STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185006**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **08/26/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MORGANTOWN CARE & REHABILITATION CENTER	**201 SOUTH WARREN STREET MORGANTOWN, KY 42261**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0157

Level of harm - Immediate jeopardy

Residents Affected - Few

Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview, record review, facility policy and procedure review, and review of hospital records, it was determined the facility failed to consult with the resident's physician and notify the resident's interested family member, when there was an accident which resulted in injury and had the potential for requiring physician intervention for one (1) of three (3) sampled residents (Resident #1).

Resident #1, who was on blood thinners, sustained a fall on 08/06/16 at approximately 2:00 AM, which resulted in two (2) hematomas to the back of the head; however, Licensed Practical Nurse (LPN) #2 failed to notify the physician and family of the fall with injury per facility policy. In addition, Resident #1 complained of head pain at 3:00 AM when he/she was administered pain medication and was still complaining of head pain and requesting an ice pack at 4:15 AM. However, the nurse did not follow facility policy, and notify the physician that the resident's pain medication was ineffective. At approximately 6:15 AM-6:30 AM, Resident #1 was found unresponsive with his/her pupils fixed. Resident #1 was transported to the hospital and diagnosed with [REDACTED]. The resident passed away at approximately 11:23 PM.

Immediate Jeopardy (IJ) was identified on 08/16/16 and was determined to exist on 08/06/16. The facility was notified of the Immediate Jeopardy (IJ) on 08/16/16. An acceptable Allegation of Compliance (AoC) was received on 08/23/16, alleging the removal of the Immediate Jeopardy (IJ) on 08/17/16. The State Survey Agency validated, on 08/26/16, that the Immediate Jeopardy (IJ) was removed on 08/17/16, as alleged. The Scope and Severity was lowered to a D while the facility develops and implements the Plan of Correction (PoC) and the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes.

The findings include:

Review of the facility's Falls policy and procedures, last revised 06/01/16, revealed if a fall occurs staff should notify the physician and family.

Review of the facility's Pain Management policy and procedure, not dated, revealed staff should determine the degree of relief experienced from pain medication by reassessing pain one (1) hour after administration. When pain medication is ineffective, evaluate pain, and communicate to the physician.

Record review revealed the facility admitted Resident #1 on 03/15/12 with [DIAGNOSES REDACTED]. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 06/09/16, revealed the facility assessed Resident #1's cognition as intact with a Brief Interview of Mental Status (BIMS) score of fifteen (15) which indicated the resident was interviewable. In addition, review of the August 2016 physician's orders [REDACTED].

Review of Resident #1's Nursing Assessment revealed he/she sustained a fall on 08/06/16 at 2:00 AM. Resident #1 was observed sitting on the floor in the bathroom and had two (2) hematomas on the back of his/her head. The Assessment stated he/she hit his/her head on the floor. Further review of the Assessment revealed the physician was made aware of the fall; however, the notification only consisted of Licensed Practical Nurse (LPN) #2 placing the incident report on the physician's clipboard for reports to be taken to him the next day instead of calling and notifying him at the time of the fall, per facility policy.

Interviews on 08/12/16 with Certified Nurse Aide (CNA) #1 at 9:15 AM and CNA #2 at 11:15 AM, revealed she and CNA #2 heard a noise and found Resident #1 on the floor in the doorway of the bathroom with his/her legs toward the resident's room. The CNAs stated the resident had two (2) hematomas (size of golf balls) on the back of his/her head, blood was running down the resident's neck onto the floor, and the resident was complaining of his/her head hurting.

Interview with CNA #4, on 08/12/16 at 12:10 PM revealed she arrived at work on 08/06/16 at 2:00 AM to relieve CNA #2. She stated CNA #2 and CNA #1 reported to her that Resident #1 had fallen and had two (2) hematomas to the back of the head. CNA #4 stated she was in Resident #1's room at approximately 3:00 AM and she noted blood in the resident's hair, and the resident complained of head pain so she made the nurse aware. She further stated when she entered Resident #1's room at approximately 4:00 AM to 4:15 AM, the resident stated the nurse had given him/her a pain pill but his/her head was still hurting. CNA #4 stated the resident asked her to get a bag of ice. She stated she wrapped the ice in a pillowcase, and the resident laid down with the ice on his/her head. CNA #4 stated she reported this to LPN #2. She stated the next time she went into Resident #1's room was at 6:15 AM, when giving report to CNA #3 and they found the resident unresponsive. She stated they immediately notified the nurses and the resident was sent out to the hospital.

Review of Resident #1's Narcotic Count for [MEDICATION NAME] 7.5 mg/325 mg revealed the resident was administered [MEDICATION NAME] on 08/06/16 at 3:00 AM. However, review of the August 2016 Electronic Medication Administration Record
[REDACTED].

Interview with LPN #2, on 08/12/16 at 10:20 AM, revealed Resident #1 was found on the floor in the bathroom on 08/06/16. She stated when she assessed the resident; the resident had two (2) bumps on the back of the head down by his/her neck and blood on neck. LPN #2 stated the resident's neuro-checks and vital signs were good, but the resident complained of a small headache. Further interview revealed LPN #2 did not follow the facility's policy and procedures as she did not call the physician or the family to make them aware of the resident's fall. She stated she placed the incident report on the physician's clipboard to be delivered to him during the day and she did not call the family because the resident was his/her own responsible party. In addition, LPN #2 stated she administered pain medication at 3:00 AM due to the resident complaining of head pain and thought she recorded it in the computer. She stated she did not recall if she followed up on the pain medication. Further interview with LPN #2 on 08/16/16 at 2:10 PM revealed she was not made aware the CNA gave ice to the resident to put on his/her head and that the resident was still complaining of pain. However, review of the Neurological Evaluation Flow Sheet revealed LPN #2 conducted a neurocheck on Resident #1 on 08/06/16 at 4:45 AM.

Review of a Nursing Note, dated 08/06/16 at 6:08 AM, and interviews on 08/12/16 with LPN #3 at 11:00 AM and Registered Nurse (RN) #1 at 12:40 PM, revealed they were informed by CNAs that Resident #1 was unresponsive. They stated RN #1 did a sternal rub on the resident with no response and when they checked the resident's pupils they were fixed (did not react to light). The resident's oxygen saturation (O2 sat) level was 89%, (normal = 95% to 100%) the resident was placed on oxygen at 2 liters a minute and the resident's O2 sat increased to 96%. Further interview revealed LPN #3 called Emergency Medical Services (EMS). LPN #3 and RN #1 stated the resident's physician should have been notified of the fall at the time of the fall especially since the resident had head injuries and was on blood thinners. In addition, they stated the physician should have been notified that the pain medication was not effective.

Review of the Hospital Records, dated 08/06/16, revealed Resident #2 was seen in the emergency room and intubated. The resident was diagnosed with [REDACTED]. The resident's family withdrew care and the resident was placed on comfort measures

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

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

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NAME OF PROVIDER OF SUPPLIER **MORGANTOWN CARE & REHABILITATION CENTER**		STREET ADDRESS, CITY, STATE, ZIP **201 SOUTH WARREN STREET MORGANTOWN, KY 42261**	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) until the resident passed away on 08/06/16 at 11:23 PM. Interviews on 08/12/16 at 11:00 AM with LPN #3; on 08/12/16 at 12:40 PM with RN #1; on 08/16/16 at 2:50 PM with the Assistant Director of Nursing (ADON); and, on 08/16/16 at 2:55 PM with LPN #5 and LPN #6, revealed it was the facility's policy to notify the physician and family immediately when a resident had a fall with injury. In addition, they stated licensed staff should follow up on as needed pain medication one (1) hour after it was administered to determine if it was effective. Further interview revealed the physician should be notified if the pain medication was not effective. Interview with the Director of Nursing (DON), on 08/12/16 at 3:10 AM and on 08/16/16 at 3:10 PM, revealed she expected the nurse to notify the physician and family after a fall. She stated she also expected the nurse to assess the resident after administering an as needed pain medication to determine if it was effective or not. She stated if the pain medication was not effective the physician would need to be contacted for further orders. Interview, on 08/15/16 at 10:05 AM, with Resident #1's attending Physician, who is also the facility's Medical Director, revealed he would have expected the nurse to make him or the on call physician aware of the fall especially since the resident had a head injury and he/she was on blood thinners. He stated he would have sent the resident out to the hospital for a Computer Topography (CT) scan of the head. He stated because the resident was on a blood thinner he/she was at a higher risk of a subdural hematoma. Interview with the Administrator on 08/16/16 at 3:25 PM, revealed she expected the nurses to notify the physician and family by phone immediately after a fall. She stated she also expected them to follow the facility's policy related to determining the effectiveness of pain medication and physician notification. The facility implemented the following actions to remove the Immediate Jeopardy: 1. The DON conducted an investigation of Resident #1's fall and identified LPN #2 failed to notify the physician and family at the time of the fall. It was also identified that the neuro evaluations were not completed according to the facility's Neurological Assessment/Monitoring Procedure. 2. A Disciplinary Action for LPN #2 was completed by the DON on 08/08/16. On 08/09/16, LPN #2 requested Family Medical Leave. 3. On 08/08/16, the Administrator met with the Medical Director, who was the attending physician for Resident #1. A plan was formulated for Charge Nurses to notify a resident's physician immediately when a resident has an unwitnessed fall and/or has a potential head injury and is receiving anticoagulant therapy. The resident is to be sent to the emergency room for evaluation and treatment. 4. On 08/12/16, current resident charts who had falls for the past four (4) months (from May-August 2016) were audited by the ADON, reviewing falls, fall interventions, care plans, fall assessments, physician and family notifications. Corrections were completed as indicated by the ADON. 5. Immediate education was initiated with licensed nurses on 08/08/16 by the Staff Development Coordinator (SDC) regarding completion of the Event Manager, location of the BIMS score, using an appropriate intervention after each incident, notification of the physician and responsible party with every fall/incident without injury. This education was completed on 08/11/16; and, no licensed nurse worked prior to receiving this education. 6. On 08/12/16, the Regional Nurse Consultant (RNC) completed a competency, the Resident Examination and Assessment Competency, with the DON. On 08/13/16, the RNC also conducted a competency, the Resident Examination and Assessment Competency, with the SDC and two (2) ADONs. 7. The SDC and two (2) ADONs conducted education with the Licensed Nurses which included PRN, Part time and full time nurses on 08/13/16 through 08/15/16 . The education was related to the facilty's policy and procedure for falls, neurological evaluation flow sheet, Event Manager, transcription on physician's orders [REDACTED]. No licensed staff worked prior to receiving this education. In addition, the Resident Examination and Assessment Competency, was completed by the SDC and two ADONs with each licensed nurse. 8. On 08/08/16, the process was initiated to notify the physician, responsible party, and On Call Administrative Nurse with every fall/incident with or without injury. 9. Beginning 08/13/16, the Interdisciplinary Team (IDT) to include but not limited to the DON, ADONs, MDS Coordinators, Medical Records Nurse, Quality of Life Director, Chaplain, Social Service Director, Social Service Assistant, Dietary Manager, and Therapy Manager, will review in the morning clinical meeting (Monday through Friday) telephone orders, change in condition, twenty-four (24) hour report, and medical records of residents to ensure timely notification, of physician and family occurred and any changes in the resident's condition were addressed timely. The RNC has been attending the meeting since 08/12/16 assisting and providing oversight and consultation. On weekends, the Administrative Nurse will be assigned to review telephone orders, SBARS (Situation, Background, and Assessment Recommendations), twenty four (24) hour reports, and medical records of residents to ensure timely notification of physician and family and any changes in resident condition were addressed timely. 10. Beginning 08/13/16, ten (10) residents charts will be audited daily by the Nursing Administration Team (DON, Unit Mangers, SDC, and MDS Coordinators and the Restorative Nurse Manager) for timely physician and family notification, change in condition being addressed, SBARs, telephone orders, and twenty-four (24) hour reports, and documentation being present, until immediacy is lifted. Then five (5) charts per day, five (5) days a week, will be checked for two (2) weeks, and then five (5) charts per week for two (2) weeks. Any issues identified will be addressed at the time of discovery. Results of the audits will be discussed in Quality Assurance Performance Improvement (QAPI) meeting. 11. Administrative oversight will be completed by the Vice President for Operations or RNC, daily until removal of immediacy beginning 08/11/16, then weekly for four (4) weeks, then monthly for six (6) months, to ensure the above audits are completed and any concerns are addressed. Oversight includes assisting with audits, reviewing charts, reviewing audits and providing oversight and consultation. 12. A QA Meeting was held on 08/08/16 with the Medial Director by phone, and an Ad Hoc QAPI meeting was held on 08/15/16 with the Medical Director, Administrator, DOM, RNC, ADONs, SDC, Chaplain, MDS Coordinators, Social Service Director, Human Resource Director, and Medical Records Coordinator were in attendance reviewing the occurrence of Resident #1 and immediate plans put in place. 13. A QAPI meeting will be held weekly until the immediacy has been removed, then monthly for six (6) months for recommendations and further follow up regarding the above stated plan. At that time based on the evaluation, the QAPI Committee will determine at what frequency any ongoing audits will need to continue. 14. Corporate Administrative oversight of the QAPI meeting will be completed by the RNC, Director of Clinical Programs, the Regional Vice President of Operations, or member of the regional staff weekly until removal of the immediacy, then weekly for four (4) weeks, and then monthly for six (6) months. **The State Survey Agency validated the corrective actions taken by the facility as follows: 1. Review of the facility's investigation, not dated, revealed the DON determined LPN #2 failed to conduct neurochecks according to facility policy and failed to notify the physician and family after the resident's fall. Interview with the DON, on 08/26/16 at 11:55 AM revealed she conducted the investigation into Resident #1's fall. She stated she identified LPN #2 had failed to conduct the neurochecks per facility policy and failed to notify the physician and family of the resident's fall. 2. Review of a Disciplinary Action, dated 08/08/16, revealed LPN #2 was counseled by the DON related to insufficient documentation on the Event Report, notification of the physician and family after a fall, and completion of neurochecks per facility policy. Review of a letter, dated 08/09/16 revealed LPN #2 requested Family Medical Leave (FML) with the Human Resource Manager. LPN #2 was placed on FML on 08/09/16. Interview with the DON, on 08/26/16 at 11:55 AM revealed she counseled LPN #2 on her failure to complete the Event Report filling in all blanks, notification of physician and family after a fall, and conducting neurochecks at the appropriate timeframes and using accurate documentation on the form. The DON stated LPN #2 requested FML and it was granted on 08/09/16. 3. Review of a Communication Form per SDC, dated 08/08/16, revealed with every fall/incident with or without injury, the Administrative Nurse, Physician, and the resident's Power of Attorney or family member would be notified. Anytime a resident has a fall with head injury, the resident is to be sent to hospital. The staff signature sheet revealed all licensed staff read the communication sheet between 08/08/16-08/11/16. Interview with the SDC, on 08/26/16, at 11:40 AM, revealed she provided the education on 08/08/16 related to notification of the Administrative Nurse, Physician and the resident's Power of Attorney or family member when a resident had a fall with

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F 0157

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 2)
or without injury. In addition, staff were educated that anytime a resident has a fall with head injury to send the resident to the hospital for evaluation.
Interviews on 08/26/16 with LPN #7 at 9:30 AM, LPN #8 at 10:40 AM, LPN #5 at 10:55 AM, RN #1 at 11:00 AM, LPN #4 at 11:25 AM
and LPN #9 at 12:00 PM, revealed they were educated on 08/08/16 that when a resident had a fall the to notify the physician, family or POA, and Administrative Nurse. In addition, they stated they should send a resident who had a fall with head injury out to the hospital for evaluation.
4. Review of the Event Reports for May-August 2016 revealed they were reviewed by the ADON on 08/12/16. The ADON identified there were falls where there was no documentation the family had been notified of the falls. Further review revealed each of the families was notified of the fall on 08/12/16 by the Nursing Administrative Team.
Interview with the ADON on 08/26/16 at 10:30 AM, revealed she reviewed the event reports for four (4) months (May-August 2016) to determine if the physician and family/POA had been notified of the fall. She stated she identified that some families had not been notified. The Nursing Administrative Teams notified the families on 08/12/16.
5. Review of the Communication Form, dated 08/08/16, revealed the SDC initiated education on 08/08/16 to all licensed staff regarding completion of the Event Manager, location of the BIMS score, using an appropriate intervention after each incident, notification of the physician and responsible party with every fall/incident with or without injury. This education was completed on 08/11/16 and no licensed nurse worked prior to receiving this education.
Interview with the SDC, on 08/26/16, at 11:40 AM, revealed she provided education to all licensed staff on 08/08/16-08/11/16 on completion of the Event Manager, using an appropriate intervention after each incident, and notification of the physician and responsible party with every fall/incident with or without injury.
Interviews on 08/26/16 with LPN #7 at 9:30 AM, LPN #8 at 10:40 AM, LPN #5 at 10:55 AM, RN #1 at 11:00 AM, LPN #4 at 11:25 AM
and LPN #9 at 12:00 PM, revealed the SDC educated them on ensuring an appropriate intervention was put in place after each fall, and notification of the physician and family/POA with every fall with or without injury.
6. Review of the Resident Examination and Assessment Competencies revealed the DON completed the competency on 08/12/16 and the SDC and two (2) ADONs completed the competencies on 08/13/16 with the RNC.
Interview with the RNC on 08/26/16 revealed she conducted Resident Examination and Assessment Competencies for the DON, SDC and ADONs.
Interviews on 08/26/16 with the SDC at 11:40 AM, and DON at 11:55 AM, revealed they had to complete Resident Examination and Assessment Competencies with the RNC.
7. Review of the Communication Form revealed the SDC and two (2) ADONs conducted education with the Licensed Nurses on 08/13/16 through 08/15/16 regarding policy and procedure for falls, neurological evaluation flow sheet, Event Manager, transcription of Physician Orders, education on narcotic sheets, physician and family notification with every incident, fall interventions, updating the care plans, and post fall assessment. No licensed staff worked prior to receiving this education. In addition, review of the Resident Examination and Assessment Competencies revealed the licensed nurses completed the competencies with the SDC and two (2) ADONs from 08/13/16 through 08/25/16. No licensed nurse worked until their competency was completed.
Interview with the SDC, on 08/26/16, at 11:40 AM, revealed she and the ADONs provided education to all licensed staff on 08/13/16-08/15/16 related to falls, neurochecks, narcotic sheets, physician and family notification, and updating care plans. She stated she had to come in over a weekend to check the licensed staff off on completing the Resident Examination and Assessment Competencies.
Interviews on 08/26/16 with LPN #7 at 9:30 AM, LPN #8 at 10:40 AM, LPN #5 at 10:55 AM, RN #1 at 11:00 AM, LPN #4 at 11:25 AM
and LPN #9 at 12:00 PM, revealed they were educated on how to conduct the neuro checks per the facility's policy, post fall assessments, how to complete the incident in the Event Manager, narcotic sheets, physician and family notification with every incident, updating care plan with appropriate interventions, and the policy and procedure for falls. They all stated they had to come in on the weekend to complete a Resident Examination and Assessment Competency.
8. Review of a Communication Form completed by the SDC, dated 08/08/16, revealed with every fall/incident with or without injury, the Administrative Nurse, Physician, and the resident's Power of Attorney or family member would be notified. Anytime a resident has a fall with head injury, the resident is to be sent to hospital. The staff signature sheet revealed all licensed staff read the communication sheet between 08/08/16-8/11/16.
Interview with the SDC, on 08/26/16 at 11:40 AM, revealed she educated licensed staff to notify the Administrative Nurse, Physician, and resident's family/POA when a resident had a fall and sustained a head injury to send the resident to the hospital for evaluation.
Interviews on 08/26/16 with LPN #7 at 9:30 AM, LPN #8 at 10:40 AM, LPN #5 at 10:55 AM, RN #1 at 11:00 AM, LPN #4 at 11:25 AM
and LPN #9 at 12:00 PM, revealed they had been educated that with every fall/incident, they should notify the physician, family/POA and Administrative Nurse and anytime a resident had a fall with a head injury to send him/her out to the hospital.
9. Review of the Clinical Whiteboard Meeting Notes revealed a review was completed for falls and physician notifications daily from 08/13/16-08/25/16 by the IDT team. Further review revealed the Administrative Nurse conducted the reviews on weekends. The RNC and/or Vice President for Operations were present every day for the meeting since 08/12/16.
Interviews on 08/26/16 with the DON at 11:55 AM and the RNC at 12:10 PM revealed they had been providing oversight in the daily Whiteboard Meeting with the IDT looking at new orders, falls, assessments, notification, and documentation. The RNC stated she or the Vice President for Operations had been present every day since 08/12/16.
10. Review of Chart Audit Compliance Forms, revealed ten (10) residents' charts were audited by the Nursing Administrative Team daily from 08/13/16 through 08/25/16.
Interview with the DON on 08/26/16 at 11:40 AM, revealed she was ensuring the Nursing Administrative Team was conducting ten (10) chart audits daily to ensure licensed staff were notifying the physician and family timely, change in conditions were being addressed, and documentation was completed. She stated once the IJ was removed they would continue to audit five (5) charts per day, five (5) days a week, for two (2) weeks, and then five (5) charts per week for two (2) weeks
11. Review of the Regional Staff Attendance Record revealed the RNC and/or Vice President for Operations were at the facility daily to provide oversight and consultation.
Interview with the RNC, on 08/26/16 at 12:10 PM revealed she would continue oversight and consultation until the removal of immediacy. Then oversight would be provided weekly for four (4) weeks, then monthly for six (6) months, to ensure the above audits were completed and any concerns were addressed.
12. Review of a note written by the Administrator revealed she spoke to the Medical Director on 08/08/16 and he suggested sending out residents who had a fall that with a head injury to the hospital for a CT scan.
Interview with the Medical Director on 08/15/16 at 10:05 AM, revealed he was at the facility on 08/08/16 and reviewed the resident's record and the facility's investigation. He stated he suggested sending residents out who had had a fall with a head injury to the hospital for a CT scan.
13. Review of a Sign In Sheets revealed a QAPI meeting was held on 08/15/16 and 08/22/16 for recommendations and further follow up regarding the above stated plan.
14. Interview with the RNC on 08/26/16 at 12:10 PM revealed she was present for the QAPI Meetings on 08/15/16 and 08/22/16.

F 0282

Level of harm - Immediate jeopardy

Residents Affected - Few

Provide care by qualified persons according to each resident's written plan of care.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on interview, record review, facility policy and procedure review and review of hospital records, revealed the facility failed to provide care in accordance with one (1) of three (3) sampled residents' written plan of care (Resident #1).
Resident #1, who was on [MEDICATION NAME] (blood thinner) sustained a fall on 08/06/16 at 2:00 AM which resulted in two (2) hematomas to the back of the head. However, the facility failed to notify the resident's physician and responsible party per the resident's care plan. In addition, Licensed Practical Nurse (LPN) #2 administered Resident #1 pain medication at 3:00 AM, but she failed to follow the care plan and assess the resident's head pain one (1) hour after the medication was administered to determine if it was effective. Resident #1 was found in bed unresponsive at 6:15 AM and sent to the emergency room . The resident was diagnosed with [REDACTED].
Immediate Jeopardy (IJ) was identified on 08/16/16 and was determined to exist on 08/06/16. The facility was notified of the

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F 0282

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 3)
Immediate Jeopardy (IJ) on 08/16/16. An acceptable Allegation of Compliance (AoC) was received on 08/23/16, alleging the removal of the Immediate Jeopardy (IJ) on 08/17/16. The State Survey Agency validated, on 08/26/16, that the Immediate Jeopardy (IJ) was removed on 08/17/16, as alleged. The Scope and Severity was lowered to a D while the facility develops and implements the Plan of Correction (PoC) and the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes.
The findings include:
Review of the facility's policy and procedures Care Plans-Comprehensive, last revised 06/01/15, revealed the Nurse/Interdisciplinary Team, in coordination with the resident, his/her family or responsible party, develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. Care plan interventions are implemented and the care plan identifies the professional services that are responsible for each element of care.
Record review revealed the facility admitted Resident #1 on 03/15/12 with diagnoses, which included [MEDICAL CONDITION], Chronic Back Pain, Restless Leg Syndrome, and [MEDICAL CONDITION]. Review of the Significant Change Minimum Data Set (MDS)
Assessment, dated 06/09/16, revealed the facility assessed Resident #1's cognition as intact with a Brief Interview of Mental Status (BIMS) score of fifteen (15) which indicated the resident was interviewable.
Review of the Comprehensive Care Plan for risk of pain and falls, last updated 06/21/16, revealed to monitor for any sign and symptoms of pain (crying, grimacing, moaning, guarding, complaints of pain, restlessness, or change in behavior), administer medication as ordered, monitor for effectiveness of pain medication and report falls to physician and responsible party.
Review of the August 2016 physician's orders [REDACTED].
Review of a Nursing Assessment for Resident #1 completed by Licensed Practical Nurse (LPN) #2, revealed the resident sustained [REDACTED]. Resident #1 was observed sitting on the floor in the bathroom and had two (2) hematomas on the back of his/her head. The resident stated he/she hit his/her head on the floor. Further review of the Assessment, revealed a neurological assessment was completed, which was within normal parameters and the resident had no pain. However, interviews on 08/12/16 with LPN #2 at 10:20 AM, CNA #1 at 9:15 AM, and CNA #2 at 11:15 AM, revealed the resident complained his/her head hurt at the time of the fall. Review of Resident #1's August 2016 Electronic Medication Administration Record (EMAR) revealed there was no evidence the resident was administered pain medication per the care plan at the time of the fall.
Further review of the Nursing Assessment revealed LPN #2 documented she notified the physician of the fall and documented the resident was aware of fall. However, interview with LPN #2 on 08/12/16 at 10:20 AM, revealed when she referred to notifying the physician she just placed the incident report on the resident's clipboard for him to see the next day, she did not call him. She also stated she documented self for family notification because the resident did not have a Power of Attorney for decision making. LPN #2 failed to notify the physician and family of the fall per care plan.
Interview with CNA #4, on 08/12/16 at 12:10 PM, revealed when she arrived at work on 08/06/16 at 2:00 AM it was reported to her Resident #1 had fallen and had two (2) hematomas on the back of his/her head. CNA #4 stated when she was in Resident #1's room at approximately 3:00 AM, the resident complained of head pain so she made the nurse aware. She stated when she entered Resident #1's room at approximately 4:00 AM to 4:15 AM, the resident stated the nurse had given him/her a pain pill but his/her head was still hurting. CNA #4 stated the resident asked her to get a bag of ice, she wrapped the ice in a pillowcase, and the resident laid down with the ice on his/her head. CNA #4 stated she reported this to LPN #2.
Interview with LPN #2, on 08/12/16 at 10:20 AM, revealed Resident #1 was found on the floor in the bathroom on 08/06/16 and had two (2) bumps on the back of his/her head down by neck and blood on neck. LPN #2 stated the resident complained of a small headache but no pain medication was administered at that time. She stated she did administer pain medication at 3:00 AM when the CNA reported the resident was complaining of head pain. LPN #2 stated she did not recall if she followed up on the pain medication per the resident's care plan. Further interview with LPN #2 on 08/16/16 at 2:10 AM revealed she was not made aware the CNA gave ice to the resident to put on his/her head and that the resident was still complaining of pain at 4:15 AM.
Review of Resident #1's Narcotic Count for [MEDICATION NAME] 7.5 mg/325 mg revealed the resident was administered [MEDICATION NAME] on 08/06/16 at 3:00 AM. However, review of the August 2016 MAR and Resident #1's Pain Flow Sheet revealed
there was no documented evidence LPN #2 followed the resident's care plan and monitored for the effectiveness of the pain medication.
Review of a Nursing Note, dated 08/06/16 at 6:08 AM, and interviews on 08/12/16 with LPN #3 at 11:00 AM and Registered Nurse (RN) #1 at 12:40 PM, revealed LPN #3 and RN #1 were informed by CNAs that Resident #1 was unresponsive. LPN #3 and RN #1 stated Resident #1 did not respond to sternal rub and his/her pupils were fixed (did not react to light). LPN #3 called Emergency Medical Services (EMS). LPN #3 and RN #1 stated the resident's physician should have been notified of the fall at the time of the fall especially since the resident had head injuries and was on blood thinners. In addition, they stated the physician should have been notified if the pain medication was not effective.
Review of the hospital emergency room Report and Discharge Summary, dated 08/06/16 revealed the resident was placed on a respirator and passed away at 11:23 PM. The resident was diagnosed with [REDACTED].
Interviews on 08/16/16 with the Assistant Director of Nursing (ADON) at 2:50 PM, and LPN #5 and LPN #6 at 2:55 PM, revealed staff were expected to follow the care plans.
Interview with the Director of Nursing (DON) on 08/16/16 at 3:10 PM revealed staff should be familiar with each resident's care plan and follow the care plan for the resident.
The facility implemented the following actions to remove the Immediate Jeopardy:
1. The DON conducted an investigation of Resident #1's fall and identified LPN #2 failed to notify the physician and family at the time of the fall. It was also identified that the neuro evaluations were not completed according to the facility's Neurological Assessment/Monitoring Procedure.
2. A Disciplinary Action for LPN #2 was completed by the DON on 08/08/16. On 08/09/16, LPN #2 requested Family Medical Leave.
3. On 08/08/16, the Administrator met with the Medical Director, who was the attending physician for Resident #1. A plan was formulated for Charge Nurses to notify a resident's physician immediately when a resident has an unwitnessed fall and/or has a potential head injury and is receiving anticoagulant therapy. The resident is to be sent to the emergency room for evaluation and treatment.
4. On 08/12/16, current resident charts who had falls for the past four (4) months (from May-August 2016) were audited by the ADON, reviewing falls, fall interventions, care plans, fall assessments, physician and family notifications. Corrections were completed as indicated by the ADON.
5. Immediate education was initiated with licensed nurses on 08/08/16 by the Staff Development Coordinator (SDC) regarding completion of the Event Manager, location of the BIMS score, using an appropriate intervention after each incident, notification of the physician and responsible party with every fall/incident without injury. This education was completed on 08/11/16; and, no licensed nurse worked prior to receiving this education.
6. On 08/12/16, the Regional Nurse Consultant (RNC) completed a competency, the Resident Examination and Assessment Competency, with the DON. On 08/13/16, the RNC also conducted a competency, the Resident Examination and Assessment Competency, with the SDC and two (2) ADONs.
7. The SDC and two (2) ADONs conducted education with the Licensed Nurses which included PRN, Part time and full time nurses on 08/13/16 through 08/15/16 . The education was related to the facilty's policy and procedure for falls, neurological evaluation flow sheet, Event Manager, transcription on physician's orders [REDACTED]. No licensed staff worked prior to receiving this education. In addition, the Resident Examination and Assessment Competency, was completed by the SDC and two ADONs with each licensed nurse.
8. On 08/08/16, the process was initiated to notify the physician, responsible party, and On Call Administrative Nurse with every fall/incident with or without injury.
9. Beginning 08/13/16, the Interdisciplinary Team (IDT) to include but not limited to the DON, ADONs, MDS Coordinators, Medical Records Nurse, Quality of Life Director, Chaplain, Social Service Director, Social Service Assistant, Dietary Manager, and Therapy Manager, will review in the morning clinical meeting (Monday through Friday) telephone orders, change in condition, twenty-four (24) hour report, and medical records of residents to ensure timely notification, of physician and family occurred and any changes in the resident's condition were addressed timely. The RNC has been attending the

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MORGANTOWN CARE & REHABILITATION CENTER	**201 SOUTH WARREN STREET MORGANTOWN, KY 42261**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0282

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 4)
meeting since 08/12/16 assisting and providing oversight and consultation. On weekends, the Administrative Nurse will be assigned to review telephone orders, SBARS (Situation, Background, and Assessment Recommendations), twenty four (24) hour reports, and medical records of residents to ensure timely notification of physician and family and any changes in resident condition were addressed timely.
10. Beginning 08/13/16, ten (10) residents charts will be audited daily by the Nursing Administration Team (DON, Unit Mangers, SDC, and MDS Coordinators and the Restorative Nurse Manager) for timely physician and family notification, change in condition being addressed, SBARs, telephone orders, and twenty-four (24) hour reports, and documentation being present, until immediacy is lifted. Then five (5) charts per day, five (5) days a week, will be checked for two (2) weeks, and then five (5) charts per week for two (2) weeks. Any issues identified will be addressed at the time of discovery. Results of the audits will be discussed in Quality Assurance Performance Improvement (QAPI) meeting.
11. Administrative oversight will be completed by the Vice President for Operations or RNC, daily until removal of immediacy beginning 08/11/16, then weekly for four (4) weeks, then monthly for six (6) months, to ensure the above audits are completed and any concerns are addressed. Oversight includes assisting with audits, reviewing charts, reviewing audits and providing oversight and consultation.
12. A QA Meeting was held on 08/08/16 with the Medial Director by phone, and an Ad Hoc QAPI meeting was held on 08/15/16 with the Medical Director, Administrator, DOM, RNC, ADONs, SDC, Chaplain, MDS Coordinators, Social Service Director, Human Resource Director, and Medical Records Coordinator were in attendance reviewing the occurrence of Resident #1 and immediate plans put in place.
13. A QAPI meeting will be held weekly until the immediacy has been removed, then monthly for six (6) months for recommendations and further follow up regarding the above stated plan. At that time based on the evaluation, the QAPI Committee will determine at what frequency any ongoing audits will need to continue.
14. Corporate Administrative oversight of the QAPI meeting will be completed by the RNC, Director of Clinical Programs, the Regional Vice President of Operations, or member of the regional staff weekly until removal of the immediacy, then weekly for four (4) weeks, and then monthly for six (6) months.
**The State Survey Agency validated the corrective actions taken by the facility as follows:
1. Review of the facility's investigation, not dated, revealed the DON determined LPN #2 failed to conduct neurochecks according to facility policy and failed to notify the physician and family after the resident's fall.
Interview with the DON, on 08/26/16 at 11:55 AM revealed she conducted the investigation into Resident #1's fall. She stated she identified LPN #2 had failed to conduct the neurochecks per facility policy and failed to notify the physician and family of the resident's fall.
2. Review of a Disciplinary Action, dated 08/08/16, revealed LPN #2 was counseled by the DON related to insufficient documentation on the Event Report, notification of the physician and family after a fall, and completion of neurochecks per facility policy. Review of a letter, dated 08/09/16 revealed LPN #2 requested Family Medical Leave (FML) with the Human Resource Manager. LPN #2 was placed on FML on 08/09/16.
Interview with the DON, on 08/26/16 at 11:55 AM revealed she counseled LPN #2 on her failure to complete the Event Report filling in all blanks, notification of physician and family after a fall, and conducting neurochecks at the appropriate timeframes and using accurate documentation on the form. The DON stated LPN #2 requested FML and it was granted on 08/09/16.
3. Review of a Communication Form per SDC, dated 08/08/16, revealed with every fall/incident with or without injury, the Administrative Nurse, Physician, and the resident's Power of Attorney or family member would be notified. Anytime a resident has a fall with head injury, the resident is to be sent to hospital. The staff signature sheet revealed all licensed staff read the communication sheet between 08/08/16-08/11/16.
Interview with the SDC, on 08/26/16, at 11:40 AM, revealed she provided the education on 08/08/16 related to notification of the Administrative Nurse, Physician and the resident's Power of Attorney or family member when a resident had a fall with or without injury. In addition, staff were educated that anytime a resident has a fall with head injury to send the resident to the hospital for evaluation.
Interviews on 08/26/16 with LPN #7 at 9:30 AM, LPN #8 at 10:40 AM, LPN #5 at 10:55 AM, RN #1 at 11:00 AM, LPN #4 at 11:25 AM
and LPN #9 at 12:00 PM, revealed they were educated on 08/08/16 that when a resident had a fall the to notify the physician, family or POA, and Administrative Nurse. In addition, they stated they should send a resident who had a fall with head injury out to the hospital for evaluation.
4. Review of the Event Reports for May-August 2016 revealed they were reviewed by the ADON on 08/12/16. The ADON identified there were falls where there was no documentation the family had been notified of the falls. Further review revealed each of the families was notified of the fall on 08/12/16 by the Nursing Administrative Team.
Interview with the ADON on 08/26/16 at 10:30 AM, revealed she reviewed the event reports for four (4) months (May-August 2016) to determine if the physician and family/POA had been notified of the fall. She stated she identified that some families had not been notified. The Nursing Administrative Teams notified the families on 08/12/16.
5. Review of the Communication Form, dated 08/08/16, revealed the SDC initiated education on 08/08/16 to all licensed staff regarding completion of the Event Manager, location of the BIMS score, using an appropriate intervention after each incident, notification of the physician and responsible party with every fall/incident with or without injury. This education was completed on 08/11/16 and no licensed nurse worked prior to receiving this education.
Interview with the SDC, on 08/26/16, at 11:40 AM, revealed she provided education to all licensed staff on 08/08/16-08/11/16 on completion of the Event Manager, using an appropriate intervention after each incident, and notification of the physician and responsible party with every fall/incident with or without injury.
Interviews on 08/26/16 with LPN #7 at 9:30 AM, LPN #8 at 10:40 AM, LPN #5 at 10:55 AM, RN #1 at 11:00 AM, LPN #4 at 11:25 AM
and LPN #9 at 12:00 PM, revealed the SDC educated them on ensuring an appropriate intervention was put in place after each fall, and notification of the physician and family/POA with every fall with or without injury.
6. Review of the Resident Examination and Assessment Competencies revealed the DON completed the competency on 08/12/16 and the SDC and two (2) ADONs completed the competencies on 08/13/16 with the RNC.
Interview with the RNC on 08/26/16 revealed she conducted Resident Examination and Assessment Competencies for the DON, SDC and ADONs.
Interviews on 08/26/16 with the SDC at 11:40 AM, and DON at 11:55 AM, revealed they had to complete Resident Examination and Assessment Competencies with the RNC.
7. Review of the Communication Form revealed the SDC and two (2) ADONs conducted education with the Licensed Nurses on 08/13/16 through 08/15/16 regarding policy and procedure for falls, neurological evaluation flow sheet, Event Manager, transcription of Physician Orders, education on narcotic sheets, physician and family notification with every incident, fall interventions, updating the care plans, and post fall assessment. No licensed staff worked prior to receiving this education. In addition, review of the Resident Examination and Assessment Competencies revealed the licensed nurses completed the competencies with the SDC and two (2) ADONs from 08/13/16 through 08/25/16. No licensed nurse worked until their competency was completed.
Interview with the SDC, on 08/26/16, at 11:40 AM, revealed she and the ADONs provided education to all licensed staff on 08/13/16-08/15/16 related to falls, neurochecks, narcotic sheets, physician and family notification, and updating care plans. She stated she had to come in over a weekend to check the licensed staff off on completing the Resident Examination and Assessment Competencies.
Interviews on 08/26/16 with LPN #7 at 9:30 AM, LPN #8 at 10:40 AM, LPN #5 at 10:55 AM, RN #1 at 11:00 AM, LPN #4 at 11:25 AM
and LPN #9 at 12:00 PM, revealed they were educated on how to conduct the neuro checks per the facility's policy, post fall assessments, how to complete the incident in the Event Manager, narcotic sheets, physician and family notification with every incident, updating care plan with appropriate interventions, and the policy and procedure for falls. They all stated they had to come in on the weekend to complete a Resident Examination and Assessment Competency.
8. Review of a Communication Form completed by the SDC, dated 08/08/16, revealed with every fall/incident with or without injury, the Administrative Nurse, Physician, and the resident's Power of Attorney or family member would be notified. Anytime a resident has a fall with head injury, the resident is to be sent to hospital. The staff signature sheet revealed all licensed staff read the communication sheet between 08/08/16-8/11/16.
Interview with the SDC, on 08/26/16 at 11:40 AM, revealed she educated licensed staff to notify the Administrative Nurse, Physician, and resident's family/POA when a resident had a fall and sustained a head injury to send the resident to the

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MORGANTOWN CARE & REHABILITATION CENTER	**201 SOUTH WARREN STREET MORGANTOWN, KY 42261**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0282

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 5)
hospital for evaluation.
Interviews on 08/26/16 with LPN #7 at 9:30 AM, LPN #8 at 10:40 AM, LPN #5 at 10:55 AM, RN #1 at 11:00 AM, LPN #4 at 11:25 AM
and LPN #9 at 12:00 PM, revealed they had been educated that with every fall/incident, they should notify the physician, family/POA and Administrative Nurse and anytime a resident had a fall with a head injury to send him/her out to the hospital.
9. Review of the Clinical Whiteboard Meeting Notes revealed a review was completed for falls and physician notifications daily from 08/13/16-08/25/16 by the IDT team. Further review revealed the Administrative Nurse conducted the reviews on weekends. The RNC and/or Vice President for Operations were present every day for the meeting since 08/12/16.
Interviews on 08/26/16 with the DON at 11:55 AM and the RNC at 12:10 PM revealed they had been providing oversight in the daily Whiteboard Meeting with the IDT looking at new orders, falls, assessments, notification, and documentation. The RNC stated she or the Vice President for Operations had been present every day since 08/12/16.
10. Review of Chart Audit Compliance Forms, revealed ten (10) residents' charts were audited by the Nursing Administrative Team daily from 08/13/16 through 08/25/16.
Interview with the DON on 08/26/16 at 11:40 AM, revealed she was ensuring the Nursing Administrative Team was conducting ten (10) chart audits daily to ensure licensed staff were notifying the physician and family timely, change in conditions were being addressed, and documentation was completed. She stated once the IJ was removed they would continue to audit five (5) charts per day, five (5) days a week, for two (2) weeks, and then five (5) charts per week for two (2) weeks
11. Review of the Regional Staff Attendance Record revealed the RNC and/or Vice President for Operations were at the facility daily to provide oversight and consultation.
Interview with the RNC, on 08/26/16 at 12:10 PM revealed she would continue oversight and consultation until the removal of immediacy. Then oversight would be provided weekly for four (4) weeks, then monthly for six (6) months, to ensure the above audits were completed and any concerns were addressed.
12. Review of a note written by the Administrator revealed she spoke to the Medical Director on 08/08/16 and he suggested sending out residents who had a fall that with a head injury to the hospital for a CT scan.
Interview with the Medical Director on 08/15/16 at 10:05 AM, revealed he was at the facility on 08/08/16 and reviewed the resident's record and the facility's investigation. He stated he suggested sending residents out who had had a fall with a head injury to the hospital for a CT scan.
13. Review of a Sign In Sheets revealed a QAPI meeting was held on 08/15/16 and 08/22/16 for recommendations and further follow up regarding the above stated plan.
14. Interview with the RNC on 08/26/16 at 12:10 PM revealed she was present for the QAPI Meetings on 08/15/16 and 08/22/16.

F 0309

Level of harm - Immediate jeopardy

Residents Affected - Few

Provide necessary care and services to maintain the highest well being of each resident
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on interview, record review, facility policy review and hospital record review, it was determined the facility failed to ensure each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care for one (1) of three (3) sampled residents (Resident #1).
Resident #1, who was on [MEDICATION NAME] (blood thinner) sustained a fall on 08/06/16 at 2:00 AM which resulted in two (2) hematomas to the back of the head. Licensed Practical Nurse (LPN #2) failed to conduct neuro-checks consistently and failed to assess the resident's head pain to determine the type and severity of pain at the time of the fall, prior to administering pain medication and one (1) hour after the pain medication had been administered to determine if it was effective per the care plan and/or facility policy. Resident #1 was found in bed unresponsive at 6:15 AM and sent to the emergency room . The resident was diagnosed with [REDACTED].
Immediate Jeopardy (IJ) was identified on 08/16/16 and was determined to exist on 08/06/16. The facility was notified of the Immediate Jeopardy (IJ) on 08/16/16. An acceptable Allegation of Compliance (AoC) was received on 08/23/16, alleging the removal of the Immediate Jeopardy (IJ) on 08/17/16. The State Survey Agency validated, on 08/26/16, that the Immediate Jeopardy (IJ) was removed on 08/17/16, as alleged. The Scope and Severity was lowered to a D while the facility develops and implements the Plan of Correction (PoC) and the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes.
The findings include:
Review of the facility's policy and procedures for Falls, last reviewed 06/01/16, revealed if a fall occurs staff should assess the resident including neurochecks, pain, range of motion, skin, joints, extremities, and vital signs; and neurochecks will be completed on residents that experience an unwitnessed fall or fall that results in head trauma. Document assessment, pertinent facts, and incident in the Event Manager (computer).
Review of the facility's policy and procedure for Neurological Assessment/Monitoring, not dated, revealed neurological assessments are indicated upon physician order, an unwitnessed fall, following a fall or other accident/injury involving head trauma, or when indicated by the resident's condition. The four (4) areas that should be monitored are the level of consciousness, ability to move extremities, eye responses and change in pupils, and vital signs. The neurochecks should be completed for seventy-two (72) hours at the following frequency: every fifteen (15) minutes time four (4) checks; every thirty (30) minutes times four (4) checks; every one (1) hour times four (4) checks; every four (4) hours times four (4) checks; and, every eight (8) hours until completed.
Review of the facility's Pain Management policy and procedure, not dated, revealed staff should use a pain scale of 0-10 with residents who understand the concept or for residents who cannot understand numerical scale to use a visual analog scale using faces indicating degrees of happy or unhappy. Staff should determine the degree of relief experienced from pain medication and reassess pain in one (1) hour after administration. When pain medication is ineffective, evaluate pain, and communicate to the physician. The Pain Management Clinical Monitoring form shall be initiated on admission and pain medication administration shall occur in the EZMAR (electronic Medication Administration Record). Documentation of indication and effectiveness shall be documented. Review of the Pain Flow Sheet revealed a pain assessment at the time the resident was identified to have pain included the characteristics of the pain, frequency, intensity, non-verbal indicators, or aggravating factors. Assessment one (1) hour after administration of pain medication included the intensity of the pain and the effectiveness of the pain medication.
Record review revealed the facility admitted Resident #1 on 03/15/12 with diagnoses, which included [MEDICAL CONDITION], Chronic Back Pain, Restless Leg Syndrome, and [MEDICAL CONDITION].
Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 06/09/16, revealed the facility assessed Resident #1's cognition as intact with a Brief Interview of Mental Status (BIMS) score of fifteen (15) which indicated the resident was interviewable. In addition, the resident required supervision and set up for transfers and minimal assistance of one (1) staff for ambulation in room and corridor.
Review of the August 2016 Electronic Medication Administration Record (EMAR) revealed Resident #1 received Aspirin 81 mg (blood thinner) every day and [MEDICATION NAME] (blood thinner) 4 milligrams (mg) every other day and alternate the 4 mg with the 3.5 mg every other day
Review of the Comprehensive Care Plan for pain, dated 09/02/14 and last updated 06/21/16, revealed to monitor for any signs and symptoms of pain (crying, grimacing, moaning, guarding, complaints of pain, restlessness, or change in behavior), and monitor for effectiveness of the pain medication.
Further review of the August 2016 EMAR revealed the resident also received a [MEDICATION NAME] (synthetic opioid pain medication) 75 micrograms (mcg)/hour patch for pain every three (3) days and [MEDICATION NAME] (medication used to treat neuropathic pain) 300 mg twice a day for pain. In addition, the resident also had an order for [REDACTED].
Review of a Nursing Assessment for Resident #1 completed by Licensed Practical Nurse (LPN) #2, revealed the resident sustained [REDACTED]. Resident #1 was observed sitting on the floor in the bathroom and had two (2) hematomas on the back of his/her head. The resident stated he/she hit his/her head on the floor. Further review of the Assessment, revealed a neurological assessment was completed and was within normal parameters and the resident had no pain. However, interviews on 08/12/16 with LPN #2 at 10:20 AM, CNA #1 at 9:15 AM, and CNA #2 at 11:15 AM, revealed the resident complained his/her head hurt at the time of the fall. LPN #2 stated she must have made a mistake in her documentation.
Interview with Certified Nurse Aide (CNA) #1, on 08/12/16 at 9:15 AM, revealed she had went over to Resident #1's hall to

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NAME OF PROVIDER OF SUPPLIER **MORGANTOWN CARE & REHABILITATION CENTER**		STREET ADDRESS, CITY, STATE, ZIP **201 SOUTH WARREN STREET MORGANTOWN, KY 42261**	

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 6) assist CNA #2 with resident care and while she was on the hall she heard a noise like a bedpan or urinal falling off the table. CNA #1 stated at that time CNA #2 came out of another resident's room and they noted Resident #1's bathroom light was on which was unusual. CNA #1 stated they entered Resident #1's room and found the resident sitting on the floor in the bathroom doorway with his/her legs sticking out into the room and a small amount of liquid was on the floor around the resident's legs. She stated the resident stated his/her legs went out from under him/her. CNA #1 stated she went to get LPN #2 and some towels/washcloths; and CNA #2 stayed with the resident. When she reentered the room she handed CNA #2 some towels to clean the resident and the floor. CNA #1 stated they identified Resident #1 had a skin tear to his/her left arm and two (2) knots to the right side of his/her head with a gap between them. She stated it looked like blood was coming from them, running down the resident's neck. CNA #1stated the resident complained his/her head was hurting. She stated at that time a call light went off on the other hall and she went to answer it. CNA #1 stated when she left, LPN #1 and CNA #2 were still in the room with the resident. She stated she did not see the nurse assess the resident's injuries before she left the room. Interview with CNA #2, on 08/12/16 at 11:15 AM, revealed on 08/06/16 when she exited another resident's room, CNA #1 heard a noise. They found Resident #1 on the floor in the doorway of his/her bathroom with his/her legs toward the resident's room and blood on the floor and on the side of his/her head. CNA #2 stated she began washing the blood off the resident while CNA #1 went to get LPN #1. She stated there was quite a bit of blood due to the resident being on [MEDICATION NAME]; and, she noted the resident had two (2) huge knots behind his/her right ear. She stated LPN #1 entered the room and asked the resident how he/she felt, and she told LPN #1 about the knots on the back of the resident's head. LPN #2 then asked them to get the resident up. She stated she asked the resident if she could bend his/her legs and she got behind the resident. LPN #2 and CNA #1 lifted the resident up underneath the arms and walked the resident to the bed. She stated she then wiped the resident down with warm washcloths and the resident helped her wipe the inner parts of his/her legs. A pullup was placed on the resident and his/her gown was changed. CNA #2 stated she put a towel on the resident's pillow so blood would not get everywhere; Resident #1 complained of his/her head hurting. She stated she then left the room so she could give CNA #3 report as she was only working until 2:00 AM. CNA #2 stated LPN #1 obtained the blood pressure cuff and when she left LPN #2 was still in the resident's room. Review of Resident #1's Narcotic Count for [MEDICATION NAME] (narcotic pain medication) 7.5 mg/325 mg revealed the resident was administered [MEDICATION NAME] on 08/06/16 at 3:00 AM. However, review of the August 2016 EMAR and Resident #1's Pain Flow Sheet revealed there was no documented evidence the resident's pain was assessed for the characteristics of the pain, frequency, intensity, non-verbal indicators, or aggravating factors prior to the administration of the pain medication or one (1) hour afterward for the effectiveness and intensity of pain after the administration of the pain medication per facility policy. Review of the Neurological Evaluation Flow Sheet, revealed LPN #2 conducted assessments on 08/06/16 at 2:00 AM, 2:15 AM, 2:30 AM, 2:45 AM, 3:15 AM, 4:45 AM and 5:45 AM. There was no documented evidence LPN #2 conducted neurochecks at 3:45 AM and 4:15 AM, per facility policy. Interview with CNA #4, on 08/12/16 at 12:10 PM revealed she came into work on 08/06/16 at 2:00 AM to relieve CNA #2. She stated CNA #2 and CNA #1 reported to her that Resident #1 had fallen and had two (2) hematomas to the back of the head. CNA #4 revealed she was in Resident #1's room at approximately 3:00 AM assisting the resident, when she noted blood in the resident's hair. CNA #4 stated the resident complained of head pain and she made the nurse aware. She further stated when she entered Resident #1's room at approximately 4:00 AM to 4:15 AM, the resident stated the nurse had given him/her a pain pill but his/her head was still hurting. CNA #4 stated the resident asked her to get a bag of ice, she wrapped the ice in a pillowcase, and the resident laid down on his/her left side with the ice on his/her head. CNA #4 stated she reported this to LPN #2. She stated the next time she went into Resident #1's room was at 6:15 AM, when she was giving report to CNA #3. They found the resident unresponsive. She stated they immediately notified the nurses and the resident was sent out to the hospital. Interview with LPN #2, on 08/12/16 at 10:20 AM, revealed Resident #1 was found on the floor in the bathroom on 08/06/16. She stated when she assessed the resident; the resident had two (2) bumps on the back of the head down by his/her neck and blood on his /her neck. LPN #2 stated the resident was assisted by the CNAs to walk to the bed but the resident was talking and was able to walk. LPN #2 stated the resident's neuro-checks and vital signs were good and the resident complained of a small headache. Further interview revealed LPN #2 stated she did not call the physician or the family. She stated she placed the incident report on the physician's clipboard to be delivered to him during the day. In addition, she stated she did not call the resident's family because the resident was his/her own responsible party. LPN #2 stated she conducted neurochecks every fifteen (15) minutes for one (1) hour, then every thirty (30) minutes for two (2) hours and if there were neurochecks that were not documented she did them, but she failed to document them. She stated the last neurocheck she conducted was at 5:45 AM with no concerns. LPN #2 stated she clocked out at 6:30 AM and when she came back up the hall that's when staff found the resident unresponsive and an ambulance was called. She stated she administered pain medication at 3:00 AM due to the resident complaining of head pain and thought she recorded it in the computer. LPN #2 stated she did not recall if she followed up on the pain medication to ensure it was effective. Further interview with LPN #2 on 08/12/16 at 1:15 PM, revealed she was not made aware the CNA gave ice to the resident to put on his/her head and that the resident was still complaining of pain. However, LPN #2 documented she conducted neurochecks on Resident #1 at 4:45 AM and 5:45 AM after the resident had complained of pain to CNA #4 and had been given an ice pack. Review of a Nursing Note, dated 08/06/16 at 6:08 AM, revealed LPN #3 was called to Resident #1's room when he/she was found unresponsive. The resident's pupils were fixed (did not react to light) and a sternum rub was performed with no response. Oxygen saturation (O2 sat) was 89% on room air (normal = 95% - 100%). Oxygen was applied at 2 liters per minute and the resident's O2 sat increased to 96%. Emergency Medical Services (EMS) was called and arrived at 6:45 AM. Report called to hospital. Interview with CNA #3, on 08/12/16 at 11:55 AM, revealed she received report at approximately 6:00 AM that Resident #1 had fallen at 2:00 AM and had two (2) hematomas on the back of the head. She stated when she entered Resident #1's room with CNA #4 at approximately 6:15 AM; the resident was on his/her right side with his/her face into the bedrail. CNA #3 stated she shook the resident twice and he/she still did not respond so she rolled the resident over. She stated there was a towel under the resident's head and an ice pack with blood on it. CNA #3 stated Registered Nurse (RN) #1 did a sternal rub and there was still no response. She stated LPN #3 checked the resident's pupils and called EMS. Interviews on 08/12/16 with LPN #3 at 11:00 AM and Registered Nurse (RN) #1 at 12:40 PM, revealed the resident was unresponsive when they entered the resident's room on 08/06/16 at approximately 6:15 AM. They stated the resident pupils were fixed, the resident was unresponsive to a sternum rub, and his/her O2 sat was low and after applying oxygen, it increased to normal. LPN #3 called EMS and RN #1 noted the resident had a golf ball sized hematoma on the back of the head and blood on the pillow. LPN #3 and RN #1 stated the neurochecks should have been completed according to facility policy and the resident's head pain should have been assessed at the time of the fall, before the pain medication was administered; and, one (1) hour after the pain medication was administered, per facility policy. Review of the Hospital Records, dated 08/06/16, revealed Resident #2 was seen in the emergency room and intubated. The resident was diagnosed with [REDACTED]. The resident's family withdrew care and the resident was placed on comfort measures until the resident passed away on 08/06/16 at 11:23 PM. Interviews on 08/16/16 with the Assistant Director of Nursing (ADON) at 2:50 PM, and LPN #5 and LPN #6 at 2:55 PM revealed licensed staff should conduct neurochecks according to facility policy. They stated when a resident complains of pain the resident's pain should be assessed before pain medication was administered and one (1) hour after pain medication was administered per facility policy. They stated the assessments should be documented on the pain flow sheet. Interview with the Director of Nursing (DON), on 08/12/16 at 3:10 AM and on 08/16/16 at 3:10 PM, revealed during her investigation of Resident #1's fall she had identified LPN #2 had failed to conduct neurochecks at the appropriate frequency per facility policy. She stated she expected the nurse to have assessed the resident's pain per the pain flow sheet and the nurse should have assessed the resident's pain one (1) hour after the pain medication was administered to determine the effectiveness of the pain medication. The facility implemented the following actions to remove the Immediate Jeopardy: 1. The DON conducted an investigation of Resident #1's fall and identified LPN #2 failed to notify the physician and family at the time of the fall. It was also identified that the neuro evaluations were not completed according to the facility's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185006**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **08/26/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MORGANTOWN CARE & REHABILITATION CENTER	**201 SOUTH WARREN STREET MORGANTOWN, KY 42261**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0309

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 7)
Neurological Assessment/Monitoring Procedure.
2. A Disciplinary Action for LPN #2 was completed by the DON on 08/08/16. On 08/09/16, LPN #2 requested Family Medical Leave.
3. On 08/08/16, the Administrator met with the Medical Director, who was the attending physician for Resident #1. A plan was formulated for Charge Nurses to notify a resident's physician immediately when a resident has an unwitnessed fall and/or has a potential head injury and is receiving anticoagulant therapy. The resident is to be sent to the emergency room for evaluation and treatment.
4. On 08/12/16, current resident charts who had falls for the past four (4) months (from May-August 2016) were audited by the ADON, reviewing falls, fall interventions, care plans, fall assessments, physician and family notifications. Corrections were completed as indicated by the ADON.
5. Immediate education was initiated with licensed nurses on 08/08/16 by the Staff Development Coordinator (SDC) regarding completion of the Event Manager, location of the BIMS score, using an appropriate intervention after each incident, notification of the physician and responsible party with every fall/incident without injury. This education was completed on 08/11/16; and, no licensed nurse worked prior to receiving this education.
6. On 08/12/16, the Regional Nurse Consultant (RNC) completed a competency, the Resident Examination and Assessment Competency, with the DON. On 08/13/16, the RNC also conducted a competency, the Resident Examination and Assessment Competency, with the SDC and two (2) ADONs.
7. The SDC and two (2) ADONs conducted education with the Licensed Nurses which included PRN, Part time and full time nurses on 08/13/16 through 08/15/16 . The education was related to the facilty's policy and procedure for falls, neurological evaluation flow sheet, Event Manager, transcription on physician's orders [REDACTED]. No licensed staff worked prior to receiving this education. In addition, the Resident Examination and Assessment Competency, was completed by the SDC and two ADONs with each licensed nurse.
8. On 08/08/16, the process was initiated to notify the physician, responsible party, and On Call Administrative Nurse with every fall/incident with or without injury.
9. Beginning 08/13/16, the Interdisciplinary Team (IDT) to include but not limited to the DON, ADONs, MDS Coordinators, Medical Records Nurse, Quality of Life Director, Chaplain, Social Service Director, Social Service Assistant, Dietary Manager, and Therapy Manager, will review in the morning clinical meeting (Monday through Friday) telephone orders, change in condition, twenty-four (24) hour report, and medical records of residents to ensure timely notification, of physician and family occurred and any changes in the resident's condition were addressed timely. The RNC has been attending the meeting since 08/12/16 assisting and providing oversight and consultation. On weekends, the Administrative Nurse will be assigned to review telephone orders, SBARS (Situation, Background, and Assessment Recommendations), twenty four (24) hour reports, and medical records of residents to ensure timely notification of physician and family and any changes in resident condition were addressed timely.
10. Beginning 08/13/16, ten (10) residents charts will be audited daily by the Nursing Administration Team (DON, Unit Mangers, SDC, and MDS Coordinators and the Restorative Nurse Manager) for timely physician and family notification, change in condition being addressed, SBARs, telephone orders, and twenty-four (24) hour reports, and documentation being present, until immediacy is lifted. Then five (5) charts per day, five (5) days a week, will be checked for two (2) weeks, and then five (5) charts per week for two (2) weeks. Any issues identified will be addressed at the time of discovery. Results of the audits will be discussed in Quality Assurance Performance Improvement (QAPI) meeting.
11. Administrative oversight will be completed by the Vice President for Operations or RNC, daily until removal of immediacy beginning 08/11/16, then weekly for four (4) weeks, then monthly for six (6) months, to ensure the above audits are completed and any concerns are addressed. Oversight includes assisting with audits, reviewing charts, reviewing audits and providing oversight and consultation.
12. A QA Meeting was held on 08/08/16 with the Medial Director by phone, and an Ad Hoc QAPI meeting was held on 08/15/16 with the Medical Director, Administrator, DOM, RNC, ADONs, SDC, Chaplain, MDS Coordinators, Social Service Director, Human Resource Director, and Medical Records Coordinator were in attendance reviewing the occurrence of Resident #1 and immediate plans put in place.
13. A QAPI meeting will be held weekly until the immediacy has been removed, then monthly for six (6) months for recommendations and further follow up regarding the above stated plan. At that time based on the evaluation, the QAPI Committee will determine at what frequency any ongoing audits will need to continue.
14. Corporate Administrative oversight of the QAPI meeting will be completed by the RNC, Director of Clinical Programs, the Regional Vice President of Operations, or member of the regional staff weekly until removal of the immediacy, then weekly for four (4) weeks, and then monthly for six (6) months.
**The State Survey Agency validated the corrective actions taken by the facility as follows:
1. Review of the facility's investigation, not dated, revealed the DON determined LPN #2 failed to conduct neurochecks according to facility policy and failed to notify the physician and family after the resident's fall.
Interview with the DON, on 08/26/16 at 11:55 AM revealed she conducted the investigation into Resident #1's fall. She stated she identified LPN #2 had failed to conduct the neurochecks per facility policy and failed to notify the physician and family of the resident's fall.
2. Review of a Disciplinary Action, dated 08/08/16, revealed LPN #2 was counseled by the DON related to insufficient documentation on the Event Report, notification of the physician and family after a fall, and completion of neurochecks per facility policy. Review of a letter, dated 08/09/16 revealed LPN #2 requested Family Medical Leave (FML) with the Human Resource Manager. LPN #2 was placed on FML on 08/09/16.
Interview with the DON, on 08/26/16 at 11:55 AM revealed she counseled LPN #2 on her failure to complete the Event Report filling in all blanks, notification of physician and family after a fall, and conducting neurochecks at the appropriate timeframes and using accurate documentation on the form. The DON stated LPN #2 requested FML and it was granted on 08/09/16.
3. Review of a Communication Form per SDC, dated 08/08/16, revealed with every fall/incident with or without injury, the Administrative Nurse, Physician, and the resident's Power of Attorney or family member would be notified. Anytime a resident has a fall with head injury, the resident is to be sent to hospital. The staff signature sheet revealed all licensed staff read the communication sheet between 08/08/16-08/11/16.
Interview with the SDC, on 08/26/16, at 11:40 AM, revealed she provided the education on 08/08/16 related to notification of the Administrative Nurse, Physician and the resident's Power of Attorney or family member when a resident had a fall with or without injury. In addition, staff were educated that anytime a resident has a fall with head injury to send the resident to the hospital for evaluation.
Interviews on 08/26/16 with LPN #7 at 9:30 AM, LPN #8 at 10:40 AM, LPN #5 at 10:55 AM, RN #1 at 11:00 AM, LPN #4 at 11:25 AM
and LPN #9 at 12:00 PM, revealed they were educated on 08/08/16 that when a resident had a fall the to notify the physician, family or POA, and Administrative Nurse. In addition, they stated they should send a resident who had a fall with head injury out to the hospital for evaluation.
4. Review of the Event Reports for May-August 2016 revealed they were reviewed by the ADON on 08/12/16. The ADON identified there were falls where there was no documentation the family had been notified of the falls. Further review revealed each of the families was notified of the fall on 08/12/16 by the Nursing Administrative Team.
Interview with the ADON on 08/26/16 at 10:30 AM, revealed she reviewed the event reports for four (4) months (May-August 2016) to determine if the physician and family/POA had been notified of the fall. She stated she identified that some families had not been notified. The Nursing Administrative Teams notified the families on 08/12/16.
5. Review of the Communication Form, dated 08/08/16, revealed the SDC initiated education on 08/08/16 to all licensed staff regarding completion of the Event Manager, location of the BIMS score, using an appropriate intervention after each incident, notification of the physician and responsible party with every fall/incident with or without injury. This education was completed on 08/11/16 and no licensed nurse worked prior to receiving this education.
Interview with the SDC, on 08/26/16, at 11:40 AM, revealed she provided education to all licensed staff on 08/08/16-08/11/16 on completion of the Event Manager, using an appropriate intervention after each incident, and notification of the physician and responsible party with every fall/incident with or without injury.
Interviews on 08/26/16 with LPN #7 at 9:30 AM, LPN #8 at 10:40 AM, LPN #5 at 10:55 AM, RN #1 at 11:00 AM, LPN #4 at 11:25 AM
and LPN #9 at 12:00 PM, revealed the SDC educated them on ensuring an appropriate intervention was put in place after each

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185006**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **08/26/2016**
NAME OF PROVIDER OF SUPPLIER **MORGANTOWN CARE & REHABILITATION CENTER**		STREET ADDRESS, CITY, STATE, ZIP **201 SOUTH WARREN STREET MORGANTOWN, KY 42261**	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 8) fall, and notification of the physician and family/POA with every fall with or without injury. 6. Review of the Resident Examination and Assessment Competencies revealed the DON completed the competency on 08/12/16 and the SDC and two (2) ADONs completed the competencies on 08/13/16 with the RNC. Interview with the RNC on 08/26/16 revealed she conducted Resident Examination and Assessment Competencies for the DON, SDC and ADONs. Interviews on 08/26/16 with the SDC at 11:40 AM, and DON at 11:55 AM, revealed they had to complete Resident Examination and Assessment Competencies with the RNC. 7. Review of the Communication Form revealed the SDC and two (2) ADONs conducted education with the Licensed Nurses on 08/13/16 through 08/15/16 regarding policy and procedure for falls, neurological evaluation flow sheet, Event Manager, transcription of Physician Orders, education on narcotic sheets, physician and family notification with every incident, fall interventions, updating the care plans, and post fall assessment. No licensed staff worked prior to receiving this education. In addition, review of the Resident Examination and Assessment Competencies revealed the licensed nurses completed the competencies with the SDC and two (2) ADONs from 08/13/16 through 08/25/16. No licensed nurse worked until their competency was completed. Interview with the SDC, on 08/26/16, at 11:40 AM, revealed she and the ADONs provided education to all licensed staff on 08/13/16-08/15/16 related to falls, neurochecks, narcotic sheets, physician and family notification, and updating care plans. She stated she had to come in over a weekend to check the licensed staff off on completing the Resident Examination and Assessment Competencies. Interviews on 08/26/16 with LPN #7 at 9:30 AM, LPN #8 at 10:40 AM, LPN #5 at 10:55 AM, RN #1 at 11:00 AM, LPN #4 at 11:25 AM and LPN #9 at 12:00 PM, revealed they were educated on how to conduct the neuro checks per the facility's policy, post fall assessments, how to complete the incident in the Event Manager, narcotic sheets, physician and family notification with every incident, updating care plan with appropriate interventions, and the policy and procedure for falls. They all stated they had to come in on the weekend to complete a Resident Examination and Assessment Competency. 8. Review of a Communication Form completed by the SDC, dated 08/08/16, revealed with every fall/incident with or without injury, the Administrative Nurse, Physician, and the resident's Power of Attorney or family member would be notified. Anytime a resident has a fall with head injury, the resident is to be sent to hospital. The staff signature sheet revealed all licensed staff read the communication sheet between 08/08/16-8/11/16. Interview with the SDC, on 08/26/16 at 11:40 AM, revealed she educated licensed staff to notify the Administrative Nurse, Physician, and resident's family/POA when a resident had a fall and sustained a head injury to send the resident to the hospital for evaluation. Interviews on 08/26/16 with LPN #7 at 9:30 AM, LPN #8 at 10:40 AM, LPN #5 at 10:55 AM, RN #1 at 11:00 AM, LPN #4 at 11:25 AM and LPN #9 at 12:00 PM, revealed they had been educated that with every fall/incident, they should notify the physician, family/POA and Administrative Nurse and anytime a resident had a fall with a head injury to send him/her out to the hospital. 9. Review of the Clinical Whiteboard Meeting Notes revealed a review was completed for falls and physician notifications daily from 08/13/16-08/25/16 by the IDT team. Further review revealed the Administrative Nurse conducted the reviews on weekends. The RNC and/or Vice President for Operations were present every day for the meeting since 08/12/16. Interviews on 08/26/16 with the DON at 11:55 AM and the RNC at 12:10 PM revealed they had been providing oversight in the daily Whiteboard Meeting with the IDT looking at new orders, falls, assessments, notification, and documentation. The RNC stated she or the Vice President for Operations had been present every day since 08/12/16. 10. Review of Chart Audit Compliance Forms, revealed ten (10) residents' charts were audited by the Nursing Administrative Team daily from 08/13/16 through 08/25/16. Interview with the DON on 08/26/16 at 11:40 AM, revealed she was ensuring the Nursing Administrative Team was conducting ten (10) chart audits daily to ensure licensed staff were notifying the physician and family timely, change in conditions were being addressed, and documentation was completed. She stated once the IJ was removed they would continue to audit five (5) charts per day, five (5) days a week, for two (2) weeks, and then five (5) charts per week for two (2) weeks 11. Review of the Regional Staff Attendance Record revealed the RNC and/or Vice President for Operations were at the facility daily to provide oversight and consultation. Interview with the RNC, on 08/26/16 at 12:10 PM revealed she would continue oversight and consultation until the removal of immediacy. Then oversight would be provided weekly for four (4) weeks, then monthly for six (6) months, to ensure the above audits were completed and any concerns were addressed. 12. Review of a note written by the Administrator revealed she spoke to the Medical Director on 08/0