STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175185	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smoky Hill Rehabilitation Center	1007 Johnstown Avenue Salina, KS 67401

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 43204 The facility identified a census of 70 residents with three residents reviewed for abuse, neglect, and exploitation. Based on record review, observation, and interview, the facility failed to ensure Resident (R) 1 remained free from neglect. On 08/16/24 at 07:00 AM Certified Nurse Aide (CNA) M entered R1's room, asked if he wanted to get up and when R1 did not answer, CNA M lifted the covers, patted the front of R1's brief, and left the room without ensuring R1 had his call light in reach. At 08:32 AM, CNA M entered R1's room and placed his food tray on the bedside table but did not raise the head of the bed or unwrap R1's silverware. R1 proceeded to eat breakfast lying flat, using his left hand, and dropping food all over the front of his shirt. At 09:18 AM R1 reached into his brief and pulled out feces. R1 still did not have a call light in reach to call for staff assistance. At 09:28 AM R1 removed a large ball of feces from his brief and placed it on the bedside table. At 09:39 AM, R1 pulled himself to a seated position on the side of the bed, and at 09:41 AM Certified Medication Aid (CMA) R entered the room and gave R1, who sat on the side of the bed, his medications. R1 picked up the ball of feces from the table and showed it to the CMA. CMA R walked out of the room without assisting the resident, leaving R1 sitting on the side of the bed, with no call light in reach, and the wheelchair pushed to R1's far right, out of his reach. Four minutes later, at 09:45 AM, R1 tried to pull the bed pad, which was covered with feces, out from underneath him using his left hand. During this action, R1 fell to the right side but due to his hemiplegia was unable to break his fall and fell to the right, hitting his head on the floor. R1 lay on the floor yelling and staff entered the room at 09:48 AM. Licensed Nurse (LN) G assessed his blood pressure, and then all staff left the room to get linens, leaving R1 on the floor yelling. The staff did not place a pillow or padding underneath R1's head. Staff returned and began cleaning the area and removing the soiled linens from R1's bed. When staff removed the bed pad, there was a soiled, soaked area under the bed pad as well. During this cleanup procedure, R1 remained on the floor, moaning and yelling. Staff did not close the privacy curtain until the cleanup was done and they assisted R1 from the floor. The facility failed to ensure R1 received the care and service he required when staff failed to ensure R1 had a call light in his reach to call for staff assistance and failed to provide assistance after R1 gestured and communicated the need for help by showing staff a ball of feces. The facility further failed to provide basic toileting and incontinent care when staff failed to thoroughly check the resident for incontinence early in the morning, also evidenced by the bed pad and linens soaked and covered with feces. The facility failed to ensure the resident's dignity was protected and failed to provide comfort measures when staff left the resident on the floor, stepping around and over him without providing padding or a pillow. This series of failures resulted in R1 falling from the bed, hitting his head, and having an acute hemorrhagic brain bleed (an emergency condition in which a ruptured blood vessel causes bleeding inside the brain). The facility's neglect placed R1 in immediate jeopardy. (continued on next page)

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.

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of right-sided hemiplegia (paralysis of one side of the body), cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain), aphasia (condition with disordered or absent language function), dysphagia (swallowing difficulty), and repeated falls. The Quarterly Minimum Data Set [MDS], dated 07/25/24, documented R1 was rarely/never understood, had short-term and long-term memory loss; R1 was able to recall the location of his room, staff names, and faces, and that he resided in a nursing home. The MDS documented R1 had impairment on one side of his upper and lower extremities and required a wheelchair for locomotion. The MDS documented R1 required substantial/maximum assistance from staff for toileting, bathing, dressing, bed mobility, and transfers. The MDS documented R1 was always incontinent of bowel and bladder. The MDS documented R1 had one non-injury fall during the lookback period. The Activity of Daily Living Care Area Assessment (CAA), dated 05/13/24, documented R1 required assistance with self-care and mobility due to weakness, limited range of motion, poor coordination, and poor balance. The Fall CAA, dated 05/13/24, documented R1 required assistance with stabilization when moving from surface to surface and took antidepressants that increased his risk for falls. R1's Care Plan documented directed staff to ensure frequently used items were within easy reach (05/16/22) and document and report to the physician as needed post-fall for seventy-two hours of pain, bruises, change in mental status, sleepiness, inability to maintain posture, or agitation (05/18/22). The plan documented R1 needed to be up in his wheelchair for all meals (09/29/22). R1's Care Plan documented R1 was on antiplatelet therapy related to a CVA and staff were to observe, document, and report to the physician any signs and symptoms of anticoagulant complications including blood-tinged or obvious blood in the urine, black tarry stools, dark or bright blood in stools, sudden severe headaches, nausea, vomiting, lethargy, bruising, sudden changes in mental status, or significant changes in vital signs (02/06/23). A soft touch call light was to be placed on the left side of the bed (06/16/23). Staff were to offer R1 toileting between meals and rounding between meals to check for incontinence (11/28/23). R1's Fall Risk Assessment, dated 07/21/24, documented a score of 18, which indicated R1 was a high fall risk. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's EMR contained a Late Entry Health Status Note, dated 08/16/24 at 09:45 AM but entered in R1's EMR on 08/17/24 at 08:20 PM, documented LN G was called to R1's room for a report of R1 being on the floor. R1 was lying on his left side wearing a t-shirt and a brief. R1 was incontinent of bowel, and he had placed his bowel movement on his side table. R1 was yelling, Saw, you saw, and was hand motioning to get up off the floor. R1's call light was not engaged. R1 was unable to give a description of what happened leading up to the fall due to a language barrier. R1 responded No when asked if he was in any pain. Once R1 was assisted back into bed and cleaned up, R1 began laughing about the situation with the staff. LN G documented she assessed R1's vital signs and neurological status. R1 was assisted to a sitting position and then assisted off the floor and into bed by three staff and a gait belt. LN G documented R1 had an abrasion noted on his right knee; the abrasion was not actively bleeding and there were no other skin concerns observed. The note recorded that staff notified Administrative Nurse D, R1's primary care physician, and R1's responsible party. LN G documented R1's responsible party reviewed camera footage and reported R1 had attempted to pull the bed pad out from underneath him which caused him to slip off the edge of the bed and fall to the floor. The Health Status Note, dated 08/16/24 at 05:21 PM, documented R1 was having emesis (vomiting) and had some bruising to the right side of his face to mid-ear, was answering to his name, and his grips were at baseline. R1's blood pressure was 176/89 millimeters of mercury (mmHg), pulse was 106 beats per minute, temperature was 97.2 degrees Fahrenheit (F), respirations were 18 breaths per minute, and oxygen saturation was at 93 percent (%). Staff notified R1's responsible party and she wanted R1 to go to the emergency room for evaluation. The on-call doctor for R1's primary care physician gave the order to send R1 to the emergency room . R1's EMR documented a Health Status Note, dated 08/16/24 at 05:37 PM, which documented Emergency Medical Services (EMS) was called at 05:35 PM and arrived at the facility at 05:45 PM. EMS left with R1 at 05:49 PM. Staff notified R1's responsible party that R1 was on his way to the emergency room . The EMS Exam and Summary, dated 08/16/24 at 06:00 PM, documented EMS was dispatched to the facility for a resident who experienced an altered level of consciousness for the last five hours. The facility reported R1 was non-ambulatory, did not speak, and had slid out of his low-standing bed onto the ground earlier that morning. Upon arrival, EMS personnel found R1 to be experiencing an altered mental status. The summary documented facility staff reported R1's current condition could be his baseline, but the nurse was not sure. R1 was transported to the local hospital. The Emergency Physician Report, dated 08/16/24 at 07:48 PM, documented R1 arrived at the hospital via EMS secondary to a fall; R1 was sitting at the side of the bed and had a mechanical fall onto his right side at approximately 09:30 AM. R1 had a history of a previous CVA and was non-verbal. R1 was on clopidogrel (medication used to prevent blood from clotting) and was activated as a head alert. A computed tomography (CT scan- test that used X-ray technology to make multiple cross-sectional views of organs, bone, soft tissue, and blood vessels) of the head demonstrated a large subdural hemorrhage (bleeding between the skull and surface of the brain) on the right side extending from the frontal region (the front part of the brain) along the temporal (the part of the brain that helps you use your senses to understand and respond to the world around you) parietal (region of the brain above the temporal region) region and up over the right convexity (curvature on the skin side) leading to a 1.6-millimeter (mm) shift (deformation of the brain that can occur after a traumatic brain injury) from right to left with compression of the right lateral ventricle (area of the brain that produces and distributes cerebrospinal fluid). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Neurosurgical Consult Note, dated 08/16/24 at 07:50 PM, documented R1 lived in a nursing home. About two years ago R1 had a left-sided stroke which left him aphasic (without the ability for speech), hemiparetic (partial paralysis), and dependent living. The note documented that day, R1 had a ground-level video-recorded fall striking his head. R1 was brought to the emergency room and found to have an acute subdural hematoma (SDH-serious condition, typically caused by head injury, where blood collects between the skull and the surface of the brain). R1's Glasgow Coma Scale (GCS-a system to measure how conscious someone is) score was four which indicated a severe traumatic brain injury. R1 had unequal pupil size and an episode of vomiting. R1 had an intracerebral hemorrhage score (ICH - a prognostic model that predicts the risk of death for patients) of four which indicated a 97% risk of death within the next thirty days. The note documented the neurosurgeon talked with R1's family and indicated R1's prognosis was poor, and the family elected to proceed with comfort care for R1. R1's EMR contained a Health Status Note, dated 08/16/24 at 08:00 PM, which documented the facility received a notification from R1's responsible party that R1 had a major traumatic brain injury (TBI) and brain bleed, and the family was deciding between surgery and comfort care. CMA R's Witness Statement, dated 08/19/24, documented CMA R gave R1 his pills around 09:22 AM. R1 was sitting on the edge of the bed eating breakfast. A short time later, CNA N came from R1's room requesting a nurse because R1 was on the floor. LN H's Witness Statement, dated 08/19/24, documented LN H was the charge nurse of R1's hall and was in a nurse's meeting at the time of the fall. LN H stated the last time she laid eyes on R1 was about 08:30 AM and R1 rested in bed at that time. CNA M's Witness Statement, dated 08/19/24, documented CNA M checked on R1 at 08:00 AM and tried to get R1 up but R1 refused. CNA M stated he checked R1's brief and R1 was dry. CNA M stated he was not aware of the fall when it happened. LN G's Witness Statement, dated 08/19/24, documented that LN G was called to R1's room for a report of R1 being on the floor at 09:45 AM. R1 was lying on his left side wearing a t-shirt and a brief. R1 was incontinent of bowel and had placed part of his bowel movement on his side table. R1 was hand motioning that he wanted to get up off the floor. R1's call light was not engaged. R1 was unable to give a description of what happened leading to his fall. R1 did respond No when asked if he was in any pain. LN G stated she checked R1's vital signs, neurological status, and range of motion. R1 was assisted to a sitting position and then assisted off the floor by three staff. An abrasion was noted on R1's right knee that was not actively bleeding; there were no other skin concerns. LN G stated she notified R1's responsible party, who reviewed the camera footage and stated that R1 had attempted to pull the bed pad from underneath himself which caused the fall because R1 got too close to the edge of the bed. R1's responsible party stated she could not tell if R1 had hit his head or not. CNA O's Witness Statement, dated 09/20/24, documented that CNA O responded to a call on the walkie involving a resident down. CNA O went to R1's room. LN G was already in the room when he got there. R1 was lying on his chest, his feet by the bed, and his head was toward the end of his roommate's bed. CNA O stated he assisted R1 to a comfortable position. CNA O stated LN G did an assessment and staff got R1 cleaned up and comfortable in bed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Facility Incident Report, dated 08/23/24, documented the morning of 08/16/24 at approximately 09:30 AM R1 fell from his bed, unwitnessed by staff. R1's family utilized a camera in his room. LN G gave report of the fall. R1's family reviewed the footage and observed R1 pulling on his bed pad which resulted in the fall. Neurological exams were initiated at the time of the fall at 09:30 AM and remained within normal limits until approximately 05:30 PM when R1's blood pressure increased and R1 began vomiting. Once vital signs were outside of normal parameters, staff notified R1's primary care physician and obtained orders for R1 to be evaluated in the ER. The staff notified R1's family as well. R1 was sent via EMS to the local hospital around 06:00 PM. Upon evaluation, R1 was found to have a brain bleed at approximately 08:20 PM. R1 was last checked prior to the fall at 08:30 AM. R1 refused to get out of bed; CNA M stated that R1 was dry, and the bedding was clean at that time. Corrective actions taken were to place a bedside commode, as R1 refused staff assistance with toileting. A review of the motion-activated video footage which also recorded audio and date and time stamps revealed the following series of events that occurred on 08/16/24: At 07:01 AM, CNA M entered R1's room and asked R1 if he wanted to get up for breakfast. R1 did not answer. CNA M said, Okay you want to stay in bed. CNA M lifted R1's blankets off him, patted R1's incontinence brief with his ungloved hand, covered R1 up, turned off the light, and left the room. R1's call light and/or cord was not visible on his bed, or anywhere in the footage. At 08:32 AM a staff member entered R1's area for the first since 07:01 AM. CNA M brought in R1's breakfast tray and placed it on the bedside table. CNA M did not raise R1's head of the bed, did not set up R1's tray by unwrapping the silverware, and did not cut up R1's sausage patties. CNA M moved the tray table over R1 as R1 laid flat in bed and left the room. R1's call light and/or cord were not visible on the bed or anywhere in the footage. R1 proceeded to pick up the scrambled eggs and sausage and eat it with his left finger. R1 dropped multiple pieces of food on his shirt. R1 manipulated his coffee cup until he could pick it up, then raised his head slightly off the pillow and attempted to drink the coffee while lying in bed. At 09:18 AM, R1 reached down into his brief with his left hand. R1 brought his left hand out of his brief, looked at his hand, which appeared to have feces on it, and cleaned his hands off on the sheets. R1's call light and/or cord were not visible on the bed or anywhere in the footage. At 09:28 AM, R1 removed his covers with his left hand and left leg. He reached down into his brief removed a large ball of what appeared to be feces and placed it on his bedside table. R1's call light and/or cord were not visible on the bed or anywhere in the footage. At 09:39 AM, R1 used the repositioning rail on the left side of his bed and struggled to pull himself up and position himself on the edge of the bed. R1's call light and/or cord were not visible on the bed or anywhere in the footage. R1's wheelchair was visible to R1's far right, past the end of the bed, and out of reach. The cushion in the wheelchair was partially hanging off the seat. At 09:41 AM, staff entered the area again for the first time since 08:32 AM. CMA R came into R1's room and gave R1 his medications in a small pill cup. CMA R opened an Ensure (nutritional drink) and placed it on the tray table. R1 pointed at the ball of feces on his bedside table. CMA R said, Okay, okay. R1 then picked up the ball of feces from the bedside table and held it out towards CMA R. CMA R then walked out of R1's room. R1's call light and/or cord were not visible on the bed or anywhere in the recorded footage. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At 09:43 AM, R1 sat on the side of his bed with his left elbow on his left knee, leaning forward. His feet were not visible, but his legs were bent at a 90-degree angle, and he appeared to have his feet on the floor. R1's wheelchair was visible in the background and R1's bed appeared to be at the same height or slightly higher than the seat of the wheelchair. R1's call light and/or cord were not visible on the bed or anywhere in the recorded footage. At 09:45 AM R1 sat on the side of the bed. R1 tried to pull the bed pad out from underneath him with his left hand. R1 then repositioned himself using his left hand to move a little to his right, then again attempted to pull the bed pad out from underneath him. R1 leaned a bit to the right and then fell off the bed, to his right. R1's right arm remained flaccid, and he fell on to the floor. The right side of R1's face struck the floor, and his back bumped into his wheelchair, which was seen to move backward with the impact. There was a large amount of feces visible on the bed pad, sheet, brief, and on R1's left buttock. There was light brownish-yellow soiling or discoloration on the area of the sheet that was previously under the bed pad that became visible after the bed pad was folded and pulled away from the area. R1 moaned as he struck the floor. At 09:47 AM, R1 lay on the floor yelling out loudly in pain. Staff can be heard outside the door saying, We're coming and asking an unknown person, not visible in the footage, if someone had a walkie. At 09:48 AM, LN G assessed R1's blood pressure using a wrist monitor on R1's left wrist. R1 remained lying on his left side. A staff member partially visible from the waist down repositioned R1's wheelchair and then pushed the chair from the room. LN G removed the wrist cuff from R1's left wrist and told R1 that staff were going to get him up and cleaned up. LN G stood up, placed the wrist cuff on the bedside table, and left the room. R1 continued to moan and yell Oh, oh, [expletive], oh [expletive]. At 09:49 AM, R1 continued to lay on his right side, his right arm was not visible. He continued to call out though all staff had exited the room. Thirty seconds later, three staff members reentered the room. R1 continued to cry out and yell. One staff member, visible from the waist down and identifiable by the attire as LN G, carried in a trash can and set it on the floor between R1 and the bedside table. LN G removed the ball of feces from the bedside and tossed it in the trash. Two staff visible from the legs down stood towards the entryway of R1's area. LN G then wiped the side of the tray table and moved the trash can farther away from the bed. R1 continued to lie on the floor repeating the same Oh [expletive] oh over and over. LN G approached the bed and told R1 to hang on as staff had to get things cleaned up so they could get him up. LN began to remove the soiled linens from R1's bed. When LN G pulled the bed pad completely, a large oval-shaped area on the sheet appeared damp and with discoloration. Another staff stood at the foot of the bed and assisted LN G in removing the soiled linens. R1 continued to call out and became louder and louder in his cries. Without speaking to R1, LN G bent down and unfastened the tape on R1's incontinence brief, then stood, and pulled the privacy curtain between R1's side of the room and his roommates and the entryway. The privacy curtain was visible floating above R1's head and lightly touching his left shoulder. LN G exits the footage viewing area towards the door, then is seen coming back and picking up the soiled linens and again moving towards the door. CNA O stood on the right side of R1's bed and proceeded to clean the mattress with wipes. LN G stood towards the foot of the bed, and CNA O pulled back the privacy curtain momentarily and reentered the area, standing in front of R1, who continued to lie on the floor on his right side crying out, and yelling. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At 09:51 AM, CNA O stood in front of R1, who remained on the floor on his right side. LN G stood behind R1, and CNA N remained on the right side of R1's bed. The staff discussed how they would get R1 off the floor while R1 continued to groan and cry out. CNA moved the bedside table and trashcan towards the wall, and then bent down and attempted to bend R1's legs and pull them towards CNA O. LN G informed R1 the staff were going to bed his legs. As CNA O bent and pulled on R1's legs, R1 screamed out and there was feces visible on R1's left hip/buttock area. CNA O let go of R1's legs and stood up. CNA N moved to the foot of the bed. LN G placed her left hand on R1's left upper arm and used her right hand to push him upward. LN G then supported R1's back as CNA O straddled R1's legs and CNA N used both hands to lift R1 from under his left arm/ armpit area. LN G moved to R1's far right and told R1 they were going to get him up. CNA O wrapped his arms around R1's torso and the three staff lifted R1 to a semi-standing position and then pivoted R1 to a seated position on the left side of the bed. The video revealed no gait belt was in use during the transfer from the floor, and no assessment was completed regarding range of motion or attempts to identify any latent injury. No pupil assessment (or hand grips) were assessed. At 09:55 AM, R1 lay in bed while LN G and CNO O provided incontinent care. At 09:57 AM, the two staff completed care and covered R1 with his blankets. At 09:58 AM, R1 lay in bed, covered by his blankets. His flat call light was visible on top of the blue blanket and the cord going off the left side of the bed. LN G stood on the right side of R1's bed and LN G took R1's blood pressure on his left wrist with a wrist monitor. The video revealed no other assessments, including pupil assessment or hand grips were conducted. At 10:00 AM, CNA N brought R1's wheelchair into the room and parked it parallel to the left lower end of the bed. CNA N left the room. At 10:28 AM, R1 lay in bed and tried to reach his water pitcher with his left hand, but the water pitcher on the bedside table was just out of reach for R1 to grab. After multiple attempts, R1 was able to push his water cup into a position that allowed him to pick up the cup. He lifted his head up off the pillow as he lay flat in the bed to take a drink through a straw. At 11:52 AM, CNA M entered R1's room and asked R1 if he was ready to get up for lunch. R1 took his covers off with his left hand. CNA M put sweatpants on R1. During the activity, an abrasion or reddened area was visible on R1's right knee. CNA M placed R1's shoes on his feet. Using a gait belt, CNA M transferred R1 to the wheelchair using a stand pivot transfer. CNA M propelled R1 out of the room. At 12:26 PM, R1 propelled himself in his wheelchair back into his room using his left hand and left leg. R1 used the repositioning rail on the left side of his bed and transferred himself into bed. R1 used his left arm and leg to get his covers up and over himself. R1 did not have his call light. At 12:52 PM, CNA M steps just inside of R1's room, and then immediately left the room without speaking or providing care. R1 did not have his call light. This was the last time staff entered R1's room until 05:21 PM. Review of all the video footage revealed no staff went into R1's room or assessed him from 12:52 PM until 05:21 PM. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 09/18/24 at 01:30 PM, CNA O stated he was in R1's room after the fall. CNA O stated R1 was yelling out in pain. CNA O stated he followed LN G's direction about getting R1 off the floor. CNA O stated staff cleaned up R1's room and bed before providing care to R1. CNA O stated there had been feces on R1's bed pad and when the bed pad was removed it revealed the sheets were urine-soaked. CNA O stated he should have given R1 a pillow and comforted R1. CNA O went on to say the staff should have obtained a lift to get R1 up off the floor instead of just lifting him up underneath his arms. CNA O stated LN G had not checked R1's pupillary response. In an interview on 09/18/24 at 10:30 AM, Administrative Nurse D stated she expected she could trust the two administrative nurses on duty on 08/16/24 to follow the facility's unwitnessed fall policy and neurological check policy. Administrative Nurse D stated the family did not bring the video clips of the events until 10 days after she had submitted the report of the fall with injury to the state. Administrative Nurse D stated they had concerns about how the two nurses and CMA R, CNA M, and CNA N handled the fall even before they saw the videos. She further stated the facility took disciplinary actions for all staff involved in the incident that day and ended up terminating LN G and LN H. Administrative Nurse D also stated the facility provided education to all staff on falls and neurological assessments, completed after she and Administrative Staff A saw the videos the family brought to them. Administrative Nurse D stated she assumed since the neurological checks were documented in R1's chart that they had been performed. Administrative Nurse D stated she expected staff to provide residents comfort after a fall and take care of their needs. Administrative Nurse D stated R1 should have been checked on more frequently and provided with incontinent care more frequently than what had been provided to him. On 09/18/24 at 10:45 AM, Administrative Staff A stated that a lot of things had been missed the day R1 fell . Administrative Staff A said there was no way for the facility staff to know the neurological assessments were not completed when the assessment results were charted in R1's EMR. Administrative Staff A stated she wished the family would have shown the facility the video footage sooner than ten days after the incident. Administrative Staff A stated the facility staff were completely invested in making sure all the residents of the facility were given the care they deserved. The facility's policy Abuse Prevention Program, revised December 2016, documented the residents have the right to be from abuse and neglect. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraints not required to treat the resident's symptoms. The facility and staff should protect all residents from abuse by anyone including but not necessarily limited to facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual. The facility will develop and implement policies and procedures to aid the facility in preventing abuse, neglect, or mistreatment of our residents. The facility will require staff training/orientation programs that include abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior. Implement measures to address factors that may lead to abusive situations. Identify and assess all possible incidents of abuse, investigate, and report any allegations of abuse within time frames as required by federal requirements, establish, and implement a QAPI review and analysis of abuse incidents, and implement changes to prevent future occurrences of abuse. Involve the resident council in monitoring and evaluating the facility's abuse prevention program. (continued on next page)

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	175185	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smoky Hill Rehabilitation Center	1007 Johnstown Avenue Salina, KS 67401

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's policy Assessing Falls and Their Causes Policy, revised December 2007, documented that if a resident has just fallen or is found on the floor without a witness to the event, nursing staff will record vital signs and evaluate for possible injury to the head, neck, spine, and extremities. Once an assessment rules out significant injury, the nursing staff will help the resident to a comfortable lying, sitting, or standing position and then document relevant details. Nursing will notify the attending physician and family in an appropriate time frame. When a fall results in significant injury or condition change, nursing staff will notify the practitioner immediately by phone. When a fall does not result in significant injury or condition change nursing staff will notify the practitioner routinely by phone. Nursing staff will observe for delayed complications of a fall for approximately 48 hours after an observed or suspected fall and will document findings in the medical record. Documentation will include any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility, and any changes in level of responsiveness or consciousness and overall function. It will note the presence or absence of significant findings. The facility's Neurological Assessment Policy, revised October 2010, documented that staff were to familiarize themselves with any existing physical, mental, and or neurological deficits or disorders the resident may have before the assessment. Assess vital signs (temperature, pulse, respirations, blood pressure). Check the resident's motor abilities and mental ability to follow simple commands by asking the resident to move extremities. Use a penlight to check pupil response by turning off room and over bed lights, moving the penlight from the outer to the inner aspect of both eyes noting pupil constriction when the light beam crosses the pupil and pupil dilation when light is removed. Check pupil size to ascertain if they are equal in size. Ask the resident to grip and squeeze your hands to assess and compare strength bilaterally. Ask the resident if he or she is experiencing any numbness, pain and or tingling in any extremity. The frequency of neurological checks will be every 15 minutes for one hour, every thirty minutes for one hour, every 60 minutes for two hours, every four hours for 16 hours, and every eight hours for 48 hours. Neurological checks will be documented in the resident's electronic medical record. The physician will be notified of the resident's change of condition and any deterioration in neurological status will be reported to the physician immediately. On 09/18/24 at 02:32 PM Administrative Staff A received copies of the Immediate Jeopardy [IJ] Templates and was informed the facility failed to prevent the neglect of R1 and ensure he received the care and service he required, when staff failed to ensure R1 had a call light in his reach to call for staff assistance and failed to provide assistance after R1 gestured and communicated the need for help by showing staff a ball of feces. The facility further failed to provide basic toileting and incontinent care when staff failed to thoroughly check the resident for incontinence early in the morning, also evidenced by the bed pad and linens

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43204 The facility identified a census of 70 residents with three residents reviewed for abuse, neglect, and exploitation. Based on record review, observation, and interview, the facility failed to ensure Resident (R) 1 received adequate post-fall treatment consistent with the standards of practice. On [DATE] at 09:45 AM R1 fell from a seated position out of bed, onto the floor. R1 fell to the right, hitting his head on the floor. R1 remained on the floor, yelling until staff entered the room at 09:48 AM. Licensed Nurse (LN) G entered the room, assessed his blood pressure with a wrist cuff then all staff left the room to get linens, leaving R1 on the floor yelling. Staff returned and began cleaning the area and preparing R1's bed. During this time, R1 remained on the floor, moaning and yelling. Certified Nurse's Aide M and Licensed Nurse (LN) G started to assist R1 off the floor. Without LN G assessing for fractures or other injuries, CNA M tried to bend R1's legs and R1 yelled out in obvious pain. LN G, CNA M, and Certified Nurse Aide (CNA) N picked R1 up using an underarm method, not using a gait belt, and placed R1 back in bed. LN G wiped the right side of R1's face but made no other assessment of his face or head though R1 had visible redness on the right side of his face and received Plavix (medication used to prevent blood from clotting) daily. LN G assessed a wrist blood pressure but did not perform a neurological assessment on R1. LN G asked R1 if he was in pain but R1 did not answer, and LN G took no further action at that time. At 10:36 AM, LN G entered R1's room again and assessed wrist blood pressure but did not perform a neurological exam. At 11:52 AM CNA M assisted R1 out to lunch and at 12:26 PM R1 self-propelled into his room and transferred himself back to bed. Staff did not reenter R1's room until 05:21 PM when staff found R1 lethargic and with vomit on his bed. R1 was transferred emergently to the acute hospital where he was diagnosed with an acute hemorrhagic brain bleed and subsequently died on [DATE]. The facility's failure to ensure R1 received adequate care consistent with the standards of care after a fall for a resident taking blood thinners placed R1 in immediate jeopardy. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of right-sided hemiplegia (paralysis of one side of the body), cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain), aphasia (condition with disordered or absent language function), dysphagia (swallowing difficulty), and repeated falls. The Quarterly Minimum Data Set [MDS], dated [DATE], documented R1 was rarely/never understood, had short-term and long-term memory loss; R1 was able to recall the location of his room, staff names, and faces, and that he resided in a nursing home. The MDS documented R1 had impairment on one side of his upper and lower extremities and required a wheelchair for locomotion. The MDS documented R1 required substantial/maximum assistance from staff for toileting, bathing, dressing, bed mobility, and transfers. The MDS documented R1 was always incontinent of bowel and bladder. The MDS documented R1 had one non-injury fall during the lookback period. The Activity of Daily Living Care Area Assessment (CAA), dated [DATE], documented R1 required assistance with self-care and mobility due to weakness, limited range of motion, poor coordination, and poor balance. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Fall CAA, dated [DATE], documented R1 required assistance with stabilization when moving from surface to surface and took antidepressants that increased his risk for falls. R1's Care Plan documented directed staff to ensure frequently used items were within easy reach ([DATE]) and document and report to the physician as needed post-fall for seventy-two hours of pain, bruises, change in mental status, sleepiness, inability to maintain posture, or agitation ([DATE]). The plan documented R1 needed to be up in his wheelchair for all meals ([DATE]). R1's Care Plan documented R1 was on antiplatelet therapy related to a CVA and staff were to observe, document, and report to the physician any signs and symptoms of anticoagulant complications including blood-tinged or obvious blood in the urine, black tarry stools, dark or bright blood in stools, sudden severe headaches, nausea, vomiting, lethargy, bruising, sudden changes in mental status, or significant changes in vital signs ([DATE]). A soft touch call light was to be placed on the left side of the bed ([DATE]). Staff were to offer R1 toileting between meals and rounding between meals to check for incontinence ([DATE]). R1's Fall Risk Assessment, dated [DATE], documented a score of 18, which indicated R1 was a high fall risk. R1's EMR contained a Late Entry Health Status Note, dated [DATE] at 09:45 AM but entered in R1's EMR on [DATE] at 08:20 PM, documented LN G was called to R1's room for a report of R1 being on the floor. R1 was lying on his left side wearing a t-shirt and a brief. R1 was incontinent of bowel, and he had placed his bowel movement on his side table. R1 was yelling, Saw, you saw, and was hand motioning to get up off the floor. R1's call light was not engaged. R1 was unable to give a description of what happened leading up to the fall due to a language barrier. R1 responded No when asked if he was in any pain. Once R1 was assisted back into bed and cleaned up, R1 began laughing about the situation with the staff. LN G documented she assessed R1's vital signs and neurological status. R1 was assisted to a sitting position and then assisted off the floor and into bed by three staff and a gait belt. LN G documented R1 had an abrasion noted on his right knee; the abrasion was not actively bleeding and there were no other skin concerns observed. The note recorded that staff notified Administrative Nurse D, R1's primary care physician, and R1's responsible party. LN G documented R1's responsible party reviewed camera footage and reported R1 had attempted to pull the bed pad out from underneath him which caused him to slip off the edge of the bed and fall to the floor. The Health Status Note, dated [DATE] at 05:21 PM, documented R1 was having emesis (vomiting) and had some bruising to the right side of his face to mid-ear, was answering to his name, and his grips were at baseline. R1's blood pressure was ,d+[DATE] millimeters of mercury (mmHg), pulse was 106 beats per minute, temperature was 97.2 degrees Fahrenheit (F), respirations were 18 breaths per minute, and oxygen saturation was at 93 percent (%). Staff notified R1's responsible party and she wanted R1 to go to the emergency room for evaluation. The on-call doctor for R1's primary care physician gave the order to send R1 to the emergency room . R1's EMR documented a Health Status Note, dated [DATE] at 05:37 PM, which documented Emergency Medical Services (EMS) was called at 05:35 PM and arrived at the facility at 05:45 PM. EMS left with R1 at 05:49 PM. Staff notified R1's responsible party that R1 was on his way to the emergency room . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The EMS Exam and Summary, dated [DATE] at 06:00 PM, documented EMS was dispatched to the facility for a resident who experienced an altered level of consciousness for the last five hours. The facility reported R1 was non-ambulatory, did not speak, and had slid out of his low-standing bed onto the ground earlier that morning. Upon arrival, EMS personnel found R1 to be experiencing an altered mental status. The summary documented facility staff reported R1's current condition could be his baseline, but the nurse was not sure. R1 was transported to the local hospital. The Emergency Physician Report, dated [DATE] at 07:48 PM, documented R1 arrived at the hospital via EMS secondary to a fall; R1 was sitting at the side of the bed and had a mechanical fall onto his right side at approximately 09:30 AM. R1 had a history of a previous CVA and was non-verbal. R1 was on clopidogrel (medication used to prevent blood from clotting) and was activated as a head alert. A computed tomography (CT scan- test that used X-ray technology to make multiple cross-sectional views of organs, bone, soft tissue, and blood vessels) of the head demonstrated a large subdural hemorrhage (bleeding between the skull and surface of the brain) on the right side extending from the frontal region (the front part of the brain) along the temporal (the part of the brain that helps you use your senses to understand and respond to the world around you) parietal (region of the brain above the temporal region) region and up over the right convexity (curvature on the skin side) leading to a 1.6-millimeter (mm) shift (deformation of the brain that can occur after a traumatic brain injury) from right to left with compression of the right lateral ventricle (area of the brain that produces and distributes cerebrospinal fluid). The Neurosurgical Consult Note, dated [DATE] at 07:50 PM, documented R1 lived in a nursing home. About two years ago R1 had a left-sided stroke which left him aphasic (without the ability for speech), hemiparetic (partial paralysis), and dependent living. The note documented that day, R1 had a ground-level video-recorded fall striking his head. R1 was brought to the emergency room and found to have an acute subdural hematoma (SDH-serious condition, typically caused by head injury, where blood collects between the skull and the surface of the brain). R1's Glasgow Coma Scale (GCS-a system to measure how conscious someone is) score was four which indicated a severe traumatic brain injury. R1 had unequal pupil size and an episode of vomiting. R1 had an intracerebral hemorrhage score (ICH - a prognostic model that predicts the risk of death for patients) of four which indicated a 97% risk of death within the next thirty days. The note documented the neurosurgeon talked with R1's family and indicated R1's prognosis was poor, and the family elected to proceed with comfort care for R1. R1's EMR contained a Health Status Note, dated [DATE] at 08:00 PM, which documented the facility received a notification from R1's responsible party that R1 had a major traumatic brain injury (TBI) and brain bleed, and the family was deciding between surgery and comfort care. CMA R's Witness Statement, dated [DATE], documented CMA R gave R1 his pills around 09:22 AM. R1 was sitting on the edge of the bed eating breakfast. A short time later, CNA N came from R1's room requesting a nurse because R1 was on the floor. LN H's Witness Statement, dated [DATE], documented LN H was the charge nurse of R1's hall and was in a nurse's meeting at the time of the fall. LN H stated the last time she laid eyes on R1 was about 08:30 AM and R1 rested in bed at that time. CNA M's Witness Statement, dated [DATE], documented CNA M checked on R1 at 08:00 AM and tried to get R1 up but R1 refused. CNA M stated he checked R1's brief and R1 was dry. CNA M stated he was not aware of the fall when it happened. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	LN G's Witness Statement, dated [DATE], documented that LN G was called to R1's room for a report of R1 being on the floor at 09:45 AM. R1 was lying on his left side wearing a t-shirt and a brief. R1 was incontinent of bowel and had placed part of his bowel movement on his side table. R1 was hand motioning that he wanted to get up off the floor. R1's call light was not engaged. R1 was unable to give a description of what happened leading to his fall. R1 did respond No when asked if he was in any pain. LN G stated she checked R1's vital signs, neurological status, and range of motion. R1 was assisted to a sitting position and then assisted off the floor by three staff. An abrasion was noted on R1's right knee that was not actively bleeding; there were no other skin concerns. LN G stated she notified R1's responsible party, who reviewed the camera footage and stated that R1 had attempted to pull the bed pad from underneath himself which caused the fall because R1 got too close to the edge of the bed. R1's responsible party stated she could not tell if R1 had hit his head or not. CNA O's Witness Statement, dated [DATE], documented that CNA O responded to a call on the walkie involving a resident down. CNA O went to R1's room. LN G was already in the room when he got there. R1 was lying on his chest, his feet by the bed, and his head was toward the end of his roommate's bed. CNA O stated he assisted R1 to a comfortable position. CNA O stated LN G did an assessment and staff got R1 cleaned up and comfortable in bed. The Facility Incident Report, dated [DATE], documented the morning of [DATE] at approximately 09:30 AM R1 fell from his bed, unwitnessed by staff. R1's family utilized a camera in his room. LN G gave report of the fall. R1's family reviewed the footage and observed R1 pulling on his bed pad which resulted in the fall. Neurological exams were initiated at the time of the fall at 09:30 AM and remained within normal limits until approximately 05:30 PM when R1's blood pressure increased and R1 began vomiting. Once vital signs were outside of normal parameters, staff notified R1's primary care physician and obtained orders for R1 to be evaluated in the ER. The staff notified R1's family as well. R1 was sent via EMS to the local hospital around 06:00 PM. Upon evaluation, R1 was found to have a brain bleed at approximately 08:20 PM. R1 was last checked prior to the fall at 08:30 AM. R1 refused to get out of bed; CNA M stated that R1 was dry, and the bedding was clean at that time. Corrective actions taken were to place a bedside commode, as R1 refused staff assistance with toileting. A review of the motion-activated video footage which also recorded audio and date and time stamps revealed the following series of events that occurred on [DATE]: At 07:01 AM, CNA M entered R1's room and asked R1 if he wanted to get up for breakfast. R1 did not answer. CNA M said, Okay you want to stay in bed. CNA M lifted R1's blankets off him, patted R1's incontinence brief with his ungloved hand, covered R1 up, turned off the light, and left the room. R1's call light and/or cord was not visible on his bed, or anywhere in the footage. At 08:32 AM a staff member entered R1's area for the first since 07:01 AM. CNA M brought in R1's breakfast tray and placed it on the bedside table. CNA M did not raise R1's head of the bed, did not set up R1's tray by unwrapping the silverware, and did not cut up R1's sausage patties. CNA M moved the tray table over R1 as R1 laid flat in bed and left the room. R1's call light and/or cord were not visible on the bed or anywhere in the footage. R1 proceeded to pick up the scrambled eggs and sausage and eat it with his left finger. R1 dropped multiple pieces of food on his shirt. R1 manipulated his coffee cup until he could pick it up, then raised his head slightly off the pillow and attempted to drink the coffee while lying in bed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At 09:18 AM, R1 reached down into his brief with his left hand. R1 brought his left hand out of his brief, looked at his hand, which appeared to have feces on it, and cleaned his hands off on the sheets. R1's call light and/or cord were not visible on the bed or anywhere in the footage. At 09:28 AM, R1 removed his covers with his left hand and left leg. He reached down into his brief removed a large ball of what appeared to be feces and placed it on his bedside table. R1's call light and/or cord were not visible on the bed or anywhere in the footage. At 09:39 AM, R1 used the repositioning rail on the left side of his bed and struggled to pull himself up and position himself on the edge of the bed. R1's call light and/or cord were not visible on the bed or anywhere in the footage. R1's wheelchair was visible to R1's far right, past the end of the bed, and out of reach. The cushion in the wheelchair was partially hanging off the seat. At 09:41 AM, staff entered the area again for the first time since 08:32 AM. CMA R came into R1's room and gave R1 his medications in a small pill cup. CMA R opened an Ensure (nutritional drink) and placed it on the tray table. R1 pointed at the ball of feces on his bedside table. CMA R said, Okay, okay. R1 then picked up the ball of feces from the bedside table and held it out towards CMA R. CMA R then walked out of R1's room. R1's call light and/or cord were not visible on the bed or anywhere in the recorded footage. At 09:43 AM, R1 sat on the side of his bed with his left elbow on his left knee, leaning forward. His feet were not visible, but his legs were bent at a 90-degree angle, and he appeared to have his feet on the floor. R1's wheelchair was visible in the background and R1's bed appeared to be at the same height or slightly higher than the seat of the wheelchair. R1's call light and/or cord were not visible on the bed or anywhere in the recorded footage. At 09:45 AM R1 sat on the side of the bed. R1 tried to pull the bed pad out from underneath him with his left hand. R1 then repositioned himself using his left hand to move a little to his right, then again attempted to pull the bed pad out from underneath him. R1 leaned a bit to the right and then fell off the bed, to his right. R1's right arm remained flaccid, and he fell on to the floor. The right side of R1's face struck the floor, and his back bumped into his wheelchair, which was seen to move backward with the impact. There was a large amount of feces visible on the bed pad, sheet, brief, and on R1's left buttock. There was light brownish-yellow soiling or discoloration on the area of the sheet that was previously under the bed pad that became visible after the bed pad was folded and pulled away from the area. R1 moaned as he struck the floor. At 09:47 AM, R1 lay on the floor yelling out loudly in pain. Staff can be heard outside the door saying, We're coming and asking an unknown person, not visible in the footage, if someone had a walkie. At 09:48 AM, LN G assessed R1's blood pressure using a wrist monitor on R1's left wrist. R1 remained lying on his left side. A staff member partially visible from the waist down repositioned R1's wheelchair and then pushed the chair from the room. LN G removed the wrist cuff from R1's left wrist and told R1 that staff were going to get him up and cleaned up. LN G stood up, placed the wrist cuff on the bedside table, and left the room. R1 continued to moan and yell Oh, oh, [expletive], oh [expletive]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At 09:49 AM, R1 continued to lay on his right side, his right arm was not visible. He continued to call out though all staff had exited the room. Thirty seconds later, three staff members reentered the room. R1 continued to cry out and yell. One staff member, visible from the waist down and identifiable by the attire as LN G, carried in a trash can and set it on the floor between R1 and the bedside table. LN G removed the ball of feces from the bedside and tossed it in the trash. Two staff visible from the legs down stood towards the entryway of R1's area. LN G then wiped the side of the tray table and moved the trash can farther away from the bed. R1 continued to lie on the floor repeating the same Oh [expletive] oh over and over. LN G approached the bed and told R1 to hang on as staff had to get things cleaned up so they could get him up. LN began to remove the soiled linens from R1's bed. When LN G pulled the bed pad completely, a large oval-shaped area on the sheet appeared damp and with discoloration. Another staff stood at the foot of the bed and assisted LN G in removing the soiled linens. R1 continued to call out and became louder and louder in his cries. Without speaking to R1, LN G bent down and unfastened the tape on R1's incontinence brief, then stood, and pulled the privacy curtain between R1's side of the room and his roommates and the entryway. The privacy curtain was visible floating above R1's head and lightly touching his left shoulder. LN G exits the footage viewing area towards the door, then is seen coming back and picking up the soiled linens and again moving towards the door. CNA O stood on the right side of R1's bed and proceeded to clean the mattress with wipes. LN G stood towards the foot of the bed, and CNA O pulled back the privacy curtain momentarily and reentered the area, standing in front of R1, who continued to lie on the floor on his right side crying out, and yelling. At 09:51 AM, CNA O stood in front of R1, who remained on the floor on his right side. LN G stood behind R1, and CNA N remained on the right side of R1's bed. The staff discussed how they would get R1 off the floor while R1 continued to groan and cry out. CNA moved the bedside table and trashcan towards the wall, and then bent down and attempted to bend R1's legs and pull them towards CNA O. LN G informed R1 the staff were going to bed his legs. As CNA O bent and pulled on R1's legs, R1 screamed out and there was feces visible on R1's left hip/buttock area. CNA O let go of R1's legs and stood up. CNA N moved to the foot of the bed. LN G placed her left hand on R1's left upper arm and used her right hand to push him upward. LN G then supported R1's back as CNA O straddled R1's legs and CNA N used both hands to lift R1 from under his left arm/ armpit area. LN G moved to R1's far right and told R1 they were going to get him up. CNA O wrapped his arms around R1's torso and the three staff lifted R1 to a semi-standing position and then pivoted R1 to a seated position on the left side of the bed. The video revealed no gait belt was in use during the transfer from the floor, and no assessment was completed regarding range of motion or attempts to identify any latent injury. No pupil assessment (or hand grips) was assessed. At 09:55 AM, R1 lay in bed while LN G and CNO O provided incontinent care. At 09:57 AM, the two staff completed care and covered R1 with his blankets. At 09:58 AM, R1 lay in bed, covered by his blankets. His flat call light was visible on top of the blue blanket and the cord going off the left side of the bed. LN G stood on the right side of R1's bed and LN G took R1's blood pressure on his left wrist with a wrist monitor. The video revealed no other assessments, including pupil assessment or hand grips were conducted. At 10:00 AM, CNA N brought R1's wheelchair into the room and parked it parallel to the left lower end of the bed. CNA N left the room. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smoky Hill Rehabilitation Center	1007 Johnstown Avenue Salina, KS 67401

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At 10:28 AM, R1 lay in bed and tried to reach his water pitcher with his left hand, but the water pitcher on the bedside table was just out of reach for R1 to grab. After multiple attempts, R1 was able to push his water cup into a position that allowed him to pick up the cup. He lifted his head up off the pillow as he lay flat in the bed to take a drink through a straw. At 11:52 AM, CNA M entered R1's room and asked R1 if he was ready to get up for lunch. R1 took his covers off with his left hand. CNA M put sweatpants on R1. During the activity, an abrasion or reddened area was visible on R1's right knee. CNA M placed R1's shoes on his feet. Using a gait belt, CNA M transferred R1 to the wheelchair using a stand pivot transfer. CNA M propelled R1 out of the room. At 12:26 PM, R1 propelled himself in his wheelchair back into his room using his left hand and left leg. R1 used the repositioning rail on the left side of his bed and transferred himself into bed. R1 used his left arm and leg to get his covers up and over himself. R1 did not have his call light. At 12:52 PM, CNA M steps just inside of R1's room, and then immediately left the room without speaking or providing care. R1 did not have his call light. This was the last time staff entered R1's room until 05:21 PM. At 01:41 PM R1 was restless in bed. R1 did not have his call light. R1's bed was not in the lowest position. At 03:10 PM, R1 was restless in bed and held his head with his left hand. At 03:25 PM, R1 rubbed his head and the right side of his face. R1 continued to move around. At 03:30 PM, R1 held his head with his left hand. At 03:45 PM, R1 rolled to his left side and vomited yellow emesis on the sheet. R1 did not have his call light. At 03:58 PM, R1 sat up using his left hand and left leg. R1 positioned himself on the left edge of the bed in a seated position, leaning forward with his head over his knee. At 04:02 PM, R1 sat on the edge of the bed and rocked back and forth and side to side. At 04:13 PM, R1 laid back in bed on his left side, on the emesis. R1 yelled out but did not have a call light. R1 held his head with his left hand. At 05:20 PM staff entered R1's room, noted the emesis and left. Review of all the video footage revealed no staff went into R1's room or assessed him from 12:52 PM until 05:21 PM. R1's EMR recorded the following neurological assessments on [DATE] although the video footage revealed R1's temperature, bilateral hand grips, pupillary function and range of motion were not assessed while R1 was in his room: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Neurological Assessment, dated [DATE] at 09:45 AM, documented R1 had a blood pressure of , d+[DATE] mm/Hg, pulse of 87 beats per minute, respirations of 20 breaths per minute, and a temperature of 97.8. R1 was documented as being alert, hand grasps were greater on the left then the right (normal finding), moved all extremities, and pupils were reactive to light. The Neurological Assessment, dated [DATE] at 10:00 AM, documented R1 had a blood pressure of , d+[DATE] mm/Hg, pulse of 83 beats per minute, respirations of 18 breaths per minute, and a temperature of 97.6. R1 was documented as being alert, hand grasps were greater on the left then the right (normal finding), moved all extremities, and pupils were reactive to light. The Neurological Assessment, dated [DATE] at 10:15 AM, documented R1 had a blood pressure of , d+[DATE] mm/Hg, pulse of 73 beats per minute, respirations of 18 breaths per minute, and a temperature of 97.6. R1 was documented as being alert, hand grasps were greater on the left then the right (normal finding), moved all extremities, and pupils were reactive to light. The Neurological Assessment, dated [DATE] at 10:30 AM, documented R1 had a blood pressure of , d+[DATE] mm/Hg, pulse of 75 beats per minute, respirations of 19 breaths per minute, and a temperature of 98.4. R1 was documented as being alert, hand grasps were greater on the left then the right (normal finding), moved all extremities, and pupils were reactive to light. The Neurological Assessment, dated [DATE] at 11:00 AM, documented R1 had a blood pressure of , d+[DATE] mm/Hg, pulse of 78 beats per minute, respirations of 18 breaths per minute, and a temperature of 97.8. R1 was documented as being alert, hand grasps were greater on the left then the right (normal finding), moved all extremities, and pupils were reactive to light. The Neurological Assessment, dated [DATE] at 11:30 AM, documented R1 had a blood pressure of , d+[DATE] mm/Hg, pulse of 83 beats per minute, respirations of 18 breaths per minute, and a temperature of 97.9. R1 was documented as being alert, hand grasps were greater on the left then the right (normal finding), moved all extremities, and pupils were reactive to light. The Neurological Assessment, dated [DATE] at 01:30 PM, documented R1 had a blood pressure of , d+[DATE] mm/Hg, pulse of 68 beats per minute, respirations of 18 breaths per minute, and a temperature of 97.5. R1 was documented as being alert, hand grasps were greater on the left then the right (normal finding), moved all extremities, and pupils were reactive to light. On [DATE] at 01:30 PM, CNA O stated he was in R1's room after the fall. CNA O stated R1 was yelling out in pain. CNA O stated he followed LN G's direction about getting R1 off the floor. CNA O stated staff cleaned up R1's room and bed before providing care to R1. CNA O stated there had been feces on R1's bed pad and when the bed pad was removed it revealed the sheets were urine-soaked. CNA O stated he should have given R1 a pillow and comforted R1. CNA O went on to say the staff should have obtained a lift to get R1 up off the floor instead of just lifting him up underneath his arms. CNA O stated LN G had not checked R1's pupillary response. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 10:30 AM, Administrative Nurse D stated she expected she could trust the two administrative nurses on duty on [DATE] to follow the facility's unwitnessed fall policy and neurological check policy. Administrative Nurse D stated the family did not bring the video clips of the events until 10 days after she had submitted the report of the fall with injury to the state. Administrative Nurse D stated they had concerns about how the two nurses and CMA R, CNA M, and CNA N handled the fall even before they saw the videos. She further stated the facility took disciplinary actions for all staff involved in the incident that day and ended up terminating LN G and LN H. Administrative Nurse D also stated the facility provided education to all staff on falls and neurological assessments, completed after she and Administrative Staff A saw the videos the family brought to them. Administrative Nurse D stated she assumed since the neurological checks were documented in R1's chart that they had been performed. Administrative Nurse D stated she expected staff to provide residents comfort after a fall and take care of their needs. Administrative Nurse D stated R1 should have been checked on more frequently and provided with incontinent care more frequently than what had been provided to him. On [DATE] at 10:45 AM, Administrative Staff A stated that a lot of things had been missed the day R1 fell . Administrative Staff A said there was no way for the facility staff to know the neurological assessments were not completed when the assessment results were charted in R1's EMR. Administrative Staff A stated she wished the family would have shown the facility the video footage sooner than ten days after the incident. Administrative Staff A stated the facility staff were completely invested in making sure all the residents of the facility were given the care they deserved. The facility's policy Assessing Falls and Their Causes Policy, revised [DATE], documented that if a resident has just fallen or is found on the floor without a witness to the event, nursing staff will record vital signs and evaluate for possible injury to the head, neck, spine, and extremities. Once an assessment rules out significant injury, the nursing staff will help the resident to a comfortable lying, sitting, or standing position and then document relevant details. Nursing will notify the attending physician and family in an appropriate time frame. When a fall results in significant injury or condition change, nursing staff will notify the practitioner immediately by phone. When a fall does not result in significant injury or condition change nursing staff will notify the practitioner routinely by phone. Nursing staff will observe for delayed complications of a fall for approximately 48 hours after an observed or suspected fall and will document findings in the medical record. Documentation will include any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility, and any changes in level of responsiveness or consciousness and overall function. It will note the presence or absence of significant findings. The facility's Neurological Assessment Policy, revised [DATE], documented that staff were to familiarize themselves with any existing physical, mental, and or neurological deficits or disorders the resident may have before the assessment. Assess vital signs (temperature, pulse, respirations, blood pressure). Check the resident's motor abilities and mental ability to follow simple commands by asking the resident to move extremities. Use a penlight to check pupil response by turning off room and over bed lights, moving the penlight from the outer to the inner aspect of both eyes noting pupil constriction when the light beam crosses the pupil and pupil dilation when light is removed. Check pupil size to ascertain if they are equal in size. Ask the resident to grip and squeeze your hands to assess and compare strength bilaterally. Ask the resident if[TRUNCATED]

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43204 The facility identified a census of 70 residents with three residents reviewed for abuse, neglect, and exploitation. Based on record review, observation, and interview, the facility failed the facility failed to implement safety interventions to ensure Resident (R) 1 remained free from falls. On [DATE], R1, laid flat in his bed around 07:00 AM. The bed was not in the lowest position and R1 did not have his call light within reach. Certified Nurse Aide (CNA) M entered R1's room, asked if R1 wanted to get up and when R1 did not answer, CNA M lifted the covers, patted the front of R1's brief and left the room without ensuring R1 had his flat call light in reach. At 08:32 AM, another staff entered R1's room, placed a food tray on the bedside table but did not ensure R1 had his call light. At 09:39 AM, R1 pulled himself to a seated position on the side of the bed. At 09:41 AM Certified Medication Aid (CMA) R entered the room and gave R1, who sat on the side of the bed, his medications. CMA R walked out of the room leaving R1 sitting on the side of the bed, with no call light in reach. Four minutes later, at 09:45 AM, R1 pulled the bed pad, which was covered with feces out from underneath him using his left hand. During this action, R1 fell to the right side but due to his hemiplegia was unable to break his fall. R1 fell to the floor from a seated position, hitting his head on the floor. As a result of the fall, R1 suffered a hemorrhagic brain bleed and subsequently died . The facility's failure to identify the resident's risks and implement immediate basic safety interventions and staff assistance to prevent a fall placed R1 in immediate jeopardy. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of right-sided hemiplegia (paralysis of one side of the body), cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain), aphasia (condition with disordered or absent language function), dysphagia (swallowing difficulty), and repeated falls. The Quarterly Minimum Data Set [MDS], dated [DATE], documented R1 was rarely/never understood, had short-term and long-term memory loss; R1 was able to recall the location of his room, staff names, and faces, and that he resided in a nursing home. The MDS documented R1 had impairment on one side of his upper and lower extremities and required a wheelchair for locomotion. The MDS documented R1 required substantial/maximum assistance from staff for toileting, bathing, dressing, bed mobility, and transfers. The MDS documented R1 was always incontinent of bowel and bladder. The MDS documented R1 had one non-injury fall during the lookback period. The Activity of Daily Living Care Area Assessment (CAA), dated [DATE], documented R1 required assistance with self-care and mobility due to weakness, limited range of motion, poor coordination, and poor balance. The Fall CAA, dated [DATE], documented R1 required assistance with stabilization when moving from surface to surface and took antidepressants that increased his risk for falls. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Care Plan documented directed staff to ensure frequently used items were within easy reach ([DATE]) and document and report to the physician as needed post-fall for seventy-two hours of pain, bruises, change in mental status, sleepiness, inability to maintain posture, or agitation ([DATE]). The plan documented R1 needed to be up in his wheelchair for all meals ([DATE]). R1's Care Plan documented R1 was on antiplatelet therapy related to a CVA and staff were to observe, document, and report to the physician any signs and symptoms of anticoagulant complications including blood-tinged or obvious blood in the urine, black tarry stools, dark or bright blood in stools, sudden severe headaches, nausea, vomiting, lethargy, bruising, sudden changes in mental status, or significant changes in vital signs ([DATE]). A soft touch call light was to be placed on the left side of the bed ([DATE]). Staff were to offer R1 toileting between meals and rounding between meals to check for incontinence ([DATE]). R1's Fall Risk Assessment, dated [DATE], documented a score of 18, which indicated R1 was a high fall risk. R1's EMR contained a Late Entry Health Status Note, dated [DATE] at 09:45 AM but entered in R1's EMR on [DATE] at 08:20 PM, documented LN G was called to R1's room for a report of R1 being on the floor. R1 was lying on his left side wearing a t-shirt and a brief. R1 was incontinent of bowel, and he had placed his bowel movement on his side table. R1 was yelling, Saw, you saw, and was hand motioning to get up off the floor. R1's call light was not engaged. R1 was unable to give a description of what happened leading up to the fall due to a language barrier. R1 responded No when asked if he was in any pain. Once R1 was assisted back into bed and cleaned up, R1 began laughing about the situation with the staff. LN G documented she assessed R1's vital signs and neurological status. R1 was assisted to a sitting position and then assisted off the floor and into bed by three staff and a gait belt. LN G documented R1 had an abrasion noted on his right knee; the abrasion was not actively bleeding and there were no other skin concerns observed. The note recorded that staff notified Administrative Nurse D, R1's primary care physician, and R1's responsible party. LN G documented R1's responsible party reviewed camera footage and reported R1 had attempted to pull the bed pad out from underneath him which caused him to slip off the edge of the bed and fall to the floor. The Health Status Note, dated [DATE] at 05:21 PM, documented R1 was having emesis (vomiting) and had some bruising to the right side of his face to mid-ear, was answering to his name, and his grips were at baseline. R1's blood pressure was ,d+[DATE] millimeters of mercury (mmHg), pulse was 106 beats per minute, temperature was 97.2 degrees Fahrenheit (F), respirations were 18 breaths per minute, and oxygen saturation was at 93 percent (%). Staff notified R1's responsible party and she wanted R1 to go to the emergency room for evaluation. The on-call doctor for R1's primary care physician gave the order to send R1 to the emergency room . R1's EMR documented a Health Status Note, dated [DATE] at 05:37 PM, which documented Emergency Medical Services (EMS) was called at 05:35 PM and arrived at the facility at 05:45 PM. EMS left with R1 at 05:49 PM. Staff notified R1's responsible party that R1 was on his way to the emergency room . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The EMS Exam and Summary, dated [DATE] at 06:00 PM, documented EMS was dispatched to the facility for a resident who experienced an altered level of consciousness for the last five hours. The facility reported R1 was non-ambulatory, did not speak, and had slid out of his low-standing bed onto the ground earlier that morning. Upon arrival, EMS personnel found R1 to be experiencing an altered mental status. The summary documented facility staff reported R1's current condition could be his baseline, but the nurse was not sure. R1 was transported to the local hospital. The Emergency Physician Report, dated [DATE] at 07:48 PM, documented R1 arrived at the hospital via EMS secondary to a fall; R1 was sitting at the side of the bed and had a mechanical fall onto his right side at approximately 09:30 AM. R1 had a history of a previous CVA and was non-verbal. R1 was on clopidogrel (medication used to prevent blood from clotting) and was activated as a head alert. A computed tomography (CT scan- test that used X-ray technology to make multiple cross-sectional views of organs, bone, soft tissue, and blood vessels) of the head demonstrated a large subdural hemorrhage (bleeding between the skull and surface of the brain) on the right side extending from the frontal region (the front part of the brain) along the temporal (the part of the brain that helps you use your senses to understand and respond to the world around you) parietal (region of the brain above the temporal region) region and up over the right convexity (curvature on the skin side) leading to a 1.6-millimeter (mm) shift (deformation of the brain that can occur after a traumatic brain injury) from right to left with compression of the right lateral ventricle (area of the brain that produces and distributes cerebrospinal fluid). The Neurosurgical Consult Note, dated [DATE] at 07:50 PM, documented R1 lived in a nursing home. About two years ago R1 had a left-sided stroke which left him aphasic (without the ability for speech), hemiparetic (partial paralysis), and dependent living. The note documented that day, R1 had a ground-level video-recorded fall striking his head. R1 was brought to the emergency room and found to have an acute subdural hematoma (SDH-serious condition, typically caused by head injury, where blood collects between the skull and the surface of the brain). R1's Glasgow Coma Scale (GCS-a system to measure how conscious someone is) score was four which indicated a severe traumatic brain injury. R1 had unequal pupil size and an episode of vomiting. R1 had an intracerebral hemorrhage score (ICH - a prognostic model that predicts the risk of death for patients) of four which indicated a 97% risk of death within the next thirty days. The note documented the neurosurgeon talked with R1's family and indicated R1's prognosis was poor, and the family elected to proceed with comfort care for R1. R1's EMR contained a Health Status Note, dated [DATE] at 08:00 PM, which documented the facility received a notification from R1's responsible party that R1 had a major traumatic brain injury (TBI) and brain bleed, and the family was deciding between surgery and comfort care. CMA R's Witness Statement, dated [DATE], documented CMA R gave R1 his pills around 09:22 AM. R1 was sitting on the edge of the bed eating breakfast. A short time later, CNA N came from R1's room requesting a nurse because R1 was on the floor. LN H's Witness Statement, dated [DATE], documented LN H was the charge nurse of R1's hall and was in a nurse's meeting at the time of the fall. LN H stated the last time she laid eyes on R1 was about 08:30 AM and R1 rested in bed at that time. CNA M's Witness Statement, dated [DATE], documented CNA M checked on R1 at 08:00 AM and tried to get R1 up but R1 refused. CNA M stated he checked R1's brief and R1 was dry. CNA M stated he was not aware of the fall when it happened. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	LN G's Witness Statement, dated [DATE], documented that LN G was called to R1's room for a report of R1 being on the floor at 09:45 AM. R1 was lying on his left side wearing a t-shirt and a brief. R1 was incontinent of bowel and had placed part of his bowel movement on his side table. R1 was hand motioning that he wanted to get up off the floor. R1's call light was not engaged. R1 was unable to give a description of what happened leading to his fall. R1 did respond No when asked if he was in any pain. LN G stated she checked R1's vital signs, neurological status, and range of motion. R1 was assisted to a sitting position and then assisted off the floor by three staff. An abrasion was noted on R1's right knee that was not actively bleeding; there were no other skin concerns. LN G stated she notified R1's responsible party, who reviewed the camera footage and stated that R1 had attempted to pull the bed pad from underneath himself which caused the fall because R1 got too close to the edge of the bed. R1's responsible party stated she could not tell if R1 had hit his head or not. CNA O's Witness Statement, dated [DATE], documented that CNA O responded to a call on the walkie involving a resident down. CNA O went to R1's room. LN G was already in the room when he got there. R1 was lying on his chest, his feet by the bed, and his head was toward the end of his roommate's bed. CNA O stated he assisted R1 to a comfortable position. CNA O stated LN G did an assessment and staff got R1 cleaned up and comfortable in bed. The Facility Incident Report, dated [DATE], documented the morning of [DATE] at approximately 09:30 AM R1 fell from his bed, unwitnessed by staff. R1's family utilized a camera in his room. LN G gave report of the fall. R1's family reviewed the footage and observed R1 pulling on his bed pad which resulted in the fall. Neurological exams were initiated at the time of the fall at 09:30 AM and remained within normal limits until approximately 05:30 PM when R1's blood pressure increased and R1 began vomiting. Once vital signs were outside of normal parameters, staff notified R1's primary care physician and obtained orders for R1 to be evaluated in the ER. The staff notified R1's family as well. R1 was sent via EMS to the local hospital around 06:00 PM. Upon evaluation, R1 was found to have a brain bleed at approximately 08:20 PM. R1 was last checked prior to the fall at 08:30 AM. R1 refused to get out of bed; CNA M stated that R1 was dry, and the bedding was clean at that time. Corrective actions taken were to place a bedside commode, as R1 refused staff assistance with toileting. A review of the motion-activated video footage which also recorded audio and date and time stamps revealed the following series of events that occurred on [DATE]: At 07:01 AM, CNA M entered R1's room and asked R1 if he wanted to get up for breakfast. R1 did not answer. CNA M said, Okay you want to stay in bed. CNA M lifted R1's blankets off him, patted R1's incontinence brief with his ungloved hand, covered R1 up, turned off the light, and left the room. R1's call light and/or cord was not visible on his bed, or anywhere in the footage. At 08:32 AM a staff member entered R1's area for the first since 07:01 AM. CNA M brought in R1's breakfast tray and placed it on the bedside table. CNA M did not raise R1's head of the bed, did not set up R1's tray by unwrapping the silverware, and did not cut up R1's sausage patties. CNA M moved the tray table over R1 as R1 laid flat in bed and left the room. R1's call light and/or cord were not visible on the bed or anywhere in the footage. R1 proceeded to pick up the scrambled eggs and sausage and eat it with his left finger. R1 dropped multiple pieces of food on his shirt. R1 manipulated his coffee cup until he could pick it up, then raised his head slightly off the pillow and attempted to drink the coffee while lying in bed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smoky Hill Rehabilitation Center	1007 Johnstown Avenue Salina, KS 67401

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At 09:18 AM, R1 reached down into his brief with his left hand. R1 brought his left hand out of his brief, looked at his hand, which appeared to have feces on it, and cleaned his hands off on the sheets. R1's call light and/or cord were not visible on the bed or anywhere in the footage. At 09:28 AM, R1 removed his covers with his left hand and left leg. He reached down into his brief removed a large ball of what appeared to be feces and placed it on his bedside table. R1's call light and/or cord were not visible on the bed or anywhere in the footage. At 09:39 AM, R1 used the repositioning rail on the left side of his bed and struggled to pull himself up and position himself on the edge of the bed. R1's call light and/or cord were not visible on the bed or anywhere in the footage. R1's wheelchair was visible to R1's far right, past the end of the bed, and out of reach. The cushion in the wheelchair was partially hanging off the seat. At 09:41 AM, staff entered the area again for the first time since 08:32 AM. CMA R came into R1's room and gave R1 his medications in a small pill cup. CMA R opened an Ensure (nutritional drink) and placed it on the tray table. R1 pointed at the ball of feces on his bedside table. CMA R said, Okay, okay. R1 then picked up the ball of feces from the bedside table and held it out towards CMA R. CMA R then walked out of R1's room. R1's call light and/or cord were not visible on the bed or anywhere in the recorded footage. At 09:43 AM, R1 sat on the side of his bed with his left elbow on his left knee, leaning forward. His feet were not visible, but his legs were bent at a 90-degree angle, and he appeared to have his feet on the floor. R1's wheelchair was visible in the background and R1's bed appeared to be at the same height or slightly higher than the seat of the wheelchair. R1's call light and/or cord were not visible on the bed or anywhere in the recorded footage. At 09:45 AM R1 sat on the side of the bed. R1 tried to pull the bed pad out from underneath him with his left hand. R1 then repositioned himself using his left hand to move a little to his right, then again attempted to pull the bed pad out from underneath him. R1 leaned a bit to the right and then fell off the bed, to his right. R1's right arm remained flaccid, and he fell on to the floor. The right side of R1's face struck the floor, and his back bumped into his wheelchair, which was seen to move backward with the impact. There was a large amount of feces visible on the bed pad, sheet, brief, and on R1's left buttock. There was light brownish-yellow soiling or discoloration on the area of the sheet that was previously under the bed pad that became visible after the bed pad was folded and pulled away from the area. R1 moaned as he struck the floor. At 09:47 AM, R1 lay on the floor yelling out loudly in pain. Staff can be heard outside the door saying, We're coming and asking an unknown person, not visible in the footage, if someone had a walkie. At 09:48 AM, LN G assessed R1's blood pressure using a wrist monitor on R1's left wrist. R1 remained lying on his left side. A staff member partially visible from the waist down repositioned R1's wheelchair and then pushed the chair from the room. LN G removed the wrist cuff from R1's left wrist and told R1 that staff were going to get him up and cleaned up. LN G stood up, placed the wrist cuff on the bedside table, and left the room. R1 continued to moan and yell Oh, oh, [expletive], oh [expletive]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At 09:49 AM, R1 continued to lay on his right side, his right arm was not visible. He continued to call out though all staff had exited the room. Thirty seconds later, three staff members reentered the room. R1 continued to cry out and yell. One staff member, visible from the waist down and identifiable by the attire as LN G, carried in a trash can and set it on the floor between R1 and the bedside table. LN G removed the ball of feces from the bedside and tossed it in the trash. Two staff visible from the legs down stood towards the entryway of R1's area. LN G then wiped the side of the tray table and moved the trash can farther away from the bed. R1 continued to lie on the floor repeating the same Oh [expletive] oh over and over. LN G approached the bed and told R1 to hang on as staff had to get things cleaned up so they could get him up. LN began to remove the soiled linens from R1's bed. When LN G pulled the bed pad completely, a large oval-shaped area on the sheet appeared damp and with discoloration. Another staff stood at the foot of the bed and assisted LN G in removing the soiled linens. R1 continued to call out and became louder and louder in his cries. Without speaking to R1, LN G bent down and unfastened the tape on R1's incontinence brief, then stood, and pulled the privacy curtain between R1's side of the room and his roommates and the entryway. The privacy curtain was visible floating above R1's head and lightly touching his left shoulder. LN G exits the footage viewing area towards the door, then is seen coming back and picking up the soiled linens and again moving towards the door. CNA O stood on the right side of R1's bed and proceeded to clean the mattress with wipes. LN G stood towards the foot of the bed, and CNA O pulled back the privacy curtain momentarily and reentered the area, standing in front of R1, who continued to lie on the floor on his right side crying out, and yelling. At 09:51 AM, CNA O stood in front of R1, who remained on the floor on his right side. LN G stood behind R1, and CNA N remained on the right side of R1's bed. The staff discussed how they would get R1 off the floor while R1 continued to groan and cry out. CNA moved the bedside table and trashcan towards the wall, and then bent down and attempted to bend R1's legs and pull them towards CNA O. LN G informed R1 the staff were going to bed his legs. As CNA O bent and pulled on R1's legs, R1 screamed out and there was feces visible on R1's left hip/buttock area. CNA O let go of R1's legs and stood up. CNA N moved to the foot of the bed. LN G placed her left hand on R1's left upper arm and used her right hand to push him upward. LN G then supported R1's back as CNA O straddled R1's legs and CNA N used both hands to lift R1 from under his left arm/ armpit area. LN G moved to R1's far right and told R1 they were going to get him up. CNA O wrapped his arms around R1's torso and the three staff lifted R1 to a semi-standing position and then pivoted R1 to a seated position on the left side of the bed. The video revealed no gait belt was in use during the transfer from the floor, and no assessment was completed regarding range of motion or attempts to identify any latent injury. No pupil assessment (or hand grips) was assessed. At 09:55 AM, R1 lay in bed while LN G and CNO O provided incontinent care. At 09:57 AM, the two staff completed care and covered R1 with his blankets. At 09:58 AM, R1 lay in bed, covered by his blankets. His flat call light was visible on top of the blue blanket and the cord going off the left side of the bed. LN G stood on the right side of R1's bed and LN G took R1's blood pressure on his left wrist with a wrist monitor. The video revealed no other assessments, including pupil assessment or hand grips were conducted. At 10:00 AM, CNA N brought R1's wheelchair into the room and parked it parallel to the left lower end of the bed. CNA N left the room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At 10:28 AM, R1 lay in bed and tried to reach his water pitcher with his left hand, but the water pitcher on the bedside table was just out of reach for R1 to grab. After multiple attempts, R1 was able to push his water cup into a position that allowed him to pick up the cup. He lifted his head up off the pillow as he lay flat in the bed to take a drink through a straw. At 11:52 AM, CNA M entered R1's room and asked R1 if he was ready to get up for lunch. R1 took his covers off with his left hand. CNA M put sweatpants on R1. During the activity, an abrasion or reddened area was visible on R1's right knee. CNA M placed R1's shoes on his feet. Using a gait belt, CNA M transferred R1 to the wheelchair using a stand pivot transfer. CNA M propelled R1 out of the room. At 12:26 PM, R1 propelled himself in his wheelchair back into his room using his left hand and left leg. R1 used the repositioning rail on the left side of his bed and transferred himself into bed. R1 used his left arm and leg to get his covers up and over himself. R1 did not have his call light. At 12:52 PM, CNA M steps just inside of R1's room, and then immediately left the room without speaking or providing care. R1 did not have his call light. This was the last time staff entered R1's room until 05:21 PM. At 01:41 PM R1 was restless in bed. R1 did not have his call light. R1's bed was not in the lowest position. At 03:10 PM, R1 was restless in bed and held his head with his left hand. At 03:25 PM, R1 rubbed his head and the right side of his face. R1 continued to move around. At 03:30 PM, R1 held his head with his left hand. At 03:45 PM, R1 rolled to his left side and vomited yellow emesis on the sheet. R1 did not have his call light. At 03:58 PM, R1 sat up using his left hand and left leg. R1 positioned himself on the left edge of the bed in a seated position, leaning forward with his head over his knee. At 04:02 PM, R1 sat on the edge of the bed and rocked back and forth and side to side. At 04:13 PM, R1 laid back in bed on his left side, on the emesis. R1 yelled out but did not have a call light. R1 held his head with his left hand. At 05:20 PM staff entered R1's room, noted the emesis and left. Review of all the video footage revealed no staff went into R1's room or assessed him from 12:52 PM until 05:21 PM. R1's EMR recorded the following neurological assessments on [DATE] although the video footage revealed R1's temperature, bilateral hand grips, pupillary function and range of motion were not assessed while R1 was in his room: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Neurological Assessment, dated [DATE] at 09:45 AM, documented R1 had a blood pressure of , d+[DATE] mm/Hg, pulse of 87 beats per minute, respirations of 20 breaths per minute, and a temperature of 97.8. R1 was documented as being alert, hand grasps were greater on the left then the right (normal finding), moved all extremities, and pupils were reactive to light. The Neurological Assessment, dated [DATE] at 10:00 AM, documented R1 had a blood pressure of , d+[DATE] mm/Hg, pulse of 83 beats per minute, respirations of 18 breaths per minute, and a temperature of 97.6. R1 was documented as being alert, hand grasps were greater on the left then the right (normal finding), moved all extremities, and pupils were reactive to light. The Neurological Assessment, dated [DATE] at 10:15 AM, documented R1 had a blood pressure of , d+[DATE] mm/Hg, pulse of 73 beats per minute, respirations of 18 breaths per minute, and a temperature of 97.6. R1 was documented as being alert, hand grasps were greater on the left then the right (normal finding), moved all extremities, and pupils were reactive to light. The Neurological Assessment, dated [DATE] at 10:30 AM, documented R1 had a blood pressure of , d+[DATE] mm/Hg, pulse of 75 beats per minute, respirations of 19 breaths per minute, and a temperature of 98.4. R1 was documented as being alert, hand grasps were greater on the left then the right (normal finding), moved all extremities, and pupils were reactive to light. The Neurological Assessment, dated [DATE] at 11:00 AM, documented R1 had a blood pressure of , d+[DATE] mm/Hg, pulse of 78 beats per minute, respirations of 18 breaths per minute, and a temperature of 97.8. R1 was documented as being alert, hand grasps were greater on the left then the right (normal finding), moved all extremities, and pupils were reactive to light. The Neurological Assessment, dated [DATE] at 11:30 AM, documented R1 had a blood pressure of , d+[DATE] mm/Hg, pulse of 83 beats per minute, respirations of 18 breaths per minute, and a temperature of 97.9. R1 was documented as being alert, hand grasps were greater on the left then the right (normal finding), moved all extremities, and pupils were reactive to light. The Neurological Assessment, dated [DATE] at 01:30 PM, documented R1 had a blood pressure of , d+[DATE] mm/Hg, pulse of 68 beats per minute, respirations of 18 breaths per minute, and a temperature of 97.5. R1 was documented as being alert, hand grasps were greater on the left then the right (normal finding), moved all extremities, and pupils were reactive to light. On [DATE] at 01:30 PM, CNA O stated he was in R1's room after the fall. CNA O stated R1 was yelling out in pain. CNA O stated he followed LN G's direction about getting R1 off the floor. CNA O stated staff cleaned up R1's room and bed before providing care to R1. CNA O stated there had been feces on R1's bed pad and when the bed pad was removed it revealed the sheets were urine-soaked. CNA O stated he should have given R1 a pillow and comforted R1. CNA O went on to say the staff should have obtained a lift to get R1 up off the floor instead of just lifting him up underneath his arms. CNA O stated LN G had not checked R1's pupillary response. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 10:30 AM, Administrative Nurse D stated she expected she could trust the two administrative nurses on duty on [DATE] to follow the facility's unwitnessed fall policy and neurological check policy. Administrative Nurse D stated the family did not bring the video clips of the events until 10 days after she had submitted the report of the fall with injury to the state. Administrative Nurse D stated they had concerns about how the two nurses and CMA R, CNA M, and CNA N handled the fall even before they saw the videos. She further stated the facility took disciplinary actions for all staff involved in the incident that day and ended up terminating LN G and LN H. Administrative Nurse D also stated the facility provided education to all staff on falls and neurological assessments, completed after she and Administrative Staff A saw the videos the family brought to them. Administrative Nurse D stated she assumed since the neurological checks were documented in R1's chart that they had been performed. Administrative Nurse D stated she expected staff to provide residents comfort after a fall and take care of their needs. Administrative Nurse D stated R1 should have been checked on more frequently and provided with incontinent care more frequently than what had been provided to him. On [DATE] at 10:45 AM, Administrative Staff A stated that a lot of things had been missed the day R1 fell . Administrative Staff A said there was no way for the facility staff to know the neurological assessments were not completed when the assessment results were charted in R1's EMR. Administrative Staff A stated she wished the family would have shown the facility the video footage sooner than ten days after the incident. Administrative Staff A stated the facility staff were completely invested in making sure all the residents of the facility were given the care they deserved. The facility's policy Assessing Falls and Their Causes Policy, revised [DATE], documented that if a resident has just fallen or is found on the floor without a witness to the event, nursing staff will record vital signs and evaluate for possible injury to the head, neck, spine, and extremities. Once an assessment rules out significant injury, the nursing staff will help the resident to a comfortable lying, sitting, or standing position and then document relevant details. Nursing will notify the attending physician and family in an appropriate time frame. When a fall results in significant injury or condition change, nursing staff will notify the practitioner immediately by phone. When a fall does not result in significant injury or condition change nursing staff will notify the practitioner routinely by phone. Nursing staff will observe for delayed complications of a fall for approximately 48 hours after an observed or suspected fall and will document findings in the medical record. Documentation will include any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility, and any changes in level of responsiveness or consciousness and overall function. It will note the presence or absence of significant findings. On [DATE] at 02:32 PM Administrative Staff A received copies of the Immediate Jeopardy [IJ] Templates and was informed that the facility's failure to identify the resident's risks and implement immediate basic safety interventions and staff assistance to prevent a fall placed R1 in immediate jeopardy. The facility identified and implemented immediate corrective actions, which were completed on [DATE] that included the following: (continued on next page)

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