STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675454	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WEST OAKS NURSING & REHAB CENTER	3625 GREEN CREST HOUSTON, TX 77082

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

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F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**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, and record review, the facility failed to promptly consult the physician when a change in condition occurred for one in 12 residents (CR#1) reviewed for physician consultation. CR#1 had a fall on [DATE] with head injury and the physician was not consulted promptly. CR#1 was assessed with [REDACTED].#1 died on [DATE]. An immediate jeopardy (IJ) was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy with a scope of pattern. The facility was continuing to monitor to ensure physicians were consulted when residents were assessed with [REDACTED]. This failure affected one resident who died in the facility and placed 16 other residents at risk for falls at risk of not having the physician consulted, which could result in a decline in their medical condition, and psychosocial well-being. Findings include: Incident intake # 4 CR#1 Record review of CR #1's face sheet revealed a [AGE] year old female admitted to the facility on [DATE] and re-admitted on [DATE]. Her [DIAGNOSES REDACTED]. Record review of CR#1's MDS dated [DATE] revealed a BIMS score of 11 out of 15, indicating moderate cognitive impairment. Further review revealed CR #1 required extensive assistance for bed mobility, transfers, walking in room, walking in corridor, dressing, locomotion off unit, toilet use, personal hygiene and bathing. The resident required limited assistance for locomotion on unit, and eating. Further review of this MDS revealed the resident had a fall with injury that was not major. Record review of CR#1's incident report dated [DATE] at 1:28p.m., revealed resident was noted on the floor lying on her left side calling for help. Injuries noted were hematoma left forehead (brow area) and abrasion to left knee. The resident was alert. Further review of this incident report revealed the resident's physician was called and a message was left about the fall on [DATE] at 1:50p.m. Record review of CR #1's care plan, which was undated, revealed she had falls on [DATE], [DATE], and [DATE]. Further review revealed a goal which read My number of falls will be reduced through next review date. I have had an actual fall on [DATE]. Target date: [DATE]. Interventions included: Educate on use of call light and to wait for staff to come help. Be sure my call light is within reach and encourage me to use it. Follow facility fall protocol. Pt. evaluate and treat as ordered or PRN. After each fall episode evaluate current interventions and modify interventions based on IDT recommendations. Record review of CR#1's neurological evaluation flow sheet, revealed it was initiated on [DATE] at 1:28p.m. and stopped on [DATE] at 6a.m. Further review revealed the following pupil reaction documentation: [DATE] at 1:28p.m. - pupils were sluggish. [DATE] at 6:45p.m. - pupils were sluggish [DATE] at 7p.m. - pupils were sluggish [DATE] at 8p.m. - pupils were sluggish [DATE] at 8:30p.m. - pupils were sluggish [DATE] at 9p.m. - pupils were sluggish [DATE] at 10p.m.-pupils were sluggish [DATE] at 6a.m. - pupils were brisk [DATE] at 6p.m. - right pupil was brisk, notation for left pupil was illegible [DATE] at 6:00a.m. - pupils were sluggish. Record review of CR#1's progress notes dated [DATE] at 2:33p.m., revealed resident was noted lying on the floor by staff crying for help. A large raised area noted on forehead, scrape noted on left knee, no internal or external rotation on both upper and lower extremities. Vital laying down ,[DATE], pulse-103, R (respiration) 18, blood pressure sitting down ,[DATE], pulse 100, respiration 18 and temperature 98. Responsible party informed, physician's office called and message left re-fall, ice park to areas on forehead and neuro checks. Interview on [DATE] at 2:23p.m., LVN#1 stated when he was notified of CR #1's fall on [DATE], he went to the patient's room and took vitals, called the physician's office and told the office staff the reason for his call. LVN #1 said he called again 20 minutes later and was told by the office staff that the physician would call him back. LVN #1 reported he called the physician 3 times, called the resident's family and continued with neuro checks. LVN #1 stated the physician did not call back throughout his shift (6a.m.-6p.m.). He further said he notified the on-coming nurse to follow up with CR #1's physician. Interview on [DATE] at 1:20p.m., CNA #1 said she cared for CR #1 on the morning of [DATE]. She said CR #1 had a bruise to her forehead but was talking. She stated she cleaned CR #1 up and fed her in bed by the resident's choice. CNA #1 said the resident made no complaints to her, but was unable to go the bathroom like she would before the fall. She had incontinent brief on and had two brief changes during her shift, she did not notice any running nose, discharges and no pain was expressed or verbalized. CNA #1 said the resident previously would talk and say help me, help me and did not like to stay in bed, but preferred to be out of her room and sit by the nurse's station. Record review of CR#1's progress notes dated [DATE] at 5:11p.m., revealed resident in bed lying down, assisted patient with putting dentures in her mouth, resident is being monitored post fall, resident has bruising to left side of forehead, left per orbital and check area and less extensive bruising to right per orbital area, resident is alert to self and able to speak. Resident is now being fed by speech therapy. Record review of CR #1's progress notes dated [DATE] at 3:30a.m., revealed Resident in bed stable at the moment, no signs and symptoms of acute distress noted. Respiration even and unlabored, skin warm and dry to touch, resident status [REDACTED]. Vital signs were: blood pressure ,[DATE], R18, oxygen saturation 98%, active range of motion on upper and lower extremities. Safety measures in place and call light within reach and bed in lowest position, will continue with the care. Two attempts were made to interview the CNAs who cared for CR #1 on Sunday morning and Sunday afternoon without success. Phone calls were not returned. Record review of CR #1's progress notes dated [DATE] at 7:02p.m., revealed Patient was not responding and vital signs were BP,[DATE], Pulse -193, R-28, oxygen saturation was 75% room air. Called out MD immediately, the doctor said call the

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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F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) daughter, notified of patient status and what the doctor said, she requested call 911 immediately and let them wait for me, 911 was called, when they arrived there was no pulse, daughter came few minutes after as she said, at this hour they are here. Further review of progress report revealed: At 7:21p.m., ADON (#1) made aware of patient status, at 6:45p.m., resident was pronounced by 911 with family present and 9:35p.m., Resident was picked up by medical examiner via stretcher accompanied by two policemen, Resident's daughter and physician notified. Record review of a written statement by LVN #2 (CR#1's charge nurse on [DATE]) read in part .on [DATE], I reported to duty at 6a.m., during rounds I observed patient (CR#1) in bed with bruises on her face and eyes closed. I greeted her, she responded with help me, help me. Her right eye was running water, I went back to the night nurse to find out what happened to her face and her condition, the nurse told me that patient fell Friday [DATE] and hit her head, neuro check is in progress and she has been in bed since then. Vital signs were ,[DATE], pulse 120. Respiration 20, temperature 98.6, oxygen saturation was 95% at room air. I called the physician about 11a.m. concerning the patient eye and the bruises on her face, no call back. She was monitored throughout and was responding with help me, help me. At about 5:45p.m., during my last round, patient was not responding, I called for help and we checked vital signs, blood pressure was ,[DATE], pulse was 193, oxygen saturation was 75% at room air, notified the ADON #1 who advised to call MD and family. Called out MD and updated him of patient status and the patient is DNR, MD ordered to call family member and ask what she wants, daughter asked to call 911 and sent patient to hospital but let the 911 staff wait I am on my way with my daughter, we are just 5 minutes away. In less than 5 minutes EMS were here and the daughter also came in, there was no pulse . Interview on [DATE] at 10:00a.m., the DON said she reviewed the 24 hour report for [DATE] looking for information indicating that staff were to follow up with notifying CR#1's physician of her fall with injury but there was none. The DON said she talked to the nurse who worked the evening shift (6p.m.-6a.m.) on [DATE] who said she was not told by the day shift nurse (LVN #1) to follow up or to call CR #1's physician. The DON agreed the resident's physician and the facility's medical director should have been promptly notified of both the fall and change in condition. The DON further said CR#1's physician said he was aware of the fall and did not think anything would have changed or been done differently. Interview on [DATE] at 2:44p.m., LVN #2 said when he made his rounds the morning of [DATE] around 6a.m. and noticed CR #1 was in bed sick with a bruise on her face. He asked the nurse what happened to CR #1 and was informed the resident fell on Friday ([DATE]). LVN #2 said the nurse told him CR #1 had not been doing well, had been in bed since the fall and Neuro checks were in progress. LVN #2 said this was all the report the outgoing night nurse gave him. LVN #2 reported he continued Neuro checks every hour, but CR #1 was not opening her eyes, so he called the physician around 11a.m. The physician did not respond and did not call back, so LVN #2 continued monitoring the resident every hour, talking to her, trying to get her to open her eyes and talk back to him. LVN #2 said about 5p.m., he noted the resident was not responding like before, so he reported it to the ADON #1 and was told to call the doctor. LVN #2 stated he called the doctor and the doctor told him to call the resident's daughter and ask what the family preferred since CR #1 was had a code status of DO NOT RESUSITATE (DNR). LVN #2 further said he called CR #1's daughter who asked him to call 911. He stated he called 911 and they arrived in about 5 minutes and found no pulse. LVN #2 said he had only one aide in the morning, so he could not use her to help him monitor the resident closely, since one aide had called in. LVN #2 said he checked the residents' vital signs twice in the morning and in the afternoon and they were all normal. He also said he expected the resident's physician was aware of the fall with head injuries and did not mention it when he called him on [DATE]. LVN #2 said after reflecting on the incident, he should have called the physician earlier when he noted the resident was not feeling well, but the nurse who worked the night before said that was how the resident had been throughout the night shift. LVN #2 said he would have continued to called the physician or report it to the ADON #1 earlier if he had known this was unusual for CR #1. LVN #2 said CR #1 was declared dead on arrival, EMS called police and medical examiner's office. Interview on [DATE] at 2:58p.m., LVN #2 when asked what CR#1 looked like during his last rounds stated CR#1 had an oxygen saturation of 75%, she was not breathing well-shallow breathing, pulse was 193 and very faint, color was normal and body was warm, no discharge was noted. Interview on [DATE] at 3:05p.m., ADON #1 said she was called by LVN #2 around after 6p.m. on [DATE]. She stated LVN #2 told her that CR #1 was unresponsive, had blood pressure and heart rate but no oxygen saturation was registering on pulse oximeter. She told LVN #2 to call the physician. ADON #1 said she called back about three minutes later and was told EMS was in the facility and the resident was dead. Interview on [DATE] at 3:20p.m., the Administrator reported she asked LVN #2 why CR#1's physician was not contacted earlier in his shift when he identified the change in her condition but he had no response. Record review of facility policy on resident rights which was not dated read in part .the facility will protect and protect the rights of each resident. The facility will immediately inform the resident and consult with the resident's physician, if appropriate when changes occur. If known, the facility shall also notify the resident's legal representative or an interested family member. Notification of changes shall include: An accident involving the resident which results in injury and has the potential for requiring physician intervention. A significant change in the resident's physical mental, or psychological status such as deterioration in health or psychosocial status in either life threatening conditions or clinical complications etc . On [DATE] at 3:38p.m., an IJ was identified and the facility Administrator was notified. The IJ was removed on [DATE]. The facility submitted and implemented the following plan to remove the IJ on [DATE]. Plan to remove immediacy: I. The Administrator and Director of Nursing were notified on [DATE] at approximately 4:15p.m. of an Immediate Jeopardy for neglect related to failure to conduct proper assessment after a fall. The following steps are the facility's plan to remove the Immediate Jeopardy. a) On [DATE], Nurse Managers, Licensed Nurses, and the Director of Nursing immediately assessed current residents (99 residents) in the facility to ensure any changes in condition were identified, physician notification has occurred, interventions implemented, documentation in the medical record reflective of the residents status and the identified change in condition were care planned completed [DATE]. b.) On [DATE], Nurse Managers, Licensed Nurses, and the Director of nursing immediately assessed (99 residents) in the facility to reflect fall risk status of resident's current condition completed [DATE]. An Ad Hoc Quality Assurance Committee meeting was held on [DATE] with the Medical Director, Director of Nursing, Administrator, and Interdisciplinary Team to review and discuss the plan of action of properly assessing a resident after a fall with injury and the plan for physician notification if the primary physician does not return a call. The nursing staff will notify the primary physician and if a call is not returned within 30 minutes, the Medical Director is to be called; if Medical Director does not return the call within 15 minutes the resident is to be sent to ER. In the event that the injury requires immediate medical attention the resident will be transported to the emergency room . This is documented on Quality Assurance Performance Improvement Agenda form. Completed [DATE]. The Director of Nursing and Nurse Managers immediately began re-educating staff (RN/LVN/C.N.A./ MA) on the following: ([DATE]) On recognizing changes in condition (Change in a residents status; the nurse will notify the resident's attending physician and family when there has been an accident or incident involving the resident, a discovery of injury of unknown source, a reaction to medication, a significant change in the resident's physical, emotional or mental condition, a need to alter the resident's medical treatment significantly, refusal of treatment or medication, a need to transfer the resident to a hospital/treatment center, a discharge without proper medical authority, and/or instructions to notify the physician of changes in the resident condition some of the symptoms may include: Recognizing changes in mental status, functional status of a resident, respiratory, GI/abdomen, GU/urine. Head injury/Neuro checks- a neurological check form will be completed for any fall involving the head or any un-witnessed fall. If there are any changes in the neurological assessment: opening eyes and changes in pupil size or reaction, motor and verbal response changes from baseline to next assessment, or changes in the overall total Glasgow Score from previous perimeter the nurse will call the physician for further recommendations. Unresponsive Resident-if a resident is found unresponsive after assessment nurse is to call 911. Assessing the resident by completion of the Interact SBAR (Assessing the resident and documenting in the clinical records of the resident; for example,

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F 0157 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 2) a significant change of condition is a decline or improvement of the resident status that will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions and also impacts more than one area of the resident's health status requires interdisciplinary review and revision to the care plan and is ultimately based on the judgment of the clinical staff and guidelines of the resident assessment instrument)-documentation in the residents medical record (documenting residents condition, any changes, when a resident admits, or discharges from the facility) for example, the nurse supervisor/charge nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status notification to the attending physicians/responsible party. The nursing staff will notify the primary physician and if a call is not returned within 30 minutes, the Medical Director is to be called; if Medical Director does not return the call within 15 minutes the resident is to be sent to ER. In the event that the injury requires immediate medical attention the resident will be transported to the emergency room . Care planning the change in condition (Care planning any change with a resident) Utilization of the Interact Stop and Watch tool -these items were in-serviced CNAs/MAs will immediately notify the charge nurse if any of the above occur. Fall education started on [DATE] by Director of Staff Development on 2- 10 shift that included License nurses re-educated to the policy and procedures of the 24 hour report. Utilization of the 24 hour report to report changes in condition. The following in-services started on [DATE] by the Director of Social Services on ,[DATE] shift. Abuse/neglect regarding assessing and documenting change in condition. Education started on [DATE] ,[DATE] shifts. Education will continue each shift until 100%of the Nursing Staff (RN/LVN/MA/CNA) is educated on the above. Those employees on leave will have their education completed upon arrival for the start of the next scheduled shift to work. Director of Staff development or designee will include in-services with the orientation process. No staff will be allowed to provide patient care until they have been trained. The DON, Nurse Managers/Designee will round daily starting [DATE] and will continue daily to ensure no changes in condition. To monitor the Director of Nursing/ designee clinical rounds to identify changes in condition. Review notifications of physician's clinical meeting. Review SBAR in clinical meetings. Review Incidents/Accidents in Clinical meeting. Weekend supervisor will conduct clinical meeting. The surveyor monitored the plan to remove the immediate jeopardy on [DATE] and [DATE] as follows: Monitoring began on [DATE]. LVNs and RNs were interviewed on two shifts on physician notification, and proper assessment following falls and changes in condition. Record review of the facility In-Services revealed: [DATE] - twelve staff members were trained on proper way of notifying/consulting the resident's physician, and facility's medical director and to call 911 if no response was received from the physicians; and staff were to notify the DON or designee of any identified changes in condition, falls with injury and the proper assessment, documentation and analysis of neurological assessment following falls with head injuries. 14 staff members were trained on physician notification of any resident with a change in condition and using the SBAR (Situation, Background, Assessment, and Recommendation) tool. [DATE] - more than 50% of the facility's nursing staff members were trained on parameters of when to notify facility administration on any changes in residents. Interview on [DATE] at 10:00 a.m., the DON stated she completed chart audits, evaluated all residents in the facility for changes in condition, falls with or without injuries and found that staff were implementing the appropriate and current plan. Record review of in-service, dated [DATE], the DON and ADONs trained all staff scheduled to work [DATE], [DATE], and [DATE]. Interviews with 6 MAs, and 5 CNAs on [DATE] between 4:25 p.m. and 5:15 p.m., revealed they received training on how to identify abuse and neglect, when to notify a charge nurse of anything usual noted about any patient, and if the nurses did not respond immediately to call the DON or the administrator. Record review of the in-service forms provided by the Administrator dated [DATE], [DATE] and [DATE] revealed on-going in-services concerning resident assessments, physicians' consultation, and post fall with head injury interventions. Interview on [DATE] at 9:30a.m., the Administrator stated she would be continuing to monitor the DON and staff to ensure the plan was implemented and effective. She further reported she would continue to monitor the facility approved plan of removal to ensure the safety of the residents. She said she was monitoring and evaluating all fall incidents to ensure staff were implementing the plan. She also stated the facility's medical director had spoken with all other doctors to ensure they understood that he would be called for intervention should they not promptly respond to facility's calls. After monitoring the implementation of the plan, the IJ was removed. The Administrator was informed the IJ was removed on [DATE] at 9:39a.m. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of pattern and a severity level of actual harm that is not immediate jeopardy. The facility was continuing to monitor their plans to ensure residents' physicians were promptly consulted following falls with injuries and following changes in condition. The Administrator reported 17 residents in the facility at high risk for falls.
F 0224 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement policies and procedures that prohibit mistreatment and neglect of residents for one of 12 residents (CR#1) reviewed for neglect. The facility failed to seek medical consultation for CR #1 who had a fall with a head injury when the resident's physician did not respond to the facility's calls. The facility failed to consult the physician for approximately 12 hours after CR #1 was assessed with [REDACTED]. The facility failed to continue to monitor, assess, and provide medical services to CR #1 after she was assessed as to having experienced a change in condition two days after a fall with a head injury. An immediate jeopardy (IJ) was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of pattern. This failure affected one resident who died in the facility and placed 16 other residents at risk for falls at risk of not receiving services necessary to ensure residents received the medical care from injuries which could lead to a decline in their health, untreated pain or death. Findings include: Incident intake # 4 CR#1 Record review of CR #1's face sheet revealed a [AGE] year old female admitted to the facility on [DATE] and re-admitted on [DATE]. Her [DIAGNOSES REDACTED]. Record review of CR#1's MDS dated [DATE] revealed a BIMS score of 11 out of 15, indicating moderate cognitive impairment. Further review revealed CR #1 required extensive assistance for bed mobility, transfers, walking in room, walking in corridor, dressing, locomotion off unit, toilet use, personal hygiene and bathing. The resident required limited assistance for locomotion on unit, and eating. Further review of this MDS revealed the resident had a fall with injury that was not major. Record review of CR#1's incident report dated [DATE] at 1:28p.m., revealed resident was noted on the floor lying on her left side calling for help. Injuries noted were hematoma left forehead (brow area) and abrasion to left knee. The resident was alert. Further review of this incident report revealed the resident's physician was called and a message was left about the fall on [DATE] at 1:50p.m. Record review of CR #1's care plan, which was undated, revealed she had falls on [DATE], [DATE] and [DATE]. Further review revealed a goal which read My number of falls will be reduced through next review date. I have had an actual fall on

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[DATE] at 6:45p.m. - pupils were sluggish [DATE] at 7p.m. - pupils were sluggish [DATE] at 8p.m. - pupils were sluggish [DATE] at 8:30p.m. - pupils were sluggish [DATE] at 9p.m. - pupils were sluggish [DATE] at 10p.m.-pupils were sluggish [DATE] at 6a.m. - pupils were brisk [DATE] at 6p.m. - right pupil was brisk, notation for left pupil was illegible [DATE] at 6:00a.m. - pupils were sluggish. Record review of CR#1's progress notes dated [DATE] at 2:33p.m., revealed resident was noted lying on the floor by staff crying for help. A large raised area noted on forehead, scrape noted on left knee, no internal or external rotation on both upper and lower extremities. Vital laying down ,[DATE], pulse-103, R (respiration) 18, blood pressure sitting down ,[DATE], pulse 100, respiration 18 and temperature 98. Responsible party informed, physician's office called and message left re-fall, ice park to areas on forehead and neuro checks. 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Respiration even and unlabored, skin warm and dry to touch, resident status [REDACTED]. Vital signs were: blood pressure ,[DATE], R18, oxygen saturation 98%, active range of motion on upper and lower extremities. Safety measures in place and call light within reach and bed in lowest position, will continue with the care. Two attempts were made to interview the CNAs who cared for CR #1 on Sunday morning and Sunday afternoon without success. Phone calls were not returned. Record review of CR #1's progress notes dated [DATE] at 7:02p.m., revealed Patient was not responding and vital signs were BP,[DATE], Pulse -193, R-28, oxygen saturation was 75% room air. Called out MD immediately, the doctor said call the daughter, notified of patient status and what the doctor said, she requested call 911 immediately and let them wait for me, 911 was called, when they arrived there was no pulse, daughter came few minutes after as she said, at this hour they are here. Further review of progress report revealed: At 7:21p.m., ADON (#1) made aware of patient status, at 6:45p.m., resident was pronounced by 911 with family present and 9:35p.m., Resident was picked up by medical examiner via stretcher accompanied by two policemen, Resident's daughter and physician notified. Record review of a written statement by LVN #2 (CR#1's charge nurse on [DATE]) read in part .on [DATE], I reported to duty at 6a.m., during rounds I observed patient (CR#1) in bed with bruises on her face and eyes closed. I greeted her, she responded with help me, help me. Her right eye was running water, I went back to the night nurse to find out what happened to her face and her condition, the nurse told me that patient fell Friday [DATE] and hit her head, neuro check is in progress and she has been in bed since then. Vital signs were ,[DATE], pulse 120. Respiration 20, temperature 98.6, oxygen saturation was 95% at room air. I called the physician about 11a.m. concerning the patient eye and the bruises on her face, no call back. She was monitored throughout and was responding with help me, help me. At about 5:45p.m., during my last round, patient was not responding, I called for help and we checked vital signs, blood pressure was ,[DATE], pulse was 193, oxygen saturation was 75% at room air, notified the ADON (#1) who advised to call MD and family. Called out MD and updated him of patient status and the patient is DNR, MD ordered to call family member and ask what she wants, daughter asked to call 911 and sent patient to hospital but let the 911 staff wait I am on my way with my daughter, we are just 5 minutes away. In less than 5 minutes EMS were here and the daughter also came in, there was no pulse . Interview on [DATE] at 10:00a.m., the DON said she reviewed the 24 hour report for [DATE] looking for information indicating that staff were to follow up with notifying CR#1's physician of her fall with injury but there was none. The DON said she talked to the nurse who worked the evening shift (6p.m.-6a.m.) on [DATE] who said she was not told by the day shift nurse (LVN #1) to follow up or to call CR #1's physician. The DON agreed the resident's physician and the facility's medical director should have been promptly notified of both the fall and change in condition. The DON further said CR#1's physician said he was aware of the fall and did not think anything would have changed or been done differently. Interview on [DATE] at 2:44p.m., LVN #2 said when he made his rounds the morning of [DATE] around 6a.m. and noticed CR #1 was in bed sick with a bruise on her face. He asked the nurse what happened to CR #1 and was informed the resident fell on Friday ([DATE]). LVN #2 said the nurse told him CR #1 had not been doing well, had been in bed since the fall and Neuro checks were in progress. LVN #2 said this was all the report the outgoing night nurse gave him. LVN #2 reported he continued Neuro checks every hour, but CR #1 was not opening her eyes, so he called the physician around 11a.m. The physician did not respond and did not call back, so LVN #2 continued monitoring the resident every hour, talking to her, trying to get her to open her eyes and talk back to him. LVN #2 said about 5p.m., he noted the resident was not responding like before, so he reported it to the ADON #1 and was told to call the doctor. LVN #2 stated he called the doctor and the doctor told him to call the resident's daughter and ask what the family preferred since CR #1 was had a code status of DO NOT RESUSITATE (DNR). LVN #2 further said he called CR #1's daughter who asked him to call 911. He stated he called 911 and they arrived in about 5 minutes and found no pulse. LVN #2 said he had only one aide in the morning, so he could not use her to help him monitor the resident closely, since one aide had called in. LVN #2 said he checked the residents' vital signs twice in the morning and in the afternoon and they were all normal. He also said he expected the resident's physician was aware of the fall with head injuries and did not mention it when he called him on [DATE]. LVN #2 said after reflecting on the incident, he should have called the physician earlier when he noted the resident was not feeling well, but the nurse who worked the night before said that was how the resident had been throughout the night shift. LVN #2 said he would have continued to called the physician or report it to the ADON #1 earlier if he had known this was unusual for CR #1. LVN #2 said CR #1 was declared dead on arrival, EMS called police and medical examiner's office. Interview on [DATE] at 2:58p.m., LVN #2 when asked what CR#1 looked like during his last rounds stated CR#1 had an oxygen saturation of 75%, she was not breathing well-shallow breathing, pulse was 193 and very faint, color was normal and body was warm, no discharge was noted. Interview on [DATE] at 3:05p.m., ADON #1 said she was called by LVN #2 around after 6p.m. on [DATE]. She stated LVN #2 told her that CR #1 was unresponsive, had blood pressure and heart rate but no oxygen saturation was registering on pulse oximeter. She told LVN #2 to call the physician. ADON #1 said she called back about three minutes later and was told EMS

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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 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) was in the facility and the resident was dead. Interview on [DATE] at 3:20p.m., the Administrator reported she asked LVN #2 why CR#1's physician was not contacted earlier in his shift when he identified the change in her condition but he had no response. Interview on [DATE] at 1:38p.m., the Administrator, who was the abuse and neglect coordinator, said she believed the facility was in immediate jeopardy because of CR #1's death. She explained she reported the incident to the state agency. The Administrator said she was not notified of CR #1's fall with injury on Friday [DATE] until Sunday night ([DATE]), when CR #1 was found unresponsive and passed away the same day. The Administrator said she started investigating the incident and realized it should be reported. She expressed the safety of the residents was her priority. She stated CR #1 always wanted to be out of her room, and preferred to sit by the nurses' station but always yelled help me, help me. Interview on [DATE] at 1:5p.m., the DON said she believed the facility was in immediate jeopardy because LVN #2, who was CR #1's nurse on Sunday [DATE], failed to respond promptly to CR #1's clinical changes. The DON said when LVN #2 was asked why he did not promptly intervene; he had no response and just said he was monitoring her. The DON agreed nurses should work together and follow up from each other provided there was communication of what needed to be done for the residents. She said she expected staff to conduct proper assessment and intervene when needed. The DON said CR #1 always liked to sit by the nurses' station and always yelled help me, help me. She stated staff should have been alarmed when CR #1 stayed in bed all day Friday, Saturday and Sunday. Interview on [DATE] at 10:00a.m., the DON said she reviewed the 24 hour report for [DATE] looking for information indicating that staff were to follow up with notifying CR#1's physician of her fall with injury but there was none. The DON said she talked to the nurse who worked the evening shift (6p.m.-6a.m.) on [DATE] who said she was not told by the day shift nurse (LVN #1) to follow up or to call CR #1's physician. The DON agreed the resident's physician and the facility's medical director should have been promptly notified of both the fall and change in condition. The DON further said CR#1's physician said he was aware of the fall and did not think anything would have changed or been done differently considering CR #1's age and advance directives of DNR. The DON agreed LVN #2 should have called 911 when the resident was found unresponsive instead calling the ADON #1, then the physician, the resident's family and lastly 911. The DON agreed the ADON #1 contacted should have advised LVN #2 to call 911 immediately. The DON also said the night nurse reported CR #1 was stable all night ([DATE]) and showed no signs of a change in condition. Record review of facility's policy on abuse and neglect, which was not dated, read in part .what constitutes neglect - neglect is failure to provide goods or services including medical services that are necessary to provide physical or emotional harm, pain, or mental illness. The facility must determine if an injury, harm to or death of a resident was due to a facility's failure to provide services, treatment or care to a resident. Failure to provide good and services or treatment and care necessary to avoid physical harm, mental anguish or mental illness . On [DATE] at 3:38p.m. an IJ was identified and the facility Administrator was notified. The IJ was removed on [DATE]. The facility submitted and implemented the following plan to remove the IJ on [DATE]. Plan to remove immediacy: I. The Administrator and Director of Nursing were notified on ,[DATE] at approximately 4:15p.m. of an Immediate Jeopardy for neglect related to failure to conduct proper assessment after a fall. The following steps are the facility's plan to remove the Immediate Jeopardy. a) On [DATE], Nurse Managers, Licensed Nurses, and the Director of Nursing immediately assessed current residents (99 residents) in the facility to ensure any changes in condition were identified, physician notification has occurred, interventions implemented, documentation in the medical record reflective of the residents status and the identified change in condition were care planned completed [DATE]. b.) On [DATE], Nurse Managers, Licensed Nurses, and the Director of nursing immediately assessed (99 residents) in the facility to reflect fall risk status of resident's current condition completed [DATE]. An Ad Hoc Quality Assurance Committee meeting was held on [DATE] with the Medical Director, Director of Nursing, Administrator, and Interdisciplinary Team to review and discuss the plan of action of properly assessing a resident after a fall with injury and the plan for physician notification if the primary physician does not return a call. The nursing staff will notify the primary physician and if a call is not returned within 30 minutes, the Medical Director is to be called; if Medical Director does not return the call within 15 minutes the resident is to be sent to ER. In the event that the injury requires immediate medical attention the resident will be transported to the emergency room . This is documented on Quality Assurance Performance Improvement Agenda form. Completed [DATE]. The Director of Nursing and Nurse Managers immediately began re-educating staff (RN/LVN/C.N.A./ MA) on the following: ([DATE]) On recognizing changes in condition (Change in a residents status; the nurse will notify the resident's attending physician and family when there has been an accident or incident involving the resident, a discovery of injury of unknown source, a reaction to medication, a significant change in the resident's physical, emotional or mental condition, a need to alter the resident's medical treatment significantly, refusal of treatment or medication, a need to transfer the resident to a hospital/treatment center, a discharge without proper medical authority, and/or instructions to notify the physician of changes in the resident condition some of the symptoms may include: Recognizing changes in mental status, functional status of a resident, respiratory, GI/abdomen, GU/urine. Head injury/Neuro checks- a neurological check form will be completed for any fall involving the head or any un-witnessed fall. If there are any changes in the neurological assessment: opening eyes and changes in pupil size or reaction, motor and verbal response changes from baseline to next assessment, or changes in the overall total Glasgow Score from previous perimeter the nurse will call the physician for further recommendations. Unresponsive Resident-if a resident is found unresponsive after assessment nurse is to call 911. Assessing the resident by completion of the Interact SBAR (Assessing the resident and documenting in the clinical records of the resident; for example, a significant change of condition is a decline or improvement of the resident status that will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions and also impacts more than one area of the resident's health status requires interdisciplinary review and revision to the care plan and is ultimately based on the judgment of the clinical staff and guidelines of the resident assessment instrument)-documentation in the residents medical record (documenting residents condition, any changes, when a resident admits, or discharges from the facility) for example, the nurse supervisor/charge nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status notification to the attending physicians/responsible party. The nursing staff will notify the primary physician and if a call is not returned within 30 minutes, the Medical Director is to be called; if Medical Director does not return the call within 15 minutes the resident is to be sent to ER. In the event that the injury requires immediate medical attention the resident will be transported to the emergency room . Care planning the change in condition (Care planning any change with a resident) Utilization of the Interact Stop and Watch tool -these items were in-serviced CNAs/MAs will immediately notify the charge nurse if any of the above occur. Fall education started on [DATE] by Director of Staff Development on 2- 10 shift that included License nurses re-educated to the policy and procedures of the 24 hour report. Utilization of the 24 hour report to report changes in condition. The following in-services started on [DATE] by the Director of Social Services on ,[DATE] shift. Abuse/neglect regarding assessing and documenting change in condition. Education started on [DATE] ,[DATE] shifts. Education will continue each shift until 100%of the Nursing Staff (RN/LVN/MA/CNA) is educated on the above. Those employees on leave will have their education completed upon arrival for the start of the next scheduled shift to work. Director of Staff development or designee will include in-services with the orientation process. No staff will be allowed to provide patient care until they have been trained. The DON, Nurse Managers/Designee will round daily starting [DATE] and will continue daily to ensure no changes in condition. To monitor the Director of Nursing/ designee clinical rounds to identify changes in condition. Review notifications of physician ' s clinical meeting. Review SBAR in clinical meetings. Review Incidents/Accidents in Clinical meeting. Weekend supervisor will conduct clinical meeting.

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F 0224 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 5) The surveyor monitored the plan to remove the immediate jeopardy on [DATE] and [DATE] as follows: Monitoring began on [DATE]. LVNs and RNs were interviewed on two shifts on physician notification, and proper assessment following falls and changes in condition. Record review of the facility In-Services revealed: [DATE] - twelve staff members were trained on proper way of notifying/consulting the resident's physician, and facility's medical director and to call 911 if no response was received from the physicians; and staff were to notify the DON or designee of any identified changes in condition, falls with injury and the proper assessment, documentation and analysis of neurological assessment following falls with head injuries. 14 staff members were trained on physician notification of any resident with a change in condition and using the SBAR (Situation, Background, Assessment, and Recommendation) tool. [DATE] - more than 50% of the facility's nursing staff members were trained on parameters of when to notify facility administration on any changes in residents. Interview on [DATE] at 10:00 a.m., the DON stated she completed chart audits, evaluated all residents in the facility for changes in condition, falls with or without injuries and found that staff were implementing the appropriate and current plan. Record review of in-service, dated [DATE], the DON and ADONs trained all staff scheduled to work [DATE], [DATE], and [DATE]. Interviews with 6 MAs, and 5 CNAs on [DATE] between 4:25 p.m. and 5:15 p.m., revealed they received training on how to identify abuse and neglect, when to notify a charge nurse of anything usual noted about any patient, and if the nurses did not respond immediately to call the DON or the administrator. Record review of the in-service forms provided by the Administrator dated [DATE], [DATE] and [DATE] revealed on-going in-services concerning resident assessments, physicians' consultation, and post fall with head injury interventions. Interview on [DATE] at 9:30a.m., the Administrator stated she would be continuing to monitor the DON and staff to ensure the plan was implemented and effective. She further reported she would continue to monitor the facility approved plan of removal to ensure the safety of the residents. She said she was monitoring and evaluating all fall incidents to ensure staff were implementing the plan. She also stated the facility's medical director had spoken with all other doctors to ensure they understood that he would be called for intervention should they not promptly respond to facility's calls. After monitoring the implementation of the plan, the IJ was removed. The Administrator was informed the IJ was removed on [DATE] at 9:39a.m. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of pattern and a severity level of actual harm that is not immediate jeopardy. The facility was continuing to monitor their plans to ensure residents' physicians were promptly consulted following falls with injuries and following changes in condition. The Administrator reported 17 residents in the facility at high risk for falls.
F 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**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 and record review the facility failed to provide necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being for one of 12 residents (CR #1) reviewed for quality of care. The facility failed to recognize CR #1's change in condition after she had a fall with a head injury and consult with the physician to obtain orders for prompt medical intervention or services. The facility failed to seek medical consultation and care for CR #1 who had a fall with a head injury and the resident's physician did not respond to the facility's calls. An immediate jeopardy (IJ) was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and scope of pattern. This failure affected one resident who died in the facility following a significant change of condition and placed 16 other residents at risk for falls at risk of not receiving services necessary to ensure residents received medical care from injuries, which could lead to a decline in their health, untreated pain or death. Findings include: Incident intake # 4 CR#1 Record review of CR #1's face sheet revealed a [AGE] year old female admitted to the facility on [DATE] and re-admitted on [DATE]. Her [DIAGNOSES REDACTED]. Record review of CR#1's MDS dated [DATE] revealed a BIMS score of 11 out of 15, indicating moderate cognitive impairment. Further review revealed CR #1 required extensive assistance for bed mobility, transfers, walking in room, walking in corridor, dressing, locomotion off unit, toilet use, personal hygiene and bathing. The resident required limited assistance for locomotion on unit, and eating. Further review of this MDS revealed the resident had a fall with injury that was not major. Record review of CR#1's incident report dated [DATE] at 1:28p.m., revealed resident was noted on the floor lying on her left side calling for help. Injuries noted were hematoma left forehead (brow area) and abrasion to left knee. The resident was alert. Further review of this incident report revealed the resident's physician was called and a message was left about the fall on [DATE] at 1:50p.m. Record review of CR #1's care plan, which was undated, revealed she had falls on [DATE], [DATE] and [DATE]. Further review revealed a goal which read My number of falls will be reduced through next review date. I have had an actual fall on [DATE]. Target date: [DATE]. Interventions included: Educate on use of call light and to wait for staff to come help. Be sure my call light is within reach and encourage me to use it. Follow facility fall protocol. Pt. evaluate and treat as ordered or PRN. After each fall episode evaluate current interventions and modify interventions based on IDT recommendations. Record review of CR#1's neurological evaluation flow sheet, revealed it was initiated on [DATE] at 1:28p.m. and stopped on [DATE] at 6a.m. Further review revealed the following pupil reaction documentation: [DATE] at 1:28p.m. - pupils were sluggish. [DATE] at 6:45p.m. - pupils were sluggish [DATE] at 7p.m. - pupils were sluggish [DATE] at 8p.m. - pupils were sluggish [DATE] at 8:30p.m. - pupils were sluggish [DATE] at 9p.m. - pupils were sluggish [DATE] at 10p.m.-pupils were sluggish [DATE] at 6a.m. - pupils were brisk [DATE] at 6p.m. - right pupil was brisk, notation for left pupil was illegible [DATE] at 6:00a.m. - pupils were sluggish. Record review of CR#1's progress notes dated [DATE] at 2:33p.m., revealed resident was noted lying on the floor by staff crying for help. A large raised area noted on forehead, scrape noted on left knee, no internal or external rotation on both upper and lower extremities. Vital laying down ,[DATE], pulse-103, R (respiration) 18, blood pressure sitting down ,[DATE], pulse 100, respiration 18 and temperature 98. Responsible party informed, physician's office called and message left re-fall, ice park to areas on forehead and neuro checks. Interview on [DATE] at 2:23p.m., LVN#1 stated when he was notified of CR #1's fall on [DATE], he went to the patient's room and took vitals, called the physician's office and told the office staff the reason for his call. LVN #1 said he called again 20 minutes later and was told by the office staff that the physician would call him back. LVN #1 reported he called the physician 3 times, called the resident's family and continued with neuro checks. LVN #1 stated the physician did not call back throughout his shift (6a.m.-6p.m.). He further said he notified the on-coming nurse to follow up with CR #1's physician. There was no other progress note documentation for [DATE]. Interview on [DATE] at 1:20p.m., CNA #1 said she cared for CR #1 on the morning of [DATE]. She said CR #1 had a bruise to her forehead but was talking. She stated she cleaned CR #1 up and fed her in bed by the resident's choice. CNA #1 said the resident made no complaints to her, but was unable to go the bathroom like she would before the fall. She had incontinent

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F 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 6) brief on and had two brief changes during her shift, she did not notice any running nose, discharges and no pain was expressed or verbalized. CNA #1 said the resident previously would talk and say help me, help me and did not like to stay in bed, but preferred to be out of her room and sit by the nurse's station. Record review of CR#1's progress notes dated [DATE] at 5:11p.m., revealed resident in bed lying down, assisted patient with putting dentures in her mouth, resident is being monitored post fall, resident has bruising to left side of forehead, left per orbital and check area and less extensive bruising to right per orbital area, resident is alert to self and able to speak. Resident is now being fed by speech therapy. There was no other progress note documentation for [DATE]. Record review of CR #1's progress notes dated [DATE] at 3:30a.m., revealed Resident in bed stable at the moment, no signs and symptoms of acute distress noted. Respiration even and unlabored, skin warm and dry to touch, resident status [REDACTED]. Vital signs were: blood pressure ,[DATE], R18, oxygen saturation 98%, active range of motion on upper and lower extremities. Safety measures in place and call light within reach and bed in lowest position, will continue with the care. Two attempts were made to interview the CNAs who cared for CR #1 on Sunday morning and Sunday afternoon without success. Phone calls were not returned. Record review of CR #1's progress notes dated [DATE] at 7:02p.m., revealed Patient was not responding and vital signs were BP,[DATE], Pulse -193, R-28, oxygen saturation was 75% room air. Called out MD immediately, the doctor said call the daughter, notified of patient status and what the doctor said, she requested call 911 immediately and let them wait for me, 911 was called, when they arrived there was no pulse, daughter came few minutes after as she said, at this hour they are here. Further review of progress report revealed: At 7:21p.m., ADON (#1) made aware of patient status, at 6:45p.m., resident was pronounced by 911 with family present and 9:35p.m., Resident was picked up by medical examiner via stretcher accompanied by two policemen, Resident's daughter and physician notified. Record review of a written statement by LVN #2 (CR#1's charge nurse on [DATE]) read in part .on [DATE], I reported to duty at 6a.m., during rounds I observed patient (CR#1) in bed with bruises on her face and eyes closed. I greeted her, she responded with help me, help me. Her right eye was running water, I went back to the night nurse to find out what happened to her face and her condition, the nurse told me that patient fell Friday [DATE] and hit her head, neuro check is in progress and she has been in bed since then. Vital signs were ,[DATE], pulse 120. Respiration 20, temperature 98.6, oxygen saturation was 95% at room air. I called the physician about 11a.m. concerning the patient eye and the bruises on her face, no call back. She was monitored throughout and was responding with help me, help me. At about 5:45p.m., during my last round, patient was not responding, I called for help and we checked vital signs, blood pressure was ,[DATE], pulse was 193, oxygen saturation was 75% at room air, notified the ADON (#1) who advised to call MD and family. Called out MD and updated him of patient status and the patient is DNR, MD ordered to call family member and ask what she wants, daughter asked to call 911 and sent patient to hospital but let the 911 staff wait I am on my way with my daughter, we are just 5 minutes away. In less than 5 minutes EMS were here and the daughter also came in, there was no pulse . Interview on [DATE] at 2:44p.m., LVN #2 said when he made his rounds the morning of [DATE] around 6a.m. and noticed CR #1 was in bed sick with a bruise on her face. He asked the nurse what happened to CR #1 and was informed the resident fell on Friday ([DATE]). LVN #2 said the nurse told him CR #1 had not been doing well, had been in bed since the fall and Neuro checks were in progress. LVN #2 said this was all the report the outgoing night nurse gave him. LVN #2 reported he continued Neuro checks every hour, but CR #1 was not opening her eyes, so he called the physician around 11a.m. The physician did not respond and did not call back, so LVN #2 continued monitoring the resident every hour, talking to her, trying to get her to open her eyes and talk back to him. LVN #2 said about 5p.m., he noted the resident was not responding like before, so he reported it to the ADON #1 and was told to call the doctor. LVN #2 stated he called the doctor and the doctor told him to call the resident's daughter and ask what the family preferred since CR #1 was had a code status of DO NOT RESUSITATE (DNR). LVN #2 further said he called CR #1's daughter who asked him to call 911. He stated he called 911 and they arrived in about 5 minutes and found no pulse. LVN #2 said he had only one aide in the morning, so he could not use her to help him monitor the resident closely, since one aide had called in. LVN #2 said he checked the residents' vital signs twice in the morning and in the afternoon and they were all normal. He also said he expected the resident's physician was aware of the fall with head injuries and did not mention it when he called him on [DATE]. LVN #2 said after reflecting on the incident, he should have called the physician earlier when he noted the resident was not feeling well, but the nurse who worked the night before said that was how the resident had been throughout the night shift. LVN #2 said he would have continued to call the physician or report it to the ADON #1 earlier if he had known this was unusual for CR #1. LVN #2 said CR #1 was declared dead on arrival, EMS called police and medical examiner's office. Interview on [DATE] at 2:58p.m., LVN #2 when asked what CR#1 looked like during his last rounds stated CR#1 had an oxygen saturation of 75%, she was not breathing well-shallow breathing, pulse was 193 and very faint, color was normal and body was warm, no discharge was noted. Interview on [DATE] at 3:05p.m., ADON #1 said she was called by LVN #2 around after 6p.m. on [DATE]. She stated LVN #2 told her that CR #1 was unresponsive, had blood pressure and heart rate but no oxygen saturation was registering on pulse oximeter. She told LVN #2 to call the physician. ADON #1 said she called back about three minutes later and was told EMS was in the facility and the resident was dead. Interview on [DATE] at 3:20p.m., the Administrator reported she asked LVN #2 why CR#1's physician was not contacted earlier in his shift when he identified the change in her condition but he had no response. Interview on [DATE] at 1:38p.m., the Administrator said she believed the facility was in immediate jeopardy because of CR #1's death. She explained she reported the incident to the state agency. The Administrator said she was not notified of CR #1's fall with injury on Friday [DATE] until Sunday night ([DATE]), when CR #1 was found unresponsive and passed away the same day. The Administrator said she started investigating the incident and realized it should be reported. She expressed the safety of the residents was her priority. She stated CR #1 always wanted to be out of her room, and preferred to sit by the nurses' station but always yelled help me, help me. Interview on [DATE] at 1:5p.m., the DON said she believed the facility was in immediate jeopardy because LVN #2, who was CR #1's nurse on Sunday [DATE], failed to respond promptly to CR #1's clinical changes. The DON said when LVN #2 was asked why he did not promptly intervene; he had no response and just said he was monitoring her. The DON agreed nurses should work together and follow up from each other provided there was communication of what needed to be done for the residents. She said she expected staff to conduct proper assessment and intervene when needed. The DON said CR #1 always liked to sit by the nurses' station and always yelled help me, help me. She stated staff should have been alarmed when CR #1 stayed in bed all day Friday, Saturday and Sunday. Interview on [DATE] at 10:00a.m., the DON said she reviewed the 24 hour report for [DATE] looking for information indicating that staff were to follow up with notifying CR#1's physician of her fall with injury but there was none. The DON said she talked to the nurse who worked the evening shift (6p.m.-6a.m.) on [DATE] who said she was not told by the day shift nurse (LVN #1) to follow up or to call CR #1's physician. The DON agreed the resident's physician and the facility's medical director should have been promptly notified of both the fall and change in condition. The DON further said CR#1's physician said he was aware of the fall and did not think anything would have changed or been done differently considering CR #1's age and advance directives of DNR. The DON agreed LVN #2 should have called 911 when the resident was found unresponsive instead calling the ADON #1, then the physician, the resident's family and lastly 911. The DON agreed the ADON #1 contacted should have advised LVN #2 to call 911 immediately. The DON also said the night nurse reported CR #1 was stable all night ([DATE]) and showed no signs of a change in condition. Record review of facility policy on resident rights which was not dated read in part .the facility will protect and protect the rights of each resident. The facility will immediately inform the resident and consult with the resident's physician, if appropriate when changes occur .Notification of changes shall include: An accident involving the resident which results in injury and has the potential for requiring physician intervention. A significant change in the resident's physical mental, or psychological status such as deterioration in health or psychosocial status in either life threatening conditions or clinical complications etc . On [DATE] at 3:38p.m., an IJ was identified and the facility Administrator was notified. The IJ was removed on [DATE]. The facility submitted and implemented the following plan to remove the IJ on [DATE]. Plan to remove immediacy:

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WEST OAKS NURSING & REHAB CENTER	3625 GREEN CREST HOUSTON, TX 77082

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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 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 7) I. The Administrator and Director of Nursing were notified on [DATE] at approximately 4:15p.m. of an Immediate Jeopardy for neglect related to failure to conduct proper assessment after a fall. The following steps are the facility's plan to remove the Immediate Jeopardy. a) On [DATE], Nurse Managers, Licensed Nurses, and the Director of Nursing immediately assessed current residents (99 residents) in the facility to ensure any changes in condition were identified, physician notification has occurred, interventions implemented, documentation in the medical record reflective of the residents status and the identified change in condition were care planned completed [DATE]. b.) On [DATE], Nurse Managers, Licensed Nurses, and the Director of nursing immediately assessed (99 residents) in the facility to reflect fall risk status of resident's current condition completed [DATE]. An Ad Hoc Quality Assurance Committee meeting was held on [DATE] with the Medical Director, Director of Nursing, Administrator, and Interdisciplinary Team to review and discuss the plan of action of properly assessing a resident after a fall with injury and the plan for physician notification if the primary physician does not return a call. The nursing staff will notify the primary physician and if a call is not returned within 30 minutes, the Medical Director is to be called; if Medical Director does not return the call within 15 minutes the resident is to be sent to ER. In the event that the injury requires immediate medical attention the resident will be transported to the emergency room . This is documented on Quality Assurance Performance Improvement Agenda form. Completed [DATE]. The Director of Nursing and Nurse Managers immediately began re-educating staff (RN/LVN/C.N.A./ MA) on the following: ([DATE]) On recognizing changes in condition (Change in a residents status; the nurse will notify the resident's attending physician and family when there has been an accident or incident involving the resident, a discovery of injury of unknown source, a reaction to medication, a significant change in the resident's physical, emotional or mental condition, a need to alter the resident's medical treatment significantly, refusal of treatment or medication, a need to transfer the resident to a hospital/treatment center, a discharge without proper medical authority, and/or instructions to notify the physician of changes in the resident condition some of the symptoms may include: Recognizing changes in mental status, functional status of a resident, respiratory, GI/abdomen, GU/urine. Head injury/Neuro checks- a neurological check form will be completed for any fall involving the head or any un-witnessed fall. If there are any changes in the neurological assessment: opening eyes and changes in pupil size or reaction, motor and verbal response changes from baseline to next assessment, or changes in the overall total Glasgow Score from previous perimeter the nurse will call the physician for further recommendations. Unresponsive Resident-if a resident is found unresponsive after assessment nurse is to call 911. Assessing the resident by completion of the Interact SBAR (Assessing the resident and documenting in the clinical records of the resident; for example, a significant change of condition is a decline or improvement of the resident status that will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions and also impacts more than one area of the resident's health status requires interdisciplinary review and revision to the care plan and is ultimately based on the judgment of the clinical staff and guidelines of the resident assessment instrument)-documentation in the residents medical record (documenting residents condition, any changes, when a resident admits, or discharges from the facility) for example, the nurse supervisor/charge nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status notification to the attending physicians/responsible party. The nursing staff will notify the primary physician and if a call is not returned within 30 minutes, the Medical Director is to be called; if Medical Director does not return the call within 15 minutes the resident is to be sent to ER. In the event that the injury requires immediate medical attention the resident will be transported to the emergency room . Care planning the change in condition (Care planning any change with a resident) Utilization of the Interact Stop and Watch tool -these items were in-serviced CNAs/MAs will immediately notify the charge nurse if any of the above occur. Fall education started on [DATE] by Director of Staff Development on 2- 10 shift that included License nurses re-educated to the policy and procedures of the 24 hour report. Utilization of the 24 hour report to report changes in condition. The following in-services started on [DATE] by the Director of Social Services on ,[DATE] shift. Abuse/neglect regarding assessing and documenting change in condition. Education started on [DATE] ,[DATE] shifts. Education will continue each shift until 100%of the Nursing Staff (RN/LVN/MA/CNA) is educated on the above. Those employees on leave will have their education completed upon arrival for the start of the next scheduled shift to work. Director of Staff development or designee will include in-services with the orientation process. No staff will be allowed to provide patient care until they have been trained. The DON, Nurse Managers/Designee will round daily starting [DATE] and will continue daily to ensure no changes in condition. To monitor the Director of Nursing/ designee clinical rounds to identify changes in condition. Review notifications of physician ' s clinical meeting. Review SBAR in clinical meetings. Review Incidents/Accidents in Clinical meeting. Weekend supervisor will conduct clinical meeting. The surveyor monitored the plan to remove the immediate jeopardy on [DATE] and [DATE] as follows: Monitoring began on [DATE]. LVNs and RNs were interviewed on two shifts on physician notification, and proper assessment following falls and changes in condition. Record review of the facility In-Services revealed: [DATE] - twelve staff members were trained on proper way of notifying/consulting the resident's physician, and facility's medical director and to call 911 if no response was received from the physicians; and staff were to notify the DON or designee of any identified changes in condition, falls with injury and the proper assessment, documentation and analysis of neurological assessment following falls with head injuries. 14 staff members were trained on physician notification of any resident with a change in condition and using the SBAR (Situation, Background, Assessment, and Recommendation) tool. [DATE] - more than 50% of the facility's nursing staff members were trained on parameters of when to notify facility administration on any changes in residents. Interview on [DATE] at 10:00 a.m., the DON stated she completed chart audits, evaluated all residents in the facility for changes in condition, falls with or without injuries and found that staff were implementing the appropriate and current plan. Record review of in-service, dated [DATE], the DON and ADONs trained all staff scheduled to work [DATE], [DATE], and [DATE]. Interviews with 6 MAs, and 5 CNAs on [DATE] between 4:25 p.m. and 5:15 p.m., revealed they received training on how to identify abuse and neglect, when to notify a charge nurse of anything usual noted about any patient, and if the nurses did not respond immediately to call the DON or the administrator. Record review of the in-service forms provided by the Administrator dated [DATE], [DATE] and [DATE] revealed on-going in-services concerning resident assessments, physicians' consultation, and post fall with head injury interventions. Interview on [DATE] at 9:30a.m., the Administrator stated she would be continuing to monitor the DON and staff to ensure the plan was implemented and effective. She further reported she would continue to monitor the facility approved plan of removal to ensure the safety of the residents. She said she was monitoring and evaluating all fall incidents to ensure staff were implementing the plan. She also stated the facility's medical director had spoken with all other doctors to ensure they understood that he would be called for intervention should they not promptly respond to facility's calls. After monitoring the implementation of the plan, the IJ was removed. The Administrator was informed the IJ was removed on [DATE] at 9:39a.m. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of pattern and a severity level of actual harm that is not immediate jeopardy. The facility was continuing to monitor their plans to ensure residents' physicians were promptly consulted following falls with injuries and following changes in condition. The Administrator reported 17 residents in the facility at high risk for falls.
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Be administered in an acceptable way that maintains the well-being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 8) Based on record review, and interviews, the administration failed to administer the facility in a manner that enabled it to use the facility's resources effectively to maintain the highest practicable physical well-being of one of 12 residents (CR #1) reviewed for quality of care. The Administrator failed to oversee and assist with the implementation of effective policies and procedures on identifying a resident with a change in condition, promptly consulting with the physician and preventing neglect. The Administrator failed to supervise the DON on training and monitoring the nursing staff to assess, monitor, provide medical care to residents and promptly consult physicians concerning a change of condition in residents. The DON failed to ensure staff were trained to monitor, assess, provide care and consult physicians timely concerning resident who have falls with head injuries and/or changes in condition. The DON failed to ensure staff were trained to assess, and identify changes requiring the need of emergency medical services for prompt interventions. An immediate jeopardy (IJ) was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and scope of pattern. This failure affected one resident who died in the facility following a significant change of condition and placed 16 other residents who were at risk for falls at risk of not being assessed, monitored, treated, and not having their physicians consulted for prompt interventions which could cause a delay in treatment, a decline in health, and death. Findings include: Incident intake # 4 Interview on [DATE] at 1:38p.m., the Administrator said she believed the facility was in immediate jeopardy because of CR #1's death. She explained she reported the incident to the state agency. The Administrator said she was not notified of CR #1's fall with injury on Friday [DATE] until Sunday night ([DATE]), when CR #1 was found unresponsive and passed away the same day. The Administrator said she started investigating the incident and realized it should be reported. She stated CR #1 always wanted to be out of her room, and preferred to sit by the nurses' station but always yelled help me, help me. She expressed the safety of the residents was her priority. The Administrator stated the nursing needs of the residents are typically addressed during daily clinical meetings when department heads who are assigned to particular residents see these needs while rounding and report them during the meetings. She further stated these needs are taken to the QA committee meetings and addressed. The Administrator stated she monitored the effectiveness of the DON through various ways including clinical meetings, monthly QA meetings, assessing the competency of the staff, and rounding. During this same interview the Administrator stated the company provided numerous resources for the Administrator and DON to utilize to assist in training and monitoring staff. She stated the company had a Medical Director, Corporate Nurses and other external resources. Interview on [DATE] at 1:55p.m., the DON said she believed the facility was in immediate jeopardy because LVN #2, who was CR #1's nurse on Sunday [DATE], failed to respond promptly to CR #1's clinical changes. The DON said when LVN #2 was asked why he did not promptly intervene; he had no response and just said he was monitoring her. The DON agreed nurses should work together and follow up from each other provided there was communication of what needed to be done for the residents. She said she expected staff to conduct proper assessment and intervene when needed. The DON said CR #1 always liked to sit by the nurses' station and always yelled help me, help me. She stated staff should have been alarmed when CR #1 stayed in bed all day Friday, Saturday and Sunday. The DON stated staff had been trained that when a fall occurred the resident should be assessed, the physician notified, family notified and his orders should be followed. She stated if a physician did not call back, staff were instructed to notify the DON. The DON stated she had numerous ways on ensuring the competency of her nursing staff which included inservices, skill check lists upon hire and yearly, education during clinical meetings, and talking to staff when things were not done correctly. The DON stated the facility offered numerous resources to assist in training and monitoring staff including a Medical Director, Nurse consultants, and Policies and Procedures. Interview on [DATE] at 10:00a.m., the DON said she reviewed the 24 hour report for [DATE] looking for information indicating that staff were to follow up with notifying CR#1's physician of her fall with injury but there was none. The DON said she talked to the nurse who worked the evening shift (6p.m.-6a.m.) on [DATE] who said she was not told by the day shift nurse (LVN #1) to follow up or to call CR #1's physician. The DON agreed the resident's physician and the facility's medical director should have been promptly notified of both the fall and change in condition. The DON further said CR#1's physician said he was aware of the fall and did not think anything would have changed or been done differently considering CR #1's age and advance directives of DNR. The DON agreed LVN #2 should have called 911 when the resident was found unresponsive instead calling the ADON #1, then the physician, the resident's family and lastly 911. The DON agreed the ADON #1 contacted should have advised LVN #2 to call 911 immediately. The DON also said the night nurse reported CR #1 was stable all night ([DATE]) and showed no signs of a change in condition. CR#1 Record review of CR #1's face sheet revealed a [AGE] year old female admitted to the facility on [DATE] and re-admitted on [DATE]. Her [DIAGNOSES REDACTED]. Record review of CR#1's MDS dated [DATE] revealed a BIMS score of 11 out of 15, indicating moderate cognitive impairment. Further review revealed CR #1 required extensive assistance for bed mobility, transfers, walking in room, walking in corridor, dressing, locomotion off unit, toilet use, personal hygiene and bathing. The resident required limited assistance for locomotion on unit, and eating. Further review of this MDS revealed the resident had a fall with injury that was not major. Record review of CR#1's incident report dated [DATE] at 1:28p.m., revealed resident was noted on the floor lying on her left side calling for help. Injuries noted were hematoma left forehead (brow area) and abrasion to left knee. The resident was alert. Further review of this incident report revealed the resident's physician was called and a message was left about the fall on [DATE] at 1:50p.m. Record review of CR #1's care plan, which was undated, revealed she had falls on [DATE], [DATE] and [DATE]. Further review revealed a goal which read My number of falls will be reduced through next review date. I have had an actual fall on [DATE]. Target date: [DATE]. Interventions included: Educate on use of call light and to wait for staff to come help. Be sure my call light is within reach and encourage me to use it. Follow facility fall protocol. Pt. evaluate and treat as ordered or PRN. After each fall episode evaluate current interventions and modify interventions based on IDT recommendations. Record review of CR#1's neurological evaluation flow sheet, revealed it was initiated on [DATE] at 1:28p.m. and stopped on [DATE] at 6a.m. Further review revealed the following pupil reaction documentation: [DATE] at 1:28p.m. - pupils were sluggish. [DATE] at 6:45p.m. - pupils were sluggish [DATE] at 7p.m. - pupils were sluggish [DATE] at 8p.m. - pupils were sluggish [DATE] at 8:30p.m. - pupils were sluggish [DATE] at 9p.m. - pupils were sluggish [DATE] at 10p.m.-pupils were sluggish [DATE] at 6a.m. - pupils were brisk [DATE] at 6p.m. - right pupil was brisk, notation for left pupil was illegible [DATE] at 6:00a.m. - pupils were sluggish. Record review of CR#1's progress notes dated [DATE] at 2:33p.m., revealed resident was noted lying on the floor by staff crying for help. A large raised area noted on forehead, scrape noted on left knee, no internal or external rotation on both upper and lower extremities. Vital laying down ,[DATE], pulse-103, R (respiration) 18, blood pressure sitting down ,[DATE], pulse 100, respiration 18 and temperature 98. Responsible party informed, physician's office called and message left re-fall, ice park to areas on forehead and neuro checks. There was no other progress note documentation for [DATE]. Record review of CR#1's progress notes dated [DATE] at 5:11p.m., revealed resident in bed lying down, assisted patient with putting dentures in her mouth, resident is being monitored post fall, resident has bruising to left side of forehead, left per orbital and check area and less extensive bruising to right per orbital area, resident is alert to self and able to speak. Resident is now being fed by speech therapy.

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 9) There was no other progress note documentation for [DATE]. Record review of CR #1's progress notes dated [DATE] at 3:30a.m., revealed Resident in bed stable at the moment, no signs and symptoms of acute distress noted. Respiration even and unlabored, skin warm and dry to touch, resident status [REDACTED]. Vital signs were: blood pressure ,[DATE], R18, oxygen saturation 98%, active range of motion on upper and lower extremities. Safety measures in place and call light within reach and bed in lowest position, will continue with the care. Record review of CR #1's progress notes dated [DATE] at 7:02p.m., revealed Patient was not responding and vital signs were BP,[DATE], Pulse -193, R-28, oxygen saturation was 75% room air. Called out MD immediately, the doctor said call the daughter, notified of patient status and what the doctor said, she requested call 911 immediately and let them wait for me, 911 was called, when they arrived there was no pulse, daughter came few minutes after as she said, at this hour they are here. Further review of progress report revealed: At 7:21p.m., ADON (#1) made aware of patient status, at 6:45p.m., resident was pronounced by 911 with family present and 9:35p.m., Resident was picked up by medical examiner via stretcher accompanied by two policemen, Resident's daughter and physician notified. Record review of a written statement by LVN #2 (CR#1's charge nurse on [DATE]) read in part .on [DATE], I reported to duty at 6a.m., during rounds I observed patient (CR#1) in bed with bruises on her face and eyes closed. I greeted her, she responded with help me, help me. Her right eye was running water, I went back to the night nurse to find out what happened to her face and her condition, the nurse told me that patient fell Friday [DATE] and hit her head, neuro check is in progress and she has been in bed since then. Vital signs were ,[DATE], pulse 120. Respiration 20, temperature 98.6, oxygen saturation was 95% at room air. I called the physician about 11a.m. concerning the patient eye and the bruises on her face, no call back. She was monitored throughout and was responding with help me, help me. At about 5:45p.m., during my last round, patient was not responding, I called for help and we checked vital signs, blood pressure was ,[DATE], pulse was 193, oxygen saturation was 75% at room air, notified the ADON (#1)who advised to call MD and family. Called out MD and updated him of patient status and the patient is DNR, MD ordered to call family member and ask what she wants, daughter asked to call 911 and sent patient to hospital but let the 911 staff wait I am on my way with my daughter, we are just 5 minutes away. In less than 5 minutes EMS were here and the daughter also came in, there was no pulse . Record review of facility's policy on abuse and neglect, which was not dated, read in part .what constitutes neglect - neglect is failure to provide goods or services including medical services that are necessary to provide physical or emotional harm, pain, or mental illness. The facility must determine if an injury, harm to or death of a resident was due to a facility's failure to provide services, treatment or care to a resident. Failure to provide good and services or treatment and care necessary to avoid physical harm, mental anguish or mental illness . Record review of facility policy on resident rights which was not dated read in part .the facility will protect and protect the rights of each resident. The facility will immediately inform the resident and consult with the resident's physician, if appropriate when changes occur. If known, the facility shall also notify the resident's legal representative or an interested family member. Notification of changes shall include: An accident involving the resident which results in injury and has the potential for requiring physician intervention. A significant change in the resident's physical mental, or psychological status such as deterioration in health or psychosocial status in either life threatening conditions or clinical complications etc . Policies on quality of care and administration were requested from the Administrator but not provided prior to exit. Please refer to CMS form 2567 tags F157, 224, and 309 for additional interviews and information. On [DATE] at 3:38p.m., an IJ was identified and the facility Administrator was notified. The IJ was removed on [DATE]. The facility submitted and implemented the following plan to remove the IJ on [DATE]. Plan to remove immediacy: I. The Administrator and Director of Nursing were notified on [DATE] at approximately 4:15p.m. of an Immediate Jeopardy for neglect related to failure to conduct proper assessment after a fall. The following steps are the facility's plan to remove the Immediate Jeopardy. a) On [DATE], Nurse Managers, Licensed Nurses, and the Director of Nursing immediately assessed current residents (99 residents) in the facility to ensure any changes in condition were identified, physician notification has occurred, interventions implemented, documentation in the medical record reflective of the residents status and the identified change in condition were care planned completed [DATE]. b.) On [DATE], Nurse Managers, Licensed Nurses, and the Director of nursing immediately assessed (99 residents) in the facility to reflect fall risk status of resident's current condition completed [DATE]. An Ad Hoc Quality Assurance Committee meeting was held on [DATE] with the Medical Director, Director of Nursing, Administrator, and Interdisciplinary Team to review and discuss the plan of action of properly assessing a resident after a fall with injury and the plan for physician notification if the primary physician does not return a call. The nursing staff will notify the primary physician and if a call is not returned within 30 minutes, the Medical Director is to be called; if Medical Director does not return the call within 15 minutes the resident is to be sent to ER. In the event that the injury requires immediate medical attention the resident will be transported to the emergency room . This is documented on Quality Assurance Performance Improvement Agenda form. Completed [DATE]. The Director of Nursing and Nurse Managers immediately began re-educating staff (RN/LVN/C.N.A./MA) on the following: ([DATE]) On recognizing changes in condition (Change in a residents status; the nurse will notify the resident's attending physician and family when there has been an accident or incident involving the resident, a discovery of injury of unknown source, a reaction to medication, a significant change in the resident's physical, emotional or mental condition, a need to alter the resident's medical treatment significantly, refusal of treatment or medication, a need to transfer the resident to a hospital/treatment center, a discharge without proper medical authority, and/or instructions to notify the physician of changes in the resident condition some of the symptoms may include: Recognizing changes in mental status, functional status of a resident, respiratory, GI/abdomen, GU/urine. 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Assessing the resident by completion of the Interact SBAR (Assessing the resident and documenting in the clinical records of the resident; for example, a significant change of condition is a decline or improvement of the resident status that will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions and also impacts more than one area of the resident's health status requires interdisciplinary review and revision to the care plan and is ultimately based on the judgment of the clinical staff and guidelines of the resident assessment instrument)-documentation in the residents medical record (documenting residents condition, any changes, when a resident admits, or discharges from the facility) for example, the nurse supervisor/charge nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status notification to the attending physicians/responsible party. The nursing staff will notify the primary physician and if a call is not returned within 30 minutes, the Medical Director is to be called; if Medical Director does not return the call within 15 minutes the resident is to be sent to ER. In the event that the injury requires immediate medical attention the resident will be transported to the emergency room . Care planning the change in condition (Care planning any change with a resident) Utilization of the Interact Stop and Watch tool -these items were in-serviced CNAs/MAs will immediately notify the charge nurse if any of the above occur. Fall education started on [DATE] by Director of Staff Development on 2 - 10 shift that included License nurses re-educated to the policy and procedures of the 24 hour report. Utilization of the 24 hour report to report changes in condition. The following in-services started on [DATE] by the Director of Social Services on ,[DATE] shift. Abuse/neglect regarding assessing and documenting change in condition. Education started on [DATE] ,[DATE] shifts. Education will continue each shift until 100%of the Nursing Staff (RN/LVN/MA/CNA) is educated on the above. Those employees on leave will have their education completed upon arrival for the start of the next scheduled shift to work. Director of Staff development or designee will include in-services with the

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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 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 10) orientation process. No staff will be allowed to provide patient care until they have been trained. The DON, Nurse Managers/Designee will round daily starting [DATE] and will continue daily to ensure no changes in condition. To monitor the Director of Nursing/ designee clinical rounds to identify changes in condition. Review notifications of physician ' s clinical meeting. Review SEAR in clinical meetings. Review Incidents/Accidents in Clinical meeting. Weekend supervisor will conduct clinical meeting. The surveyor monitored the plan to remove the immediate jeopardy on [DATE] and [DATE] as follows: Monitoring began on [DATE]. LVNs and RNs were interviewed on two shifts on physician notification, and proper assessment following falls and changes in condition. Record review of the facility In-Services revealed: [DATE] - twelve staff members were trained on proper way of notifying/consulting the resident's physician, and facility's medical director and to call 911 if no response was received from the physicians; and staff were to notify the DON or designee of any identified changes in condition, falls with injury and the proper assessment, documentation and analysis of neurological assessment following falls with head injuries. 14 staff members were trained on physician notification of any resident with a change in condition and using the SBAR (Situation, Background, Assessment, and Recommendation) tool. [DATE] - more than 50% of the facility's nursing staff members were trained on parameters of when to notify facility administration on any changes in residents. Interview on [DATE] at 10:00 a.m., the DON stated she completed chart audits, evaluated all residents in the facility for changes in condition, falls with or without injuries and found that staff were implementing the appropriate and current plan. Record review of in-service, dated [DATE], the DON and ADONs trained all staff scheduled to work [DATE], [DATE], and [DATE]. Interviews with 6 MAs, and 5 CNAs on [DATE] between 4:25 p.m. and 5:15 p.m., revealed they received training on how to identify abuse and neglect, when to notify a charge nurse of anything usual noted about any patient, and if the nurses did not respond immediately to call the DON or the administrator. Record review of the in-service forms provided by the Administrator dated [DATE], [DATE] and [DATE] revealed on-going in-services concerning resident assessments, physicians' consultation, and post fall with head injury interventions. Interview on [DATE] at 9:30a.m., the Administrator stated she would be continuing to monitor the DON and staff to ensure the plan was implemented and effective. She further reported she would continue to monitor the facility approved plan of removal to ensure the safety of the residents. She said she was monitoring and evaluating all fall incidents to ensure staff were implementing the plan. She also stated the facility's medical director had contacted and communicated with all other doctors to ensure they understood that he would be called for intervention should they not promptly respond to facility's calls. After monitoring the implementation of the plan, the IJ was removed. The Administrator was informed the IJ was removed on [DATE] at 9:39a.m. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of pattern and a severity level of actual harm that is not immediate jeopardy. The facility was continuing to monitor their plans to ensure residents' physicians were promptly consulted following falls with injuries and following changes in condition. The Administrator reported 17 residents in the facility at high risk for falls.