STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675321	A. Building B. Wing	07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradigm at Faith Memorial	811 Garner Rd Pasadena, TX 77502

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 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** 37059 Based on interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #1) of five residents reviewed for quality of care. The facility failed to utilize emergency transport after Resident #1 had an unwitnessed fall which resulted in a subdural hematoma and 2.5-hour delay in care. Resident #1 was sent to the hospital and placed in the ICU. An Immediate Jeopardy (IJ) situation was identified on 7/26/24 at 6:10 PM. While the IJ was removed on 07/28/24, the facility remained out of compliance at a scope of isolated with the potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk for delay in needed treatment and care, resulting in further injury, hospitalization , and/or death. Findings included: Record review of Resident #1's face sheet dated 7/26/24 revealed an [AGE] year-old female who was admitted originally to the facility on [DATE] and most recently on 4/24/24 with diagnoses including Dementia (group of symptoms affecting memory, thinking and social abilities), insomnia (Trouble falling and/or staying asleep), glaucoma (eye conditions that damage the optic nerve), blindness right and left eye, bipolar (eye conditions that damage the optic nerve). Record review of Resident #1's MDS dated [DATE], revealed her BIM score was 00 which indicated she had severe cognitive impairment. Resident #1 used a wheelchair for mobility, required supervision or touch to transfer to the wheelchair, sit to stand, and was independent to walk 10 feet. Record review of Resident #1's care plan dated 7/26/24 revealed the following in part: A. Focus: Sits and crawls on floor, will attempt to stand on WC or dining room table, 7.24.24 fall w/injury to face, sent to hospital. Date initiated 10/10/22 and revised on 7/25/24. Goal: none (continued on next page)

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Intervention/Task: Observe for early warning signs of behavior - approach in a calm manner, call by name, remove from unwanted stimuli. Date initiated 10/10/22 . B. Focus: [Resident #1 reside in life engagement unit [secured unit] due to need for structured environment and poor safety awareness. Date initiated 10/10/22. Goal: Dignity will be maintained thru [through] next review. Date initiated 10/10/22. Interventions/Task: .Keep environment free of possible hazards . C. Focus: [Resident #1] is at risk for falls and fall related injuries R/T gait imbalance impaired memory, and Dementia .5/8/24 [Resident #1 on floor, bruises noted to rt back shoulder area, bruises to lt buttocks. 6/14/24 actual fall, lost balance, hitting head. Bruise to head. 7/1/24 unwitnessed fall causing laceration to lip and rt side of forehead. Sent to ER for eval. 7/3/24 put feet on dining room table while still in wheelchair. Pushed and caused self to tip over backwards. No injuries. Date initiated 9/23/23. Goal: [Resident #1] will be free from fall related injuries over the next 90-day review period. Date initiated 9/26/23. Interventions/Task: Anticipate needs - provide prompt assistance. D. Focus: [Resident #1] reside in secure unit for wandering elopement risk need for controlled environment poor safety awareness. Date initiated 4.25.24. Goal: . [Resident #1 will be safe thru [through] next review. Date initiated 4.25.24. Interventions/Task: Keep environment free of possible hazards . Record review of Resident #1's orders dated 7/26/24 revealed that her observation behaviors were crawling on the floor and standing on furniture. Record review of Resident #1's progress notes dated 7/24/24 (written by LVN A) reflected the following: Text: At about 7:45p [pm] pt. was found on floor in room, under her wheelchair with a small laceration above L eye. the L eye is swollen shut and she has a busted lip. [Pain medication] 325mg 2 tabs was given for pain/discomfort and icepack to eye. V/S [vital signs] are 126/71 P [pulse] 54, SpO2 97% and T [temp]-97.2 [degrees]. DON and on-call notified. Pt. to be sent out to [Hospital] for ER CT scan Record review of Resident #1's hospital admission report dated 7/24/2024 revealed the following in part: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	.07/24/24 2238 [10:48 PM] Presentation Chief Complaint Fall, Head injury Onset Occurred Today, Unknown Symptom Duration Constant Progression since Onset .Notes [AGE] year-old female patient was brought in by EMS alert but nonverbal, found on the floor as an unwitnessed fall. She has a hematoma above the left eye with a small abrasion to that area that caused some bleeding on the scene. Patient had no vomiting no other symptoms. Neurologically at baseline per EMS transport staff from the nursing home . Acute 5.8 mm subdural hematoma [A condition due to bleeding under the membrane covering the brain] along the right tentorium [extension of one of the membranes covering the largest part of the brain] . reviewed the head CT. There is a thin layer of blood overlying the tentorium on the right without mass effect. No convexity subdural hematoma or brain contusion. Plan: 1. Admit to ICU and repeat head CT in AM 2. No need for anticonvulsants [drugs that prevent or reduce seizures by stabilizing nerve cell activity in the brain]. 7. In an interview on 7/26/24 at 4:12 PM, LVN A said she was called to Resident #1's room by CNA B after Resident #1 was found on the floor. She said she completed and documented a head-to-toe assessment, skin assessment and took Resident #1's vitals. She said Resident #1's vitals were stable and within normal range. She said she made notifications, one of which was the on call medical professional. She said NP A directed her to send Resident #1 to the ER. LVN A said she sent Resident #1 via non-emergency transportation to the ER because Resident #1 had falls before, did not have bleeding and her vitals were within her normal limits. LVN A said she called 3 transportation services and selected the services with the shortest response time (1 1/2 hour). She said she performed neuro checks for approximately 1 hour and a half until Resident #1 went to sleep approximately around 9:00 PM. LVN A said she passed medications on another hall until EMS picked up Resident #1 approximately at 10:00 PM. She said she was not required to document the neuro check and had not been trained to document the neuro checks. She said she did not think Resident #1 was at risk by going out non-emergency transports versus going out sooner with 911. Interview on 7/26/24 at 10:58 AM, CNA A said she was called around 7:30 PM by CNA B to assist with Resident #1. CNA A said Resident #1 was on the floor under her wheelchair. She said CNA B then went to tell LVN A what happened. CNA A said LVN A came in, completed the assessment and they turned Resident #1 over and placed her back in bed. CNA A said Resident #1 had a bump over her left eye and a cut to her lip. She said she continued her duties after Resident #1 was put back in bed. She said Resident #1 was sent out the emergency room , but it was after 9:30 PM. In an observation on 7/26/24 at 11:55 AM, Resident #1 was in bed in the ICU unit of the hospital. Her eyes were closed and she had the covers to her chin. She had a dark purple bruise above her left eye and a family member stood over her wiping her face. In an attempted interview on 7/26/24 at 11:55 AM, the surveyor introduced themselves to Resident #1 and asked her how she felt. Resident #1 did not respond or open her eyes to acknowledge the surveyor. The family member told the surveyor that she was non-verbal. In an interview on 7/26/24 at 12:05 PM, RN A at hospital stated that Resident #1 was admitted to the ICU on 7/24/24 at 11:30 PM after she had received several CT head scans. Her injuries were bruising of the left eye and a subdural hematoma. She explained that the hospital's EMS had an urgent response time and a 2. 5-hour delay in emergency services was detrimental because you could not determine how bad a head injury was until after a resident received their scans. RN stated luckily Resident #1's hemorrhagic area was not too big because if it had been larger, Resident #1 would have needed surgery. (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 7/26/24 at 12:13 PM, a family member of Resident #1, stated she had a missed call from the facility regarding the fall of Resident #1 on 7/24/24 at 8:36 PM. She called the facility back for further information at 9:58 PM and was told that Resident #1 had just left the facility and was headed to the hospital. She stated that she arrived at the hospital after 10 PM and she waited for Resident #1 to arrive at 10:30 PM. She explained that the hospital was not busy and she believed that there was a delay in care on the facility's part. In an interview on 7/26/24 at 1:56 PM with CNA A, she explained that some of Resident #1's behaviors were trying to climb tables, her wheelchair, and she would climb on the floor. In the room, there were two wheelchairs pushed seat first to the opposite wall of Resident #1's bed. CNA A stated that when they were preparing residents for bed, they like to tend to Resident #1 first so they could know her whereabouts as they tended to other residents. She explained that when she would work with Resident #1, she would normally take the wheelchairs out of the room because the resident was a fall risk and liked to stand up on the wheelchair. She explained that on the night on 7/24/24, CNA B called her to come down to Resident #1's room because she found her on the floor. When she came into her room, Resident #1 was laying on the floor in fetal position underneath one of her wheelchairs. They called for LVN A, who came in and assessed the resident. In an interview on 7/26/24 at 2:15 PM with the ADON, she stated that she was off on 7/24/24. She explained that the protocol for an unwitnessed fall with head injury was to call the physician, the DON, then fill out physician orders. Nurses were to perform, vitals, a pain assessment, fall assessment, skin assessment, document any risks, and complete a SBAR (change in condition documentation). She stated that if she saw a situation that seemed to be an emergency, she would use her nursing judgement to call 911 and let the physician know that she did. She stated that all nurses can notify the doctor after hours through an app (online application). She said that she always educated staff that if they could not reach anyone after 20 minutes, they were to contact the physician directly. Interview on 7/26/24 at 2:31 PM, the DON said she was notified Resident #1 was found on the floor with a head injury. LVN A gave Resident #1 ice for the swelling, Tylenol, and sent her a picture. Once she saw the picture, she told LVN A that she thought Resident #1 needed a CT scan and the physician notified, also agreed. She said she initially thought LVN A sent Resident #1 out via 911. She said after an interview with LVN A, she found out that Resident #1 was sent out via non-emergency transport. The DON said Resident #1 was picked up at approximately 10:00 PM. She said LVN A was told by the on call NP to send to the ER which did not necessarily mean 911. She said because Resident #1 was stable, not on anticoagulants, not bleeding, and was at baseline she would have preferred emergency services, but non emergent services was fine in this incident. In an interview on 7/26/24 at 2:55 PM, CNA B said she found Resident #1 on the floor in her room in the fetal position with her wheelchair on top of her. CNA B said she asked for help from CNA A and LVN A. CNA B said LVN A came, removed the wheelchair off of Resident #1 and began the assessments and tookher vitals. She said Resident #1 had a bump over her left eye and her lip was split. She said Resident #1 was sent to the ER but she could not remember what time Resident #1 left. She said Resident #1 did not leave within the first hour after the incident. CNA A said Resident #1 had a behavior of crawling on the floor and standing up on wheelchairs and furniture. (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 7/26/24 at 3:13 PM, the Medical Director said she was notified of Resident #1's unwitnessed fall. The Medical Director said NP A was the on-call respondent. She said based on what she was told, Resident #1 vitals were stable and there was no blood, it was fair to send Resident #1 out within a few hours by non-emergency transportation. In an interview on 7/28/24 at 4:31 p.m., NP A said she was notified Resident #1 was found on the floor with a wheelchair on top of her. NP A said she was told Resident #1 had an injury to her head and was not bleeding. NP A said she was notified Resident #1's vitals were with in normal range. She advised LVN A to send Resident #1 to the ER. NP A said it was a nursing judgement call whether to send out Resident #1 by 911 or non-emergency transport to ER was the facilities choice. Record review of facility policy Nursing Policies and Procedures - Fall Management (revised 1/2019) revealed the following in part: Policy: It is the policy of this facility to evaluate extent of injury after a fall, prevent complications and to provide emergency care . Purpose: 1. To identify resident at risk in a timely manner .4. To respond to a fall in a manner that will ensure the resident is treated timely and safely .In the Event of a Fall: 1. The resident will be checked for any abnormalities: i.e. A. Deformed, discolored or painful body parts. B. Bumps. C. Bruises D. Cuts. E. Abrasions F. Scrapes G. Confusion H. Level of consciousness. 3. Obtain vital signs .5. Initiate neurological checks for any fall where a resident his his/her head or for any unwitnessed fall .Note1. If condition from fall is life threatening, the nurse shall initiate EMS (Emergency Medical Services) stat and then place a call to physician, hospice, and family/responsible party . This was determined to be an Immediate Jeopardy (IJ) on 7/26/24 at 6:10 PM. The DON and ADON were notified. The DON was provided with the IJ template on 7/26/24 at 6:10 PM. The following Plan of Removal submitted by the facility was accepted on 07/27/24 at 4:00 PM: Facility- IJ Plan of Removal for F684 7/26/2024 Allegation F684: Quality of Care The facility failed to obtain emergency services for unwitnessed fall for Resident #1 after a fall on 7/24/24 that resulted in bruising to a subdural hematoma to the left side of her head. Resident #1 arrived at the ER approximately two and a half hours after the injury had occurred. On 7/24/24 Resident #1 was transferred to the hospital. LVN A was suspended pending investigation 7/25/24 based on Self Report to HHSC. The Administrator and Director of Nursing notified the Medical Director of the IJ on 7/26/24. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Regional Nurse Consultant provided 1:1 education with the DON on 7/26/24 on the following topics: o Conducting an Investigation Post Falls o Fall Management o Changes of Condition Warranting 911 Transfer o Neuros Vital Signs Status Post Falls The Director of Nursing initiated education with Licensed staff members on 7/26/24 on: o Fall Management o Change of Condition Warranting 911 Transfer o Neuro Vital Signs Status Post Falls o Incident & Accident Quick Guide *All License Staff will be Educated Prior to Working & Complete Post Test to Demonstrate Competency. All Training to be Completed by 7/27/24. Audit of Resident Falls x last 30 Days Completed; DON & ADON Assessed Residents Identified to ensure there were no adverse effects status post fall that had not been addressed. Assessments Completed 7/26/24. Ad Hoc QAPI Conducted 7/26/24 with Medical Director, Administrator, DON, & ADON. Monitoring Day 1: Saturday July 27th, 2024 (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 7/27/24 at 4:08 PM with the DON, she stated she was educated on doing neuro checks and what the time frame was. The neuro documentation sheets were changed to front and back copies to help keep up with them. She discussed that if there were any changes in neuro responses, it was an acute change and it was an emergency. There was also a quick guide for falls created a copy is held at each nurse's station for them to review. The quick guide gives examples for everything that was required and considerations of what to do after a fall. Fall management covered that prior to a fall, and doing a fall assessment, nurses needed to pay attention to the score. They were responsible for recognizing the score and putting something in place at that time. Some patients have fall injuries and may need a fall mat. If it is a trip hazard, nurses have to wave that out. Nurses need to make sure that anytime there is a fall intervention in place it makes sure that we are looking at each person's care plan. The nurse can add interventions in the risk management, and it will be reviewed by the IDT team and DON in the morning. In the event of a fall, herself and the Regional Nurse covered to make sure they did skin assessment, initiated neuro checks, evaluated cause of fall, and did a complete vital sign, neuro check, and range of motion. Staff must notify her of all falls and if the doctor they are trying to reach had not responded in 1 hour, they must notify the Medical Director. Nurses must notify RP and if a resident is their own RP, instead of leaving blank that section blank in the documentation, nurses are to add the resident's name to state they are their own RP. Everything must be documented and passed on to the report. If the condition was life threatening, they would notify EMS, then they would call the doctor and notify the DON. They also covered in the education that anytime a resident changes the level of plane it is still a fall. Unless there was evident of something otherwise, if a resident is on the floor, then a fall is considered to have happened. The DON stated she discussed with nurses the signs of a head Injury such as unequal pupils, loss of consciousness, change in cognition, nausea and vomiting, and/or a headache. If the resident already had a something nurses were monitoring like aspirin or blood thinners, the nurse would send the resident out to be evaluated. The facility added a table for what type of treatment would need to be done for time frames to be viewed at the nurses station as well. If there were any abnormal neuro changes, muscle or skeletal issues, they needed to be in the ER within an hour. If there was any bleeding or anything with large lacerations, residents could be sent out, stating that They are nurses and should still be ale to use judgement. In an interview on 7/27/24 at 4:38 PM, LVN B stated that she had worked at the facility for 5 months and worked from 6AM- 6PM. She stated for the fall protocol, they covered the procedure for and an unwitnessed and witnessed fall. An unwitnessed fall automatically needed neuro checks. They were to do assessments, vitals before they have been moved, and check for pain and any possible dislocations. Nurses were to do a whole assessment, notify the doctor and receive orders, and notify the DON, and family. Witnessed falls with head injury called for the same procedure except they would medicate immediately, do neuro checks, and vitals. If there was an emergency and they needed to call 911, nurses can call them and let the doctor and family know. Some examples of emergencies were an acute change in cognition, head injuries, suspected dislocation, pain upon movement, headaches, and suspected bleeding. Everything that needed to be documented after a fall would be the SBAR, risk management, pain assessment, skin assessment, fall assessment, and neuros. LVN B stated that the quick guide for fall assessments was located at the nurse's station and they gave each nurses a copy after the in-service. (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 with on 7/27/24 at 4:47 PM with LVN C, she stated that she had started work at the facility on 6/5/24 and worked the 6AM- 6PM shift. She explained the fall protocol was to assess the patient before the touched them for injuries and check their vitals. If it was an unwitnessed fall she would we do neuro checks and check head to toe to make sure there was no other pain. Nurses will also make sure the doctor and DON was aware. If on blood thinners, they would send the resident to the hospital. Vitals should be monitored and if they have major symptoms like bleeding, unresponsiveness, not alert and oriented, she would send them out because she did not want to take any chances. LVN C also stated that the doctor, family, and DON must be aware. For every fall, nurse complete a SBAR, fall assessment, pain assessment, skin assessment, and do neuro checks. Neuro checks were especially completed if the fall was unwitnessed or witnessed with a head injury. If there was an emergency like the patient was unresponsive or a mood change in condition, she would call 911 first and the call the doctor. She explained that they have quick sheets for fall protocols and book for the neuros that she kept at her desk at the nurse's station. In an interview on 7/27/24 at 4:53 PM with LVN D, she stated she started working at the facility on 06/01/24 and she worked the 6AM- 6PM shift. She explained that in the fall protocol in-service, they covered what to do in a witnessed and unwitnessed fall. Nurses have to do an incident t report and SBAR. If the CNAs found the resident first, she would make sure they don't touch them, and continue with vitals, neuro checks, and check for broken bones. She would also check to see if the resident was on blood thinners and if there was an emergency, she would call 911 immediately without waiting on a response from the doctor. Examples of emergencies would be if they were on a blood thinner and hit their head, visibly bleeding profusely, broken limbs, unconscious, headaches, seizures, and if there was something she couldn't control. She explained when was had to call 911 for emergency, she would notify the DON, she would stay with the resident, and assign someone else to call 911. She would also doctor or on call if they take too long, she would call the Medical Director and notify the family. If the resident was their own RP, she would write that in the risk management assessment and SBAR, as well as in her own progress note. There was a fall protocol quick note sheet she was given during the education that she placed at her desk and she stated that she also kept all of the paperwork from facility in-services in her work bag. Nursing also had a flow sheet for monitoring neuros, which was just updated. LVN C said for neuros, they have to follow up every 30 minutes, for up to 72 hours and it was self-explanatory. (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 7/27/24 at 5:15 PM with the ADON, she stated that in the fall protocol nurses went over the steps of what to do when there was a fall, what documentation, and who to notify when you can and cannot notify the physician. The documentation was the risk assessment of incident report, SBAR, fall assessment, pain assessment, and skin assessment. They were to make sure to notify the physician and RP if there was one and the DON for protocol because there was a change in condition. She stated she also does a progress note. It the fall was unwitnessed and with a head injury, nurses have to start neuros. When a resident falls, they go to the resident and let CNA's know not to touch them. They perform a full head to toe assessment, do range of motion, and check skin integrity for any tears bumps bruising. Then she would assess if they were in pain and if so, immediately address with PRN pain meds, and if none I get an order form the physician. Nurses do not have to contact the physician first if there was a 911 situation. She explained she would do what was best based off her nursing judgment. Emergencies would be any changes in head or skin, nonstop bleeding, headaches non-retractive, unstable vitals, changes in neurological conditions, and vomiting. If they contact the doctor and they have not responded after 15-20 minutes, she would contact the DON and the medical director by phone call to let them know what is going on. The fall quick notes are kept at the nurse's station and it outlined step by step what also needed to be done in care of a fall, including neuro checks done every 30 minutes. In an interview on 07/27/24 at 5:30 PM with the WCN, she stated she been here since 4/22/24, and worked Monday through Friday from 8AM- 6PM. She stated that in the fall protocol, they went over what the policies were if the fall was witnessed or unwitnessed, neuro checks, and what the procedures were. When a resident falls, she would do a head-to-toe assessment, vital signs, and contact the physician and notify the family. If the fall was unwitnessed, she would start her neuro checks. She stated that she would count the vitals she did initially as her first check and start from there. Assessments completed were the neuro assessment, pain assessment, progress note, SBAR, fall assessment, range of motion, and skin assessment. If the resident was nonverbal, we look for verbal cues. Nurses can call 911 if there was an emergency and they needed medical attention before contacting the doctor. These emergencies included bleeding, possible fracture, unresponsiveness, seizures, change in condition, headaches, injuries, or bleeding. If she could not reach the doctor, she would still have to notify the DON, ADON, and the medical director. The fall protocol quick sheets were kept at the nursing stations. If the form said RP on the neuro check sheet and the resident was their own RP, she would still contact the emergency contact because she wanted to let someone know what was going on. Day 2: Sunday July 28th, 2024 In an interview on 07/28/24 at 1:10 PM with LVN E, said she was in-serviced on fall protocol policy. She said a head-to-toe assessment, neuro checks, SBAR, fall assessment, pain assessment and skin assessment had to be completed for residents who had a witness or unwitnessed fall. She said vital signs and range of motion had to be completed and documented. She said a resident who was bleeding, took blood thinners, vital sign out of normal range, unconscious, broken bones would be sent out 911. She said she would make notifications to the RP, Administrator, DON, ADON and the physician. She said there was a cheat sheet located at the nurses' station for reference if needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675321	A. Building B. Wing	07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradigm at Faith Memorial	811 Garner Rd Pasadena, TX 77502

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 07/28/24 at 1:37 PM with LVN F said she was in-serviced on fall protocols. She said there was a binder at the nurse's station to refer to if needed. She said residents who had a change in condition, unresponsive, on blood thinners/had bleeding, fractures would be sent out 911. She said the Doctor, DON, ADON, Administrator and RP would be notified. She said a head-to-toe assessment would be completed along with SBAR, range of motion, pain, skin and fall assessments. She said neuro checks would be completed in various intervals indicated on the neuro check form. In an interview on 07/28/24 at 2:03 PM with LVN G said with a fall and a resident has a head injury he would do assessment head to toe, take vital signs, check range of motion and call the Doctor, DON, Administrator and family. He said he would document in the nursing notes along with neuros checks, pain, fall and skin assessment. If they hit their head, we send the resident out 911 if there was bleeding, on anticoagulants, unresponsive and change of condition that was not at the resident's baseline. He said we have a binder at the nursing station to refer to if needed on the steps to take after a fall. In an interview on 07/28/24 at 2:09 PM with LVN H said she had been in-serviced and was aware of the steps to follow after a witness or unwitnessed fall. She said a head-to-toe assessment would be completed with range of motion to detect any fractures. She said residents with fractures, bleeding, on anticoagulants, and unresponsive would be sent out by 911. She said residents who had a witness or unwitnessed fall, neuro checks, SBAR, fall assessment, pain assessment and skin assessment had to be completed. She said the DON, Administrator, Family and Doctor is notified. He said there was a quick guide at the nurses' station with all of the fall protocol steps. In an interview on 07/28/24 at 2:29 PM with LVN I said he was aware of the fall protocols. He said he would check a resident's vitals, range of motion and head to toe assessment for unwitnessed or witnessed falls. He said if a resident was not responsive, bleeding, on blood thinners, change in condition, or broken bones the resident would be sent out 911. He said after a resident had a fall, neuros, fall, pain, and skin assessments had to be completed. He said there was a reference guide at the nurses' station with the fall protocol. He said the steps taken after a fall had to be documented and notifications made to the doctor, family, DON and Administrator. In an interview on 07/28/24 at 2:48 PM with LVN J said after a fall all steps taken had to be documented. She said a quick guide for falls was located at the nurse's station. She said a SBAR, risk management, pain assessment, skin assessment, fall assessment, and neuros had to be completed. She said when there was a change in condition, bleeding, head injuries, unconscious or fractures a resident would be seen out 911. She said notifications should be made to the family, DON, ADON, Administrator and the physician. In an interview on 7/28/24 at 7:12 AM with LVN K said she was in serviced on the facility's fall policy. She said all actions taken after a fall had to be documented. She said a fall assessment, neuro checks, skin and pain assessments had to be completed. She said notifications to the physician, family and DON should be completed. She said the facility placed a quick guide at the nurses' stations to reference the steps after a fall. She said residents would be sent out 911 after a fall, if they had bleeding, unconscious, range of motion issues that indicated broken bones, and abnormal vitals. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of facility Education In-services on Quick Guide - Falls, Change in Condition Communication, Neurological Neuro Checks, Fall Management, Investigation of Falls, Fall Management Post Test dated 7/26/24-7/28/24 revealed all staff were trained on the Fall Management Policies and tested on knowledge of the policies. The Admin was informed the Immediate Jeopardy (IJ) was removed on 7/28/24 at 7:09 PM. While the IJ was removed, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their plan of removal.