STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0000	A. BUILDING _____ B. WING _____	C 05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stone Valley	123 MAIN ST ANYWHERE, US 66000

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689 SS=G	E2 (DON) on 5/11/18 at 3:00 PM. Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		6/25/18

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F 689	Continued From page 1 Cross refer to F 684 and F 678 Based on review of clinical records and interviews it was determined that the facility failed to provide adequate supervision resulting in an unsupervised fall, immediately followed by non-responsiveness which resulted in the need for CPR, emergent care and hospital transport for one (R1) out of 5 sampled residents. R1 sustained harm when he was left alone unsupervised and fell during a period of change in status that was later followed by non-responsiveness. This failure by the facility culminated in transport of R1 to the emergency room. Findings include: Review of R1's clinical record and hospital record revealed the following; R1 was admitted to the hospital on 4/15/18 with a diagnosis of a subarachnoid hemorrhage and a subdural hemorrhage. R1 was discharged from the hospital to the facility on 4/27/18. The interagency transfer form, a form that described R1's status and care from the hospital provided to the facility, documented R1 as confused, oriented to person, cooperative, able to communicate and understand using speech, a fall risk with a history of falls, requiring partial assistance to transfer and ambulate. Discharge instructions provided advised to get help right away if experiencing: Sudden weakness in face, arm, leg. Trouble talking or understanding. Trouble walking. Loss of balance or movement clumsy and uncoordinated. Suddenly have a very bad headache. R1 was admitted to the facility on Friday, 4/27/18 at 7:18 PM.	F 689	F-tag 689 A. No corrective action was taken related to the resident being transferred to the hospital. B. All residents have the potential to be affected by the cited deficiency during a change in condition resulting in an unsupervised fall. The corrective action is noted in section C. C. A revision in our policy titled: Physician Notification of Resident Change of Condition has been made. The revised policy adds a guideline of delegating a staff member to remain with a resident after a significant change in condition. The revised policy will be reviewed with professional nurse and therapy staff and during orientation. (Attachment # 11-Physician Notification policy) Professional staff will attest in writing that the policy and the compliance expectations were reviewed. (Attachment # 7 &11 Revised policy and attestation) D. Electronic Medical Record documentation will be audited by the Nursing Manager for residents experiencing a significant change in condition requiring the need for Emergency Services and the delegation of a staff member to remain with the resident until such services has arrived. The following audit schedule will be utilized: 3 times a week until 2 weeks of consecutive compliance is noted. The audit will then be completed once a week for 2 consecutive weeks of 100% compliance.	

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F 689	Continued From page 2 4/27/18 at 9:59 PM - a progress note written by E11 (LPN) documented R1 "arrived to the facility at 7:18 PM alert with confusion, no signs or symptoms of respiratory distress and multiple diagnoses including left temporal fracture with sub-arachnoid hemorrhage, history of recent fall, heart attack (MI), and mild stroke (TIA) and range of motion within normal limits". 4/27/18 at 10:30 PM [Approximately 3 hours after admission] A progress note written by E11 documented "upon assessment R1 noted to have fluid draining from his left ear." There is no evidence that a physician or supervisor was notified of this change. 4/27/18 - An initial fall risk assessment scored R1 as an "18" and moderately at risk for falls. 4/28/18 at 8:37 AM - A progress note written by E4 (RN) documented "received report from 11-7 nurse [E10 (LPN)] that resident had drainage leaking from left ear." E4 [approximately 10 hours after the above documented ear drainage] immediately went to assess R1. E8 (CNA) reported that she had cleaned yellow brownish drainage from resident's ear during ADL's. Vital signs and neurological checks were performed and hand grasps were weak. R1 reported he had a headache and felt weak. E4 documented she told "R1 he would get something for his headache, notified the supervisor [at the nurses station] and E10 of the assessment and to call a doctor to make them aware of the concerns. The next moment I was informed [by E9 (CNA)] the resident had fallen on the floor. Upon re-entering the room, R1 was laying on his back. R1's roommate reported that the resident hit his head	F 689	Once 100% compliance has been achieved throughout the auditing process, overall compliance will be considered as reached. (Attachment #13 -Audit). The audit process and audit results will be reviewed at the Quarterly Q & A Meeting for discussion and recommendations and recorded in the meeting minutes.	

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F 689	Continued From page 3 on the oxygen machine when he fell." 4/28/18 - E8 (CNA) documented in a written statement that "R1 was on the floor when I went in, he was not responsive, we did a sternal rub and he came to .....within seconds he became unresponsive again and we did the sternal rub again, no response then he started turning blue, I called for a crash cart because we had a pulse for a couple of minutes." E8 documented this occurred at an estimated time of 7:40 AM. 4/28/18 - An un-timed written statement by E9 (CNA) documented "this morning around 8:00 AM I walked down the hallway with the food cart to pass breakfast trays I turned to go into a resident room and saw R1 on the floor." 4/28/18 - An untimed physical therapy note written by E7 (PT) documented "When entering R1's room, patient presented with signs of distress and legs dangling out of bed. R1 was unable to speak clearly and complaining about a headache. All extremities were flaccid, patient needed assistance of two staff for sitting at the edge of the bed. Communicated with nurse [E4 RN] about concerns and her opinion about sending R1 out. R1 fell from the bed unattended and was found unresponsive." On an additional written statement documented on 5/10/18 E7 estimated her arrival to R1's room on 4/28/18 to be "around 7:00 AM." During an interview on 5/10/18 at 11:15 AM with E8 (CNA) it was reported that after assisting E7 (PT) in positioning R1 in bed, E8 left R1 in the room for "about 15 minutes then, E9 (CNA) said he was on the floor." E8 confirmed that R1 had a	F 689		

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F 689	Continued From page 4 change in status between ADL care and the physical therapy assessment, stating earlier during ADL care, R1"was talking and stated he wasn't in pain." During an interview on 5/11/18 at 9:08 AM with E4 (RN) it was reported that E4 "entered R1's room at the beginning of the shift and R1 complained of a headache and E8 (CNA) confirmed drainage from his ear. E4 then told the supervisor that she was concerned about R1 due to his recent medical history and was instructed to perform neurological checks and then notify the doctor. E4 stated she went back to read through R1's chart and hospital records then returned to R1's room to perform the neurological checks." When E4 assessed R1 she stated "he was alert, but not talking to me, but he had talked to aide previously during his bath, he had some overall all weakness, and hand grasp weakness on the right side." E4 reported that she was told by E7 (PT) that the description of the resident on the hospital discharge record was different from her assessment; and E7 stated that R1, according to the prior record could walk, but E7 assessed a lot of weakness. E4 reports she finished report to relieve E10 (LPN) who was the assigned nurse prior shift, received keys to her cart then E9 (CNA) told her that R1 was on the floor. E4 estimated having left R1 alone after the neurological assessment "about 15 minutes." The surveyor asked if R1 should have been monitored and supervised while having a change in status as evidenced by a new onset complaint of headache, decreased verbal response and weakness, E4 indicated that the resident should have been monitored but stated no, but I had to call the doctor. E4 explained she did not delegate to E8 to stay with R1 because he was in bed and	F 689		

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F 689	Continued From page 5 the breakfast trays were on the unit to be handed out to residents. During the same interview on 5/11/18 at 9:08 AM with E4 (RN) it was reported that on 4/28/18 "I went in the room and R1 was on the floor ...and he wasn't looking good and I guess when he fell, his nasal [nose] cannula [tube to deliver oxygen] had fell out, his oxygen level was reading 76 and I titrated and it wasn't going up so I told the aide I was gonna [sic] go get a non-rebreather mask." Following a documented change of status as evidenced by a new onset of ear drainage, new onset of a headache, documented weakness during neurological checks and decreased verbal response, R1 was left unsupervised and experienced an unwitnessed fall on the morning of 4/28/18. R1 developed signs and symptoms of respiratory distress and the need for emergent care following this unwitnessed fall. R1 had been left unsupervised for an estimated 15 minutes during which R1 experienced a fall and hit his head on the oxygen machine. R1 experienced an avoidable accident related to the absence of supervision and monitoring during a change in status. These findings were reviewed with E1 (NHA) and E2 (DON) on 5/11/18 at 3:00 PM.	F 689		