussed at the quarterly QAPI meeting. Once the QAPI committee determines the	

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dated 01/10/22. This MDS assessed the resident with long and short term memory impairment and severe impairment in daily decision making skills. Resident #1 was also assessed as requiring total assistance from at least one staff person for bed mobility, transfers, dressing, toileting, and extensive assistance for eating and hygiene. This MDS documented that the resident did not ambulate in room or corridor during the look back period. In Section G 0300. "Balance during transitions and walking" Resident #1 was assessed as "activity did not occur" for the following: moving from seated to standing position, walking, turning around, and/or moving on and off the toilet. This MDS assessed the resident as having one fall since readmission (12/24/21), not major in injury. This MDS assessed Resident #1 as receiving scheduled and PRN medications for pain and "unable to answer" pain presence.

Resident #1's clinical records were reviewed and included the following:

A physician's progress note dated 01/07/22 at 3:01 PM documented, "...to be seen...for positive COVID...generalized weakness...cognitive impairment, advanced age, frail...muscle weakness...signed by nurse practitioner (NP)." There was no information regarding a fall in the NP's note.

A skin assessment dated 01/07/22 timed 3:42 PM documented, "...skin without impairment: no...multiple ecchymosis and bruising to bilateral arms and hands, otherwise skin intact..."

A progress note dated 01/09/22 at 1:58 AM documented, "Patient grimacing and moaning,

problem no longer exists, the reviews will be conducted on a random basis.
The Administrator/Director of Nursing are responsible for implementation of the plan of correction.
Date of compliance: 03/21/2022

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Tylenol...given, well tolerated...continue to monitor for changes..."

A post fall assessment dated 01/09/22 and timed 2:46 PM documented, "...date and time of fall: 01/09/22 1:00 AM...date and time physician notified: 01/09/22 1:00 AM...date and time RP (responsible party) notified 01/09/22 1:15 AM...two person assist...chair bound, requires assistance to transfer...pain management/assessment...patient assisted back to bed...staff members assisted...2...signed LPN (licensed practical nurse) #1." There was no other information on the post fall assessment.

A progress note dated 01/09/22 at 3:33 PM, which documented, "Patient observed lying on the floor beside her bed face down, hematoma observed on right side of the head close to the forehead VS (vital signs)...ROM (range of motion) within normal limit (sic)...MD (medical doctor) and RP notified...signature of LPN#1."

A progress note dated 01/09/22 at 3:54 PM documented, "Patient observed lying on the floor beside her bed face down, hematoma observed on right side of the head close to the forehead VS...ROM within normal limit (sic)...MD and RP notified...signature of LPN #1."

A physician's progress note dated 01/09/22 at 5:17 PM documented, "...S/P (status post) fall and right anterior forehead hematoma...generalized weakness...Vital Signs: (Resident #1's blood pressure, pulse and respiration were dated from 12/24/21 on this progress note, and were not current as of the date of 01/09/22 note) cognitive impairment, advanced age, frail...muscle weakness...fall

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precautions...forehead hematoma start apply ice to hematoma TID (three times daily) Start Tylenol 650 mg for pain...signed by NP."

There was no mention of Resident #1 being on an long term anticoagulant therapy (Xalrelto 15 mg daily since June 2020).

A progress note dated 01/09/22 at 10:18 PM documented, "Situation: Post fall 3-11...history of...A-Fib...right hemiparesis. Assessment (RN)/Appearance (LPN): Head to toe assessment done heamatoma (sic) noted on right side of the head close to the forehead, NP and supervisor aware, ROM within normal limit, remain afebrile...continue to monitor...educate resident to call for help, bed in the lowest position...signature of LPN #1."

No other documentation was located in Resident #1's clinical record regarding the details of this fall. According to the documentation in the resident's clinical records the resident sustained a fall with injury on 01/09/22.

A progress note dated 01/10/22 at 10:48 AM documented, "Situation: S/P fall 7-3 shift Background: ...hemi-neglect of right side...AFIB, HTN, Dysphagia. Assessment (RN)/Appearance (LPN): Pt. is alert and verbally responsive. Meds given as ordered, tolerated well. No changes in mental status...Bruise remain on pt. (patient) both knees and hematoma forehead...ROM with in normal limit...No distress noted during shift...signature of RN #3."

A progress note dated 01/10/22 at 4:01 PM documented, "...Alert and confused. Total assist with ADL (activities of daily living)...fluid

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encouraged..."

A progress note dated 01/10/22 at 6:48 PM documented, "...A-Fib...expressive aphasia...alert and verbally responsive...meds given...no change in mental status...bruise remain on both knees and on hematoma her forehead (sic)...ate with assist...monitor frequently..."

Progress note dated 01/11/22 at 8:00 PM documented, "...hematoma to the right side of the head...healing in progress, ROM within normal limit...continue with plan of care..."

A progress noted dated 01/12/22 a 8:23 PM documented, "...alert...responsive...bruise remain on both knees and hematoma on her forehead...observed...weak...meals...staff assist...NP notified..."

A progress noted dated 01/13/22 at 1:46 PM documented, "Pt. received in bed this am...care provided by staff with total assist. Meds given as ordered, pt. observed very weak on shift, open her eye (sic) intermittently and fall back to sleep...NP notified...RP updated about pt condition..."

A progress note dated 01/13/22 at 9:59 PM documented, "...VS obtained at this time...daughter came in to visit. Pt. to be send (sic) with non emergency for further eval NP aware (name of transport) called." Resident #1 was sent out to the hospital the following day 01/14/22, at 11:14 AM.

Resident #1's current CCP (comprehensive care plan) at the time of the fall documented, "...The resident is at risk for falls related to gait/balance

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problems/poor safety awareness...assist bars for bed mobility, wheelchair for locomotion, pommel cushion for w/c positioning...call light in reach...encourage resident to use it for assistance as needed...educate caregivers about safety reminders and what to do if a fall occurs...rounding and close monitoring, and anticipate to meet the resident's needs...environment free of hazards...is on anticoagulant therapy related to Atrial Fibrillation (created on 05/12/2020)...Lab work as ordered...meds as ordered...Monitor for bleeding such as unusual bruising, bloody or black tarry stool, red or dark brown urine, abdominal pain...swelling...bleeding from eyes, gums, nose...report symptoms to MD...Observe for any signs/symptoms of bleeding related to anticoagulation therapy...SKIN: bruises to bilateral forearms, right head hematoma (revised on 01/09/22)..."

On 02/15/22 at approximately 10:00 AM, the administrator, DON (director of nursing) and the corporate nurse were made aware of a complaint regarding Resident #1 and were asked for any information or investigation regarding a fall with injury for Resident #1 in January 2022. The administrator stated that the investigation was currently underway and that it would be completed on 02/16/22. The administrator stated they were made aware that Resident #1 had a fall on 01/09/22 by the Unit Manager (LPN #2) in a "morning meeting" on 01/10/22. The administrator stated that it wasn't until an investigator called and came to the facility on 02/08/22 that they were made aware of concerns regarding alleged significant injuries. The administrator stated that was when the investigation was initiated and that this

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information was what prompted the investigation. The administrator stated that there had not been any other investigation regarding Resident #1.

On 02/15/22 at approximately 2:30 PM, the hospital medical records obtained by the facility were presented for review. The ED (emergency department) provider note dated 01/14/22 at 11:22 AM documented, "Sent to the ER for evaluation of lethargy and mental status change since yesterday...Patient is on Xalrelto. It is reported that patient has been lethargic and sleeping all day since yesterday...report of a fall that occurred last week...Altered mental status, lethargy...patient non verbal, not following commands, lying on stretcher with eyes closed...Ecchymosis (bruises) to forehead and orbital left eye...A-fib at 100 bpm (beats per minute)...Trauma and CNS (central nervous system) failure or compromise...C1 anterior tubercle fracture, right and left posterior arch fracture of C1 with moderate distraction of fracture fragments, non-displaced fracture C3 left facet...left superior articular facet fracture of C2 extending into L (left) vertebral foramen, right impacted fracture of proximal femur...1:20 PM...awake, not following commands...opens eyes on own, pushes away noxious stimuli, moans, makes unintelligible sounds...Right forehead/scalp hematoma...Left peri-orbital ecchymosis...right forearm ecchymosis...HIP, LEG, FOOT: left withdrawals to pain...right...deformity right foot, right leg shortened, yellowing ecchymosis right knee, healing abrasions to right upper thigh...right hip fracture...trauma consulted...hold Xalrelto...C1-C3 fractures...right proximal femur displaced impacted fracture..."

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On 02/16/22 at approximately 9:00 AM, the administrator and corporate nurse presented their final investigation for review.

The investigation had an incident report dated, 01/09/22 which documented, "...UN-witnessed: (Name of patient)...Nursing Description: observed lying on the floor beside her bed on the floor face down. Patient Description: cannot explain due to dementia...Immediate Action Taken: Head to Toe assessment done, hematoma observed on right side of the head close to forehead, pt (patient) assisted back to bed by two staff...Hematoma top of scalp...alert...oriented to person...Level of consciousness: (blank)...No witness found."

Also included in the investigation was LPN #1's statement which documented, "...date of incident: 7-3 (shift) 01/07/22...On 01/07/22 I was the only nurse for 7-3 shift on that day, when my manager (Name of LPN #2/Unit Manager) called me in room (number) with urgency...I was in middle of doing patient care (in another room) but I have to run to him due to the urgency from him...upon getting into the room (number) I saw resident (Name of Resident #1) lying on the floor with my manager in the room told me she fell...manager was suppose (sic) to do the necessary documentation...In report out going nurse reported about (Resident #1) huge swelling on patient head...signed on 02/11/22 by LPN #1."

CNA (certified nursing assistant) #6's statement documented, "...I was not around when the accident happened, I came back to work I went to patient room to change patient and I saw bump and black eye on patient forehead (sic) and patient daughter came in the room and said

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patient in a bad condition and she asked me what happened to patient and I told her that I don't know what happened to patient because I was not around...signed on 02/10/22 by CNA #6." The statement by CNA #6 did not provide a date as to when the CNA "returned to work" or observed the "bump and black eye" on Resident #1.

RN #5's statement documented, "...Return to work on Monday (01/10/22). I was told resident had a fall over the weekend...signed RN #5 02/11/22."

CNA #8's statement documented, "I came to work on 3-11 shift patient was in bed I change her (sic) and seen she had bruises on both knees nurse was notified...signed CNA #8." The statement by CNA #8 did not provide a date as to when the CNA saw the bruising on Resident #1.

On 02/16/22 at 10:25 AM, Resident #1's daughter was interviewed. The daughter stated that she was informed of the fall on 01/09/22 and she saw Resident #1 on Monday 01/10/22. She stated that LPN #2 told her not to worry they were taking care of Resident #1. The daughter stated that she asked what happened and no one could tell her what happened to her mother. The daughter stated that bump on her mother's head was "So big, I knew it was a head injury." The daughter asked the facility staff to send Resident #1out and stated they acted as though they didn't want to. The daughter stated that she went back on Thursday (01/13/22) and her mother was "gone", she wasn't responding, and "She was unconscious." The daughter stated that she cried and wanted Resident #1 to go to the hospital and that staff told her, "maybe it's time to let her go.'" The daughter stated that she was so upset and

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finally the nurse called to have Resident #1 sent out, but not 911, because it wasn't an emergency. The daughter stated that she left at around 10 PM on 01/13/22 and the facility staff called her around 3:00 AM and told her that transport would pick her mother up between 7 and 8 AM. The daughter stated that Resident #1 went to the hospital and was admitted with a broken neck and broken hip.

On 02/16/22 at 1:35 PM, Resident #1's attending physician was interviewed. The physician stated that he did not see Resident #1 after the fall. The physician stated that NP saw Resident #1 and completed an assessment. The physician stated that he was notified, but was unsure of when, and stated, "I get so many calls." The physician stated that he was unsure of the details and did not see Resident #1 during this time.

On 02/16/22 at 1:55 PM, the NP was interviewed regarding Resident #1's fall. The NP was made aware of the investigation and the statement by LPN #1 that Resident #1's fall occurred on 01/07/22. The NP stated that she was notified of the fall on the 9th and that when she saw Resident #1 she had a hematoma and she was fully assessed. The NP was asked if she knew what happened. The NP stated, "...she literally fell out of the wheelchair..." The NP was asked where that information came from as the resident's clinical records did not document that information in the notes or the post fall assessment. The NP stated it was documented somewhere. The NP stated that she palpated the resident's head and the resident did show discomfort and stated that Resident #1 had some bruising on both knees. The NP was asked if Resident #1 should have been sent out at that

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time for an evaluation, as the resident had sustained a head injury and was on Xalrelto 15 mg daily at the time of the fall. . The NP stated, "In most cases yes, the placement (of the hematoma), I figured it would go away, and based on my assessment didn't show any distress, but probably should have sent her out." The NP was asked if she saw the resident anytime after 01/09/22. The NP stated that she had not, and that staff did not call her all week long with any changes. The NP stated that on 01/13/22 around 9 or 10 PM, she was notified about sending Resident #1 out for an evaluation because she was "sleepy." The NP was asked why the resident was not sent via 911, instead of being sent non-emergentl. The NP stated, "Yes, sent out non-emergent...the way it was described, the patient is sleepy and vital signs were stable."

On 02/16/22 at 2:20 PM, LPN #1 was interviewed via phone. LPN #1 stated, "It happened on Friday (01/07/22); I was the only nurse on the floor and around at that time and Resident #1 tested positive and was sent to the COVID positive floor (5th floor). I was in the middle of care and my manager was calling me with urgency to come. I get into the room, patient is lying on the floor face down, he (LPN #2) asked me to help get the patient back to bed." LPN #1 stated that he was not in the room when it happened and that he did not know what happened. LPN #1 stated that LPN #2 didn't say what happened to Resident #1 but it did happen on the 7th (not the 9th as documented). LPN #1 stated that Resident #1 was on the 3rd floor, tested positive and was moved to the 5th floor, it was in the afternoon, and that he worked the 7-3 shift and he wasn't there much longer before he left for the day. LPN #1 stated that he passed it on in report to the

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CHERRYDALE HEALTH AND REHABILITATION CENTER	3710 LEE HIGHWAY ARLINGTON, VA 22207

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oncoming nurse that the resident fell, but did not report it to the physician. LPN #1 stated that LPN #2 was the one who found Resident #1 and was supposed to do all that and the paperwork. LPN #1 stated that the only people in the room were the patient, LPN #1 and LPN #2, and that Resident #1 was put back in bed. LPN #1 stated, "I just noticed swelling on the face." LPN #1 stated that he didn't notice any bruising at that time. LPN #1 stated, "I did not witness the fall that was on Friday." LPN #1 stated that he was off on Saturday and picked up another shift on Sunday. When he came in on Sunday he noticed there was no documentation regarding the fall, so he called LPN #2 and asked why he didn't document the fall and report for Resident #1. LPN #1 stated that LPN #2 told him that since he wasn't in the facility that LPN #1 needed to do it. LPN #1 then stated that is when he documented the fall on 01/09/22, but it happened on 01/07/22. LPN #1 stated that he texted the NP and informed her of the fall on 01/09/22. LPN #1 was asked if Resident #1 was assessed. LPN #1 stated that he did not assess Resident #1 or notify the physician, and that LPN #2 (the unit manager) must not have either.

A policy titled, "Falls Management Program" documented, "...the center considers all patients to be at risk for falls...fall is defined as unintentional change in position coming to rest on the ground or...next lower surface...Notify the physician, responsible party, and/or EMS (emergency medical services), as well as the Supervisor/Administrative personnel...evaluate, monitor and document patient response...include neurological assessment if the fall was unwitnessed and/or the patient hit his/her head..."

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F 684	Continued From page 48 On 02/16/22 at 2:35 PM, the administrator, DON , and corporate nurse were made aware of the concerns regarding the lack of immediate care and assessment for Resident #1 related to the fall that occurred on 01/07/22, but was documented as 01/09/22. Resident #1 was not assessed or seen by the NP until two days later. The facility staff were also made aware that the resident began to have a decline with noticeable changes documented by nursing staff leading up to the notification of the NP on 01/13/22 and Resident #1 was not assessed by the NP or MD or sent out at that time for evaluation. The staff were also made aware of concerns that when nursing contacted the NP on 01/13/22 at 9:59 PM, that the NP agreed to send the resident out for evaluation non-emergently. Resident #1 left the facility on 01/14/22 at 11:14 AM, sent to the hospital, and found with altered mental status and lethargy, a right femur fracture, fractures to the neck (C1 through C3), hematoma to the head with bruising to the eyes, and bruising to the knees. The DON stated that she was on vacation when the fall occurred and she was made aware after (on 01/17/22 upon return to work). The administrator stated that she was made aware that the resident had a fall on 01/09/22 in a morning meeting on 01/10/22. The corporate nurse stated, "I see missteps in our process, unfortunately there is room for performance improvement." The corporate nurse stated, "No one can tell we saw this in this patient (sic)...we base on our own findings and our own review." No further information and/or documentation was presented prior to the exit conference on 02/17/22.	F 684		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use	F 758		3/21/22

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F 758	Continued From page 49 CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is	F 758		

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F 758	Continued From page 50 appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on family interview, staff interview, clinical record review, facility document review, and in the course of a complaint investigation, the facility staff failed to ensure one of 9 residents, Resident #1, was free from an unnecessary anti-anxiety medication, resulting in harm. Resident #1 was originally ordered Xanax 0.25 mg (milligrams) one tablet every 24 hours PRN (as needed). The medication was changed to a scheduled dose of Xanax 0.25 mg TID (three times daily) without a clinical rationale or justification of need. Resident #1 was administered the medication over the course of several days, became lethargic and was sent to the hospital for evaluation. Findings include: Resident #1 was admitted to the facility on 06/29/18, with the most current readmission on 12/24/21. The resident was discharged from the facility on 01/14/22 and did not return. Diagnoses for Resident #1 included, but were not limited to: Atrial fibrillation with long term anticoagulant therapy (Xalrelto 15 mg/milligrams daily), history of a stroke with right sided hemiparesis/hemiplegia, dysphagia, constipation, dementia, anxiety and depression	F 758	F758 1. Resident #1 is no longer a resident in the center. 2. A review will be conducted for residents on psychotropic medications to ensure appropriateness of the need and diagnosis for usage of the medications. 3. Licensed nurses will be educated by the SDC/designee on appropriate diagnosis for the usage of psychotropic medications. In addition, education will include documentation in the medical records for resident□s behaviors. 4. Nursing Leadership/designee will review in clinical meeting 5x weekly any new orders for psychotropic medications and/or changes in psychotropic medications to ensure appropriate diagnosis for medications and the reasoning for the change. 5. The results of the review will be discussed at the quarterly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be conducted on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan	

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F 758	Continued From page 51 The most recent full MDS (minimum data set) was an admission (5 day/annual) assessment dated 01/10/22. This MDS assessed the resident with long and short term memory impairment and severe impairment in daily decision making skills. Resident #1 was also assessed as requiring total assistance from at least one staff person for bed mobility, transfers, dressing, toileting, and extensive assistance for eating and hygiene. In Section E 0200. Behavior, Resident #1 was coded as not having any behaviors to include screaming or disruptive sounds during the seven day look back period. This MDS assessed that Resident #1 did not receive any anti-anxiety medications in the previous seven day look back period. Resident's #1's current POS (physician's order set) for January 2022 included orders for the following: "...Alprazolam (Xanax) tablet 0.25 mg Give one tablet by mouth every 24 hours as needed for Anxiety for 14 days (order date: 01/04/22...start date: 01/04/22)" "...Alprazolam (Xanax) tablet 0.25. mg Give 1 tablet by mouth three times...(order date: 01/10/22...start date: 01/11/22)..." Resident #1's current CCP (comprehensive care plan) for January 2022 documented, "...behavioral symptoms related to depression and anxiety: MONITOR FOR THE FOLLOWING: (crying, screaming and getting out of bed without assistance)...screams while in and also screams when out of bed...administer medications as ordered, monitor /document side effects and effectiveness...anticipate needs...uses psychotropic medications related to depression	F 758	of correction. Date of compliance: 03/21/2022	

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and anxiety...monitor for side effects, psych consult as needed, psychiatrist to review for gradual dose reduction...use alternatives to PRN medication...The resident is at risk for falls related to gait/balance problems/poor safety awareness...wheelchair for locomotion, pommel cushion for w/c (wheelchair) positioning...call light in reach...encourage resident to use...educate caregivers about safety reminders and what to do if a fall occurs...rounding and close monitoring...anticipate...meet the resident's needs...environment free of hazards...on anticoagulant therapy related to Atrial Fibrillation (created on 05/12/2020)...Lab work as ordered...meds as ordered...Monitor for bleeding such as unusual bruising, bloody or black tarry stool....pain...swelling...bleeding from eyes, gums, nose...report symptoms to MD...Observe for any signs/symptoms of bleeding related to anticoagulation therapy...SKIN: bruises to bilateral forearms, right head hematoma (revised on 01/09/22)..."

A "Geriatric Psychiatry" note dated 12/31/21 documented, "...hospitalized and returned...in part failed GDR (gradual dose reduction) of antidepressant...alert...dysfluent...expressive language problems...Xanax 0.25 (mg) PRN...Depression-stable, failed part GDR no med changes...dementia follow up done...recommend treatment as clearly described above...provided staff education...the facility will follow the recommendations outlined above...signature of mental health MD."

The resident's MARs (medication administration records) were reviewed for January 2022. According to Resident #1's MAR, the resident received one dose of PRN Xanax 0.25 mg on

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01/06/22. There was no documentation as to why the resident received this dose of the anti-anxiety medication.

The MAR also had a section for monitoring symptoms, "ANTIANXIETY MEDICATION MONITOR FOR DROWSINESS, SLURRED SPEECH, DIZZINESS, NAUSEA, AGGRESSIVE/IMPULSIVE BEHAVIOR. Document if any of the above observed every shift..." This section was marked with a check mark and initials for 01/06/22."

Resident #1 did not received any additional doses of PRN Xanax until the scheduled (three times daily) dose was started on 01/11/22.

The resident's January 2022 MAR documented Resident #1 received the Xanax 0.25 mg three times daily (scheduled dose) starting on 01/11/22. Resident #1 received three doses on 01/11/22, three more doses on 01/12/22, and the 9:00 AM dose on 01/13/22. The 01/13/22 2:00 PM and 9:00 PM doses documented the number 5 (hold/see progress notes).

The MAR monitoring section for symptoms, "ANTIANXIETY MEDICATION MONITOR FOR DROWSINESS, SLURRED SPEECH, DIZZINESS, NAUSEA, AGGRESSIVE/IMPULSIVE BEHAVIOR. Document if any of the above observed every shift..." This section was marked with a check mark and initials from 01/11/22 through 01/14/22 (2:00 PM)."

A progress note dated 01/13/22 at 1:46 PM documented, "Pt. (patient) received in bed this am...care provided by staff with total assist. Meds

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given as ordered, pt. observed very weak on shift, open her eye (sic) intermittently and fall back to sleep...NP notified...RP updated about pt condition..."

A progress note dated 01/13/22 at 4:57 PM documented, "Orders Administration Note: Alprazolam 0.25 mg Give 1 tablet by mouth three times a day...Pt. is very sleepy."

A progress note dated 01/13/22 at 7:36 PM documented,"...patient remain sleepy open her eyes intermittently. care provided by staff with total assist..."

A progress note dated 01/13/22 at 8:23 PM documented, "...Orders Administration Note: Alprazolam 0.25 mg Give 1 tablet by mouth three times a day...medication held, pt is sleepy."

A progress note dated 01/13/22 at 9:59 PM documented, "...VS obtained at this time...daughter came in to visit. Pt. to be send (sic) with non emergency for further eval (evaluation) NP aware (Name of transport) called."

A progress noted dated 01/14/22 at 9:51 AM documented, "...held for pt. been sleepy."

On 02/16/22 at 1:55 PM, the NP was interviewed and asked why Resident #1's anti-anxiety medication Alprazolam (Xanax) 0.25 mg had been changed from one tablet every 24 hours as needed to one tablet three times daily scheduled. The NP was made aware that according to progress notes Residednt #1 recently had a fall and sustained a head injury with bruising, and there was no documentation regarding Resident

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#1 having any behaviors, anxiety, agitation or aggression. The NP stated that she didn't know and stated that she didn't change the order and agreed stating, "That doesn't make sense" in regards to a medication increase. The NP was made aware that according to progress notes Resident #1 started to exhibit a decline and the medication was held per staff documenting the resident was "sleepy." The NP was asked if she was made aware that Resident #1's medication was held or that the resident was showing a decline and/or change in condition with sleepiness/weakness as documented in the progress notes. The NP stated that she did not see Resident #1 at any time after 01/09/22. She further stated that did not get any calls or notification of any concerns from staff regarding Resident #1 until around 9 or 10 PM on 01/13/22 and was told the resident was sleepy. The NP stated that she had not been contacted by staff all week for any concerns until 01/13/22 around 9 or 10 PM. The NP stated that according to nursing staff Resident #1's vital signs were stable and the resident wasn't in respiratory distress so she decided to send the resident out non-emergently for an evaluation. The NP was asked why she would not go ahead and send the resident out via 911 given that the resident had a fall days prior with a head injury and now the resident was exhibiting weakness and sleepiness. The NP again stated that staff reported to her that Resident #1 was "just sleepy."

On 02/16/22 at approximately 2:15 PM, the corporate nurse was asked for a policy on physician notification regarding medications held and change of condition. The policy titled, "Administration Procedures for All Medications" documented, "...Monitor for side effects or

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adverse drug reactions immediately after administration and throughout shift...when administering "as needed" (PRN) medications, document the reason for giving...Notify the attending physician and/or prescriber of...Held medications...suspected drug reactions..." A policy titled, "Documentation and Notification" documented, "...nurse is responsible for notifying the physician...whenever there is a change related to the care of a patient...change in condition, change in the medication regiment (sic)..."

The NP was interviewed again on 02/16/22 at 2:28 PM regarding Resident #1's medication change. The NP again stated that she was not notified of any changes with Resident #1 until 01/13/22 at around 9 or 10 PM. The NP was asked if she changed or ordered the scheduled Xanax order. The NP stated, "No, I didn't change it." The NP stated that you can look in the system and see who entered the order and the name of the ordering provider. The order was reviewed with the NP present. The order had been entered by RN (registered nurse) #3 on 01/10/22 at 9:27 PM under the physician's name (as the ordering provider), not the NP. It was documented, "prescriber written." The NP was asked what that meant and where it was written. The NP stated that you have to have an actual prescription for this type of medication and it's faxed to the pharmacy. The NP was asked if the facility keeps a photocopy of the actual written prescription.

The NP was made aware that she had documented and referenced in a medical progress note dated 01/09/22 that Resident #1 was on scheduled Xanax three times a day and "alert and oriented x 1, increased agitation/anxiety

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(per daughter)..." The NP stated that the notes are auto fill and that information was probably in there from a previous time. The NP was asked why didn't she delete the irrelevant information and keep Resident #1's current medications and current status. The NP stated that she didn't know why she didn't remove the information. The NP was made aware that she had dated and signed the medical progress note as being current for 01/09/22. The NP again stated that it was incorrect documentation and should have been removed from the note. The NP stated that she saw and assessed the resident on 01/09/22 after she was notified of the fall with injury on 01/09/22. The NP stated that she did not see Resident #1 at any time after 01/09/22 and did not get any calls or notifications of any concerns from staff regarding Resident #1 until around 9 or 10 on 01/13/22 and was told the resident was sleepy. The NP was asked if the resident was crying or in pain or showing any signs and symptoms of a need for the Xanax to be increased and scheduled around the clock. The NP stated, "She (Resident #1) did not have increased agitation or anxiety at the time of this note, Resident #1 was calm and shouldn't have been prescribed (Xanax) three times daily." The NP was asked if she had spoken with Resident #1's daughter regarding the resident's condition. The NP stated that she had not. The NP was asked if Resident #1 was exhibiting pain. The NP stated that Resident #1 did not appear to be in pain, except when she (NP) palpated the resident's head (hematoma). The NP was asked how Resident #1 could be prescribed and administered Xanax three times a day if the resident didn't need it. The NP stated, "I don't know, I'm very confused."

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On 02/16/22 at 3:00 PM, the corporate nurse was asked for assistance in locating a photocopy of the prescription for Resident #1 regarding the Xanax 0.25 mg three times daily.

On 02/16/22 at 4:28 PM, Resident #1's daughter was interviewed. The daughter was asked if the NP had spoken with her either in person or via phone regarding Resident #1 having increased agitation and anxiety. Resident #1's daughter stated neither the NP nor nursing staff person had not spoken to her regarding any medication changes or increased anxiety or agitation.

On 02/16/22 at 4:50 PM, the physician was interviewed regarding the concerns related to Resident #1 receiving an anti-anxiety medication three times daily with no clinical rationale and was asked if he had written a prescription for Xanax for Resident #1. The physician stated that you have to have an actual "script" to change that medication and stated that he did not know anything about it, and he never received any calls. The physician stated, "No, I didn't order. I would have faxed a script and I can't remember the last time I faxed a script for this facility."

On 02/16/22 at 5:10 PM, the pharmacy was called. The pharmacy tech #4 was interviewed and asked to find the prescription. The pharmacy tech #4 stated that the medication was last dispensed was on January 10th for Xanax 0.25 mg TID and 90 (pills). The pharmacy tech #4 stated that (Name of NP) is who wrote the order and a valid prescription was faxed on 6:26 PM on 01/10/22. The pharmacy tech #4 stated that there was not a diagnosis listed for what the medication was prescribed for.

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On 02/16/22 at approximately 5:30 PM, the corporate nurse presented a photocopy of the prescription. The prescription documented the name of Resident #1 and the date written (01/10/22) for Alprazolam 0.25 mg by mouth 1 tab TID dispense 90. The prescription had one refill and was signed by the NP.

On 02/16/22 at 5:45 PM, RN#3 was interviewed. RN #3 stated, "It was (Name of NP) that gave the order." RN #3 was made aware that the order was entered into the system by her and that it had the physician's name as the ordering provider. RN #3 stated, "I may have hit (Name of physician) instead of (Name of NP)." RN#3 was asked if she knew why the order was written. RN #3 stated, "(Name of Resident #1) cries a lot and had been crying..." RN #3 was asked why Resident #1 was crying and if she thought Resident #1 may have been in pain related to the fall with injury days prior. RN #3 stated, "I can't say if she was in pain, but she was crying a lot."

The ED (emergency department) provider note dated 01/14/22 at 11:22 AM documented, "Sent to the ER for evaluation of lethargy and mental status change since yesterday...Patient is on Xalrelto. It is reported that patient has been lethargic and sleeping all day since yesterday...report of a fall that occurred last week...Altered mental status, lethargy...patient non verbal, not following commands, lying on stretcher with eyes closed...Ecchymosis (bruises) to forehead and orbital left eye...A-fib at 100 bpm (beats per minute)...Trauma and CNS (central nervous system) failure or compromise...C1 anterior tubercle fracture, right and left posterior arch fracture of C1 with moderate distraction of fracture fragments, non-displaced fracture C3 left

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facet...left superior articular facet fracture of C2 extending into L (left) vertebral foramen, right impacted fracture of proximal femur...1:20 PM...awake, not following commands...opens eyes on own, pushes away noxious stimuli, moans, makes unintelligible sounds...Right forehead/scalp hematoma...Left peri-orbital ecchymosis...right forearm ecchymosis...HIP, LEG, FOOT: left withdrawals to pain...right...deformity right foot, right leg shortened, yellowing ecchymosis right knee, healing abrasions to right upper thigh...right hip fracture...trauma consulted...hold Xalrelto...C1-C3 fractures...right proximal femur displaced impacted fracture...

A progress note dated 01/14/22 and timed 12:19 PM documented, "...Summary for Providers...change in condition...food and/or fluid intake decreased or unable to eat/drink adequate amounts...Resident had the following medication changes in the past week: NONE...Resident is on anticoagulant: YES...Observed been sleepy and weak with poor appetite send to ER for further eval...send resident to hospital..."

On 02/16/22 at approximately 6:30 PM, the administrator, DON (director of nursing), and corporate nurse were made aware of the concerns related to Resident #1 receiving an increase in anti-anxiety medication after a fall with a head injury, and without clinical rationale or justification for the medication. Resident #1 had a decline over the course of several days after the medication was prescribed and administered and according to the NP she was not made aware of the changes documented by nursing staff and on 01/14/22 the resident was subsequently sent to the hospital for evaluation

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F 758	Continued From page 61 and admission. On 02/17/22 at 9:00 AM, the administrator, DON, and corporate nurse were again made aware of the concerns regarding Resident #1. The corporate nurse stated, "Last points, looking at this case, a lesson to be learned, but based on the information received, no documentation and no indication that the patient has injury beyond the bump or hematoma and transferred for something different." No further information was presented prior to the exit conference on 02/17/22.	F 758		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential	F 842		3/21/22

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all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

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F 842	Continued From page 63 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on family interview, staff interview, clinical record review, and in the course of a complaint investigation, the facility staff failed ensure a complete and accurate clinical record for one of 9 residents, Resident #1. Findings include: Resident #1 was admitted to the facility on 06/29/18, with the most current readmission on 12/24/21. The resident was discharged from the facility on 01/14/22 and did not return. Diagnoses for Resident #1 included, but were not limited to: Atrial fibrillation with long term anticoagulant therapy (Xalrelto 15 mg/milligrams daily), history of a stroke with right sided hemiparesis/hemiplegia, dysphagia, constipation, dementia, anxiety and depression The most recent full MDS (minimum data set) was an admission (5 day/annual) assessment dated 01/10/22. This MDS assessed the resident with long and short term memory impairment and severe impairment in daily decision making skills. Resident #1 was also assessed as requiring total assistance from at least one staff person for bed mobility, transfers, dressing, toileting, and extensive assistance for eating and hygiene. In Section E 0200. Behavior, Resident #1 was coded as not having any behaviors to include screaming or disruptive sounds during the seven day look back period. This MDS assessed that Resident #1 did not receive any anti-anxiety	F 842	F842 1. Resident #1 is no longer a resident in the center. 2. A review of NP progress notes for the last 30 days will be reviewed to ensure the information documented is current and accurate. 3. Medical Director/designee will educate the Nurse Practitioner(s) on writing and updating an electronic medical progress note and how to avoid automated noncurrent information in an electronic medical progress note. 4. The Medical Director/ designee will review 5 progress notes written by the NP weekly to ensure the documentation is up to date and accurate. 5. The results of the review will be discussed at the quarterly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be conducted on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. Date of compliance: 03/21/2022	

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medications in the previous seven day look back period.

Resident's #1's current POS (physician's order set) for January 2022 included orders for the following: "...Alprazolam (Xanax) tablet 0.25 mg Give one tablet by mouth every 24 hours as needed for Anxiety for 14 days (order date: 01/04/22...start date: 01/04/22)"

"...Alprazolam (Xanax) tablet 0.25. mg Give 1 tablet by mouth three times...(order date: 01/10/22...start date: 01/11/22)..."

Resident #1's current CCP (comprehensive care plan) for January 2022 documented, "...behavioral symptoms related to depression and anxiety: MONITOR FOR THE FOLLOWING: (crying, screaming and getting out of bed without assistance)...screams while in and also screams when out of bed...administer medications as ordered, monitor /document side effects and effectiveness...anticipate needs...uses psychotropic medications related to depression and anxiety...monitor for side effects, psych consult as needed, psychiatrist to review for gradual dose reduction...use alternatives to PRN medication...The resident is at risk for falls related to gait/balance problems/poor safety awareness...wheelchair for locomotion, pommel cushion for w/c (wheelchair) positioning...call light in reach...encourage resident to use...educate caregivers about safety reminders and what to do if a fall occurs...rounding and close monitoring...anticipate...meet the resident's needs...environment free of hazards...on anticoagulant therapy related to Atrial Fibrillation (created on 05/12/2020)...Lab work as ordered...meds as ordered...Monitor for bleeding

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such as unusual bruising, bloody or black tarry stool....pain...swelling...bleeding from eyes, gums, nose...report symptoms to MD...Observe for any signs/symptoms of bleeding related to anticoagulation therapy...SKIN: bruises to bilateral forearms, right head hematoma (revised on 01/09/22)..."

A "Geriatric Psychiatry" note dated 12/31/21 documented, "...hospitalized and returned...in part failed GDR (gradual dose reduction) of antidepressant...alert...dysfluent...expressive language problems...Xanax 0.25 (mg) PRN...Depression-stable, failed part GDR no med changes...dementia follow up done...recommend treatment as clearly described above...provided staff education...the facility will follow the recommendations outlined above...signature of mental health MD."

On 02/16/22 at 1:55 PM, the NP was interviewed and asked why Resident #1's anti-anxiety medication Alprazolam (Xanax) 0.25 mg had been changed from one tablet every 24 hours as needed to one tablet three times daily scheduled. The NP was made aware that according to progress notes Residednt #1 recently had a fall and sustained a head injury with bruising, and there was no documentation regarding Resident #1 having any behaviors, anxiety, agitation or aggression. The NP stated that she didn't know and stated that she didn't change the order and agreed stating, "That doesn't make sense" in regards to a medication increase.

On 02/16/22 at 2:28 PM, the NP was interviewed again regarding the resident's medication change. The NP was made aware that she had documented and referenced in a medical

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progress note dated 01/09/22 that Resident #1 was on scheduled Xanax three times a day and "alert and oriented x 1, increased agitation/anxiety (per daughter)..." The NP stated that the notes are auto fill and that information was probably in there from a previous time. The NP was asked why didn't she delete the irrelevant information and keep Resident #1's current medications and current status. The NP stated that she didn't know why she didn't remove the information. The NP was made aware that she had dated and signed the medical progress note as being current for 01/09/22. The NP again stated that it was incorrect documentation and should have been removed from the note. The NP stated that she saw and assessed the resident on 01/09/22 after she was notified of the fall with injury on 01/09/22. The NP stated that she did not see Resident #1 at any time after 01/09/22 and did not get any calls or notifications of any concerns from staff regarding Resident #1 until around 9 or 10 on 01/13/22 and was told the resident was sleepy. The NP was asked if the resident was crying or in pain or showing any signs and symptoms of a need for the Xanax to be increased and scheduled around the clock. The NP stated, "She (Resident #1) did not have increased agitation or anxiety at the time of this note, Resident #1 was calm and shouldn't have been prescribed (Xanax) three times daily." The NP was asked if she had spoken with Resident #1's daughter regarding the resident's condition. The NP stated that she had not. The NP was asked if Resident #1 was exhibiting pain. The NP stated that Resident #1 did not appear to be in pain, except when she (NP) palpated the resident's head (hematoma). The NP was asked how Resident #1 could be prescribed and administered Xanax three times a day if the

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resident didn't need it. The NP stated, "I don't know, I'm very confused." The NP again stated that the documentation that she signed on 01/09/22 was inaccurate documentation regarding Resident #1.

On 02/16/22 at 4:28 PM, Resident #1's daughter was interviewed. The daughter was asked if the NP had spoken with her either in person or via phone regarding Resident #1 having increased agitation and anxiety. Resident #1's daughter stated neither the NP nor nursing staff person had not spoken to her regarding any medication changes or increased anxiety or agitation.

On 02/16/22 at approximately 6:30 PM, the administrator, DON (director of nursing), and corporate nurse were made aware of the concerns regarding the NP's documentation for Resident #1 on 01/09/22. The NP stated the information she documented, dated and signed on 01/09/22, was inaccurate information for Resident #1. The administrator, DON, and corporate nurse were asked how you would know the resident's status if the NP stated that she assessed the resident and documented, but then then stated the information documented was incorrect? The administrator stated, "You don't."

On 02/17/22 at 9:00 AM, the administrator, DON, and corporate nurse were again made aware of the concerns regarding the NP documenting inaccurate information for Resident #1. No further information and/or documentation was presented prior to the exit conference on 02/17/22.