STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355069	A. BUILDING _____ B. WING _____	C 08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	**620 14TH AVE NE DEVILS LAKE, ND 58301**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An on-site complaint survey was completed on August 8-9, 2018.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph	F 580		9/18/18

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

Electronically Signed | 09/10/2018

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F 580	Continued From page 1 (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, record review, review of facility policy, and staff interview, the facility failed to immediately notify the resident's physician and/or resident representative for 1 of 1 sampled resident (Resident #7) and 1 closed resident record (Resident #9) who experienced a fall with a major injury. Failure to promptly notify the physician and/or resident representative of a fall with major injury limited their ability to make informed decisions regarding medical care. Findings include: Information provided by the complainant indicated the resident representatives were not notified when a resident was injured secondary to a fall. Review of the facility policy titled "Falls-Resident" occurred on 08/09/18. This policy, revised July	F 580	F580-Notify of changes- 1. Resident #9 is no longer in the facility. Resident #7 family and Physician have all been notified. 2. All residents at risk for falls have the potential to be affected. 3. All nursing staff education was presented on 9/7/18 to change the frequency of neurochecks and vital signs after a fall according to the revised Falls policy and procedure (at the time of the fall, every 15 minutes for 1 hour, every 30 minutes for 1 hour, every 4 hours for 24 hours and every 8 hours for 24 hours). Education was also provided on recognition of change of condition related to falls and injury and timely notification of provider, family and nursing manager. All documentation of vital signs and neurochecks are documented in the EHR according to the revised Fall policy.	

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F 580	Continued From page 2 2017, stated, " . . . The physician/practitioner must be notified of a fall immediately if there appears to be any significant injury/change in condition. . . . Inform the resident's responsible party for all falls . . ." - Review of Resident #9's medical record occurred on August 8-9, 2018. The progress notes, dated 01/07/18, identified the following: * At 3:10 a.m., ". . . Resident fell self transferring to the bathroom . . . found in middle of room floor on his left side . . . resident has a large contusion to the left side of his forehead. . . . Ice applied to forehead, and skin tear . . . Physician . . . Fax prepared to notify. . . . Family . . . Am staff to update family in the am due to time of night. . . ." * At 4:57 a.m., ". . . Resident is complaining of a headache . . ." * At 7:30 a.m., ". . . resident was very confused and anxious. . . . could not speak what he needed or what was wrong. . . . but made sounds. . . . very unsteady and non compliant. . . . not able to follow commands correctly . . . not comfortable sitting or standing . . . ." * At 7:40 a.m., "Resident . . . continues to be very anxious and confused. . . ." * At 7:43 a.m., (4 hours and 33 minutes after Resident #9 was found on the floor) "[Family member] . . . called and updated on resident status and the fall. [Family member] did request that he be taken to the ER [emergency room]. . . ." * At 8:00 a.m., "Resident was taken to [ER] . . ." * At 9:29 a.m., "[Family member] called and stated that resident has a large subderal [sic]hematoma [collection of blood outside the	F 580	4. The DON or designee will be responsible for monitoring all neurochecks, vital signs and documentation of change in condition beginning 9/7/2018 , on all residents who have fallen as well as family and physician notification related to all falls. Audits will be conducted Daily for 4 weeks, 4X per week for 4 weeks, 2X per week for 2 months and randomly thereafter for accuracy and that implemented solutions are sustainable. Random audits will be completed for 6 months or as recommended by the QA Committee. Results will be immediately communicated to the Executive Director and if concerns are identified for immediate corrective action to be implemented. The DON or designee will present a report to the QA Committee at each scheduled meeting. 5. Date of substantial compliance September 18th 2018	

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F 580	Continued From page 3	F 580		

brain] and states that they will be keeping him at the hospital for comfort cares . . ."

There was no evidence in the medical record to indicate Resident #9's physician was notified of Resident #9's significant fall/injury prior to the resident's hospitalization.

During an interview on 08/09/18 at 11:15 a.m., two administrative staff members (#1 and #2) acknowledged facility staff failed to notify Resident #9's physician and resident representative of his fall with head injury, and agreed staff had ample opportunity to do so immediately after the fall as per facility policy and/or throughout the morning as he became more symptomatic.

- Review of Resident #7's medical record occurred on August 8-9, 2018

The progress notes identified the following:
* 05/29/18 at 6:40 p.m. ". . .Resident was heard calling out in pain and found lying on the floor . . . Resident complains of pain to left shoulder and withdraws left arm when touched. Facial grimacing and calling out occurs when arm is moved . . . Fax sent to [name of physician] at 7:30 p.m. . . . Family Notified: [persons name] (husband) . . ."
* 05/29/18 at 9:10 p.m. ". . . Resident is resting in bed. She continues to show signs of pain to left shoulder including withdrawing the left arm when touch [sic], grimacing, and crying out when arm is touched. . . "
* 05/30/18 at 1:20 a.m. ". . . Writer called to resident's room to assess her pain. . . . On assessment, the left arm and shoulder is warm . .

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F 580	Continued From page 4 . mild swelling of shoulder present; resident guards arm when touched . . . she grimaces and cries out when arm is abducted [move away from the midline of the body]. Provided resident with prn [as needed] Tylenol and will monitor pain . . ." * 05/30/18 at 6:16 a.m. ". . . Resident continues with pain to left shoulder, guarding. . . . shoulder is swollen. Will contact family and provider to update." * 05/30/18 at 6:18 a.m. "Faxed [name of physician] and updated regarding increased swelling to left shoulder." * 05/30/18 at 7:47 a.m. "Resident's husband arrived to facility this morning . . . He requests we make contact with [name of physician] office to obtain order for xray to left arm/shoulder." * 05/30/18 at 8:30 a.m. "[name of nurse practitioner] was here to see resident. She gave orders for resident to go to clinic for xray of the left shoulder. . ." * 05/30/18 at 9:30 a.m. "[name of resident] was taken up to clinic for xray per our facility van. . . ." * 05/30/18 at 11:38 a.m. "Call from [name of person at clinic] to notify of humeral head [top of the arm bone] fracture. . . ." During an interview on 08/09/18 at 11:15 a.m., an administrative staff member (#1) agreed the physician would not be notified by a fax sent to the clinic in the evening or night time hours, and both administrative staff members (#1 and #2) acknowledged the facility staff failed to notify Resident #7's physician immediately after a fall with symptoms of significant injury.	F 580		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F 658		9/18/18

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F 658	Continued From page 5 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, record review, review of professional reference, review of facility policy, and staff interview, the facility failed to provide care in accordance with professional standards for 1 of 7 sampled residents (Resident #3) with a fall with injury and 1 closed resident record (Resident #9) who experienced a fall with head injury. Failure of the facility staff to complete neurological exams per facility policy and complete a set of vital signs with each neurological assessment following a fall has the potential for a head injury and/or change in health condition to go undetected. Findings include: Information provided by the complainant indicated facility staff failed to assess/reassess a resident who sustained a head injury during a fall. Walters and Kluwar, "Lippincott's Nursing Procedures," 5th Edition, 2009, pages 66-67 stated, "Managing Falls . . . Provide first aid for minor injuries as needed. Monitor the patient's status for the next 24 hours. Even if the patient shows no signs of distress or has sustained only minor injuries, monitor vital signs every 15 minutes for 1 hour, then every 30 minutes for 1 hour, then every 1 hour for 2 hours, or until his condition stabilizes. Monitor neurological	F 658	F658- Services provided meet professional standards 1. Resident # 9 is no longer in the facility. Resident #3 was reassessed and is safe. Neurochecks, vital signs will be completed per protocol after an unwitnessed fall. Any falls resulting in a change in condition will be reported to family and physician as soon as possible and notification of the nurse/nurse manager to assure continuous care. 2. All resident that have an unwitnessed fall have the potential to be affected. 3. All nursing staff education was presented on 9/7/18 to change the frequency of neurochecks and vital signs after a fall according to the revised Falls policy and procedure (at the time of the fall, every 15 minutes for 1 hour, every 30 minutes for 1 hour, every 4 hours for 24 hours and every 8 hours for 24 hours). Education was also provided on recognition of change of condition related to falls and injury and timely notification of provider, family and nursing manager. All documentation of vital signs and neurochecks are documented in the EHR according to the revised Fall policy. 4. The DON or designee will be responsible for monitoring all neurochecks, vital signs and documentation of change in condition	

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F 658	Continued From page 6 assessments with vital signs . . ." Review of the facility policy titled "Falls-Resident" occurred on 08/09/18. This policy, revised July 2017, stated, " . . . Residents who have hit their head or had an unwitnessed fall will have neuro checks, including vital signs, done as follows: upon initial assessment, 2 hours post fall, then every 8 hours x 3. . . ." Review of the facility policy titled "Neurological Assessment" occurred on 08/09/18. This policy, revised May 2013, stated, ". . . A nurse will perform the neuro assessment . . . and . . . notify the practitioner of any noted changes. . . . Vital Signs are to be taken with each neuro check: blood pressure, pulse, respiratory rate, temperature. . . . " - Review of Resident #9's medical record occurred on August 8-9, 2018. A progress note, dated 12/31/17 at 7:30 p.m., stated, ". . . Resident was found on the floor in front of his recliner. . . . Resident did not put the foot rest of his recliner down and his chair was tipped over. . . ." The neuro check flow sheets were completed at the following times and identified the following: * 12/31/17 at 7:40 p.m., reflected vital signs taken at 10:11 p.m. * 12/31/17 at 10:11 p.m. * 01/01/18 at 12:50 a.m., also reflected vital signs taken at 10:11 p.m. * 01/01/18 at 9:39 a.m. * 01/01/18 at 4:42 p.m. The facility staff failed to complete neuro checks	F 658	beginning 9/07/2018. The software developer will be contacted to remove the auto-populate feature, until accomplished the DON or designee will audit the neuro checklists on all neuros to assure timing and vital accuracy. Audits on all residents who have fallen as well as family and physician notification related to all falls occurring Daily for 4 weeks, 4X weekly for 4 weeks, 2x per week for 2 months and random audits thereafter for timeliness, accuracy and that implemented solutions are sustainable. Audits will be continue as recommended by the QA Committee. Results will be immediately communicated to the Executive Director and if concerns are identified immediate corrective action will be implemented. The DON or designee will present a report to the QA Committee at each scheduled meeting. 5. Date of substantial compliance September 18th 2018	

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F 658	Continued From page 7	F 658		

and vital signs on 12/31/17 at 9:30 p.m., on 01/01/18 at 5:30 a.m., and 1:30 p.m. per policy. The staff used vital signs obtained at an earlier or later time on two of the neuro check flow sheets listed above.

A progress note, dated 01/07/18 at 3:10 a.m., stated, ". . . Resident fell self transferring to the bathroom . . . found in middle of room floor on his left side . . . resident has a large contusion to the left side of his forehead. . . . Ice applied to forehead, and skin tear . . ."

The neuro check flow sheets were completed at the following times and identified the following:
* 01/07/18 at 3:47 a.m. (37 minutes after the resident was found) vital signs taken.
* 01/07/18 at 5:38 a.m. (1 hour and 51 minutes later) indicated Resident #9 appeared confused. The facility staff failed to notify the physician of the change in Resident #9's status and failed to follow up with additional neuro assessments based on the resident's change of status.

- Review of Resident #3's medical record occurred on August 8-9, 2018.

A progress note, dated 06/12/18 at 4:38 a.m., stated, ". . . resident was found on floor in bathroom. Floor was wet . . ."

The neuro check flow sheets were completed at the following times and identified the following:
* 06/12/18 at 4:38 a.m.
* 06/12/18 at 5:04 a.m.
* 06/12/18 at 7:16 a.m. reflected vital signs taken at 5:05 a.m.
* 06/12/18 at 2:10 p.m.

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F 658	Continued From page 8 * 06/13/18 at 5:00 a.m. * 06/14/18 at 3:32 a.m. reflected vitals taken on 06/13/18 at 5:01 a.m. (one day prior) The facility staff failed to complete neuro checks and vital signs on 06/12/18 at 6:38 a..m., and 10:10 p.m., per policy. The staff used vital signs obtained at an earlier time on two of the neuro check flow sheets listed above. A progress note, dated 06/22/18 at 4:35 a.m., stated, ". . . found resident on the floor. . . ." The neuro check flow sheets were completed at the following times and identified the following* * 06/22/18 at 4:35 a.m., reflected vital signs were from 06/13/18 at 5:01 a.m. (nine days prior) * 06/22/18 at 6:50 a.m., reflected vital signs: B/P (blood pressure) taken 06/22/18 at 3:51 p.m. * 06/22/18 at 2:51 p.m., reflected vital signs: B/P (blood pressure) taken 06/22/18 at 3:51 p.m. and P, T, and R, taken on 06/22/18 at 6:51 a.m. The facility staff failed to complete neuro checks and vital signs at 10:51 p.m., and on 06/23/18 at 6:51 a.m., per policy. The staff used vital signs obtained at an earlier or later time on three of the neuro check flow sheets listed above. A progress note, dated 07/04/18 at 3:15 a.m., stated, ". . . found resident sitting on floor with back up against bed and leaning on right elbow. . . ." The neuro check flow sheets were completed at the following times and identified the following: * 07/04/18 at 3:39 a.m., reflected vital signs taken on 06/30/18 at 12:21 p.m. * 07/04/18 at 4:40 a.m., reflected vital signs taken on 06/30/18 at 12:21 p.m.	F 658		

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F 658	Continued From page 9 * 07/04/18 at 12:24 p.m. * 07/05/18 at 1:19 a.m. The facility staff failed to complete neuro checks and vital signs at 5:15 a.m., 1:15 p.m. and 9:15 p.m., per policy. The staff used vital signs obtained from four days prior on two of the neuro check flow sheets listed above. During an interview on 08/09/18 at 11:15 a.m., two administrative staff members (#1 and #2) acknowledged facility staff failed to complete a set of vital signs with each neuro check and did not follow facility policy regarding the frequency on neurological assessments following the incidents that occurred with Resident #3 and #9.	F 658		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, record review, review of professional reference, review of facility policy, and staff interview, the facility failed to provide the necessary care and services to promote optimal well-being for 1 of 1 sampled resident (Resident #7) and 1 closed record resident (Resident #9) who experienced a fall resulting in a major injury. Failure to assess and provide	F 684	F684 Quality of Care 1. Resident # 9 is no longer in the facility. Resident # 7 is safe and no longer has pain from shoulder fracture. Family and physician were informed of change in condition. Any falls resulting in a change in condition will be reported to family and physician as soon as possible and notification of the nurse/nurse	9/18/18

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F 684	Continued From page 10 prompt treatment as changes occurred following a fall resulted in Resident #7 experiencing over 13 hours of significant pain related to her untreated arm fracture and may have contributed to Resident #9's death. Findings include: Information provided by the complainant indicated facility staff failed to assess, identify, and respond to changes in the mental status of a resident who sustained a head injury during a fall. Walters and Kluwar, "Lippincott's Nursing Procedures," 5th Edition, 2009, pages 66-67 stated, "Managing Falls . . . Provide first aid for minor injuries as needed. Monitor the patient's status for the next 24 hours. Even if the patient shows no signs of distress or has sustained only minor injuries, monitor vital signs every 15 minutes for 1 hour, then every 30 minutes for 1 hour, then every 1 hour for 2 hours, or until his condition stabilizes. Monitor neurological assessments with vital signs . . ." Review of the facility policy titled "Falls-Resident" occurred on 08/09/18. This policy, revised July 2017, stated, " . . . The two most critical problems to watch for are fractures and head injuries (especially if it was an unwitnessed fall to the floor). . . . Residents who have hit their head or had an unwitnessed fall will have neuro checks, including vital signs, done as follows: upon initial assessment, 2 hours post fall, then every 8 hours x 3 . . . The physician/practitioner must be notified of a fall immediately if there appears to be any significant injury/change in condition. . . ."	F 684	manager to assure continuous care. 2. All resident that are a fall risk the potential to be affected and all residents assessed on admission and measure implemented and care plans updated. 3. All nursing staff education presented on 9/7/18 to change the frequency of neurochecks and vital signs after a fall according to the revised Falls policy and procedure (at the time of the fall, every 15 minutes for 1 hour, every 30 minutes for 1 hour, every 4 hours for 24 hours and every 8 hours for 24 hours). Education was also provided on recognition of change of condition related to falls and injury and timely notification of provider, family and nursing manager. All documentation of vital signs and neurochecks are documented in the EHR according to the revised Fall policy. 4. The DON or designee will be responsible for monitoring all neurochecks, vital signs and documentation of change in condition beginning 9/7/2018, on all residents who have fallen as well as family and physician notification related to all falls occurring Daily for 4 weeks, 4x per week for 4 weeks, 2x per week for 2 months and random thereafter to ensure timeliness, accuracy and that implemented solutions are sustainable. Random audits will continue as recommended by the QA Committee. Results will be immediately communicated to the Executive Director and if concerns are identified immediate corrective action will be implemented.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355069	A. BUILDING _____ B. WING _____	C 08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	**620 14TH AVE NE DEVILS LAKE, ND 58301**

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F 684	Continued From page 11 - Review of Resident #7's medical record occurred on August 8-9, 2018. Diagnoses included Alzheimer's disease and history of falls with fractures. The annual MDS, dated 05/10/18, identified severely impaired cognition and extensive assistance of two persons required for activities of daily living. Resident #7's current care plan identified, ". . . Actual falls related to cognitive and mobility deficit. . . she has a Hx [history] of fall with Fx [fracture] previous to admit . . . displays a decreased safety awareness. . . scores at high risk for fall with hx of falls in facility. The progress notes identified the following: * 05/29/18 at 6:40 p.m. ". . . Resident was heard calling out in pain and found lying on the floor in front of her wheelchair . . . Resident complains of pain to left shoulder and withdraws left arm when touched. Facial grimacing and calling out occurs when arm is moved . . ." * 05/29/18 at 9:10 p.m. ". . . 2 hour recheck s/p [status post] fall completed. Resident is resting in bed. She continues to show signs of pain to left shoulder including withdrawing the left arm when touch [sic], grimacing, and crying out when arm is touched. . . " * 05/30/18 at 1:20 a.m. (6 hours and 40 minutes after the fall) ". . . Writer called to resident's room to assess her pain. . . . On assessment, the left arm and shoulder is warm . . . mild swelling of shoulder present; resident guards arm when touched . . . she grimaces and cries out when arm is abducted [moved away from the midline of the body]. Provided resident with prn [as needed] Tylenol and will monitor pain . . ."	F 684	The DON or designee will present a report to the QA Committee at each scheduled meeting. 5. Date of substantial compliance September 18th 2018	

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F 684	Continued From page 12	F 684		

* 05/30/18 at 6:16 a.m. (11 hours a 36 minutes after the fall)". . . Resident continues with pain to left shoulder, guarding. . . . shoulder is swollen."
* 05/30/18 at 8:30 a.m. (13 hours and 50 minutes after the fall) "[name of nurse practitioner] was here to see resident. She gave orders for resident to go to clinic for xray of the left shoulder. . ."

Facility staff failed to recognize and respond appropriately to Resident #7's continued signs of unmanaged pain and increased swelling, and failed to notify her physician in a timely manner.

- Review of Resident #9's medical record occurred on August 8-9, 2018. The admission Minimum Data Set (MDS), dated 10/26/17, identified moderately impaired cognition.

Resident #9's most recent care plan identified, ". . . RISK FOR FALLS . . . Scores high risk for falls . . . Appropriate footwear with transfers, Bed at standard height . . . Wheel chair pedals with staff assisted locomotion. . . ."

A progress note, dated 01/07/18 at 3:10 a.m., identified, ". . . Resident fell self transferring to the bathroom . . . found in middle of room floor on his left side . . . resident has a large contusion to the left side of his forehead. . . . Ice applied to forehead, and skin tear 1 cm [centimeter] by 1 cm, cleansed to left outer wrist xeroform and border gauze applied. . . . Physician . . . Fax prepared to notify. . . . Family . . . Am staff to update family in the am due to time of night. . . ."

A neuro check flow sheet, dated 01/07/18 at 3:47 a.m. (37 minutes after the resident was found),

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F 684	Continued From page 13	F 684		

identified Resident #9 was alert, oriented, and following commands.

A progress note, dated 01/07/18 at 4:57 a.m. (1 hour and 47 minutes after the resident was found), identified, ". . . "OxyCODONE HCl [pain medication] . . . Resident is complaining of a headache . . ."

A neuro check flow sheet, dated 01/07/18 at 5:38 a.m. (2 hours and 28 minutes after the resident was found), described Resident #9 as "confused."

The progress notes, dated 01/07/18, identified the following:
* At 7:30 a.m. (4 hours 20 minutes after the resident was found), "CNA [certified nursing assistant] called writer to resident room and resident was very confused and anxious. He could not speak what he needed or what was wrong. Resident appears SOB [short of breath] and has taken 02 [oxygen] off, 02 placed and 02 was up to 92% 2L/nc [2 liters/nasal cannula]. Resident continued to not be able to speak but made sounds. CNA did request to put resident on the PAL [mechanical stand lift] due to confusion and that CNA had tried to stand resident and he was very unsteady and noncompliant. Writer did observe PAL transfer and resident was not able to follow commands correctly and did try to "walk" off the PAL lift. Resident was put into wheelchair. . . . Resident was not comfortable sitting or standing and very unsteady and very anxious."
* At 7:40 a.m., "Resident at NS [nurses' station] and continues to be very anxious and confused. 02 is at 93% 2L/nc. . . ."
* At 7:43 a.m., (4 hours and 33 minutes after

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F 684	Continued From page 14 Resident #9 was found on the floor) "[Family member] . . . called and updated on resident status and the fall. Daughter did request that he be taken to the ER [emergency room]. . . ." * At 8:00 a.m., "Resident was taken to [ER] per [facility] van and staff." * At 8:50 a.m., "[Physician] did call up here and was updated regarding ER transfer and fall." * At 9:29 a.m., "[Family member] called and stated that resident has a large subderal [sic] hematoma [collection of blood outside the brain] and states that they will be keeping him at the hospital for comfort cares . . ." Resident #9 died the following day. The certificate of death identified, ". . . IMMEDIATE CAUSE OF DEATH: Late complications of contusion to head as a consequence of subdural hematoma and subarachnoid hemorrhage . . ." Facility staff failed to reassess Resident #9 after he developed a headache and showed increased signs of confusion, and failed to notify his physician in a timely manner. During an interview on 08/09/18 at 11:15 a.m., two administrative staff members (#1 and #2) acknowledged facility staff failed to recognize/respond to changes/decline in health condition for Resident's #7 and #9 which limited the physician's ability to make informed decisions regarding medical care.	F 684		