STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING ______ B. WING ______	C 02/27/2023

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THE CARROLTON OF WILLIAMSTON	**119 GATLING STREET WILLIAMSTON, NC 27892**

(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 The surveyor entered the facility on 2/16/2023 to conduct a complaint investigation and exited on 2/17/2023. Additional information was obtained on 2/23/2023, 2/24/2023, and 2/27/2023. Therefore the exit date was changed to 2/27/2023. Event ID # KW3U11. The following intakes were investigated: NC00198247, NC00196870, and NC00197214. One of the eleven allegations resulted in deficiency.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State	F 609		3/7/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/01/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 609	Continued From page 1 Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to report to the state agency an injury of unknown origin and initiate an investigation into a right leg fracture for one (Resident #1) of one resident reviewed for injuries of unknown origin. Findings included: Resident #1 was admitted to the facility on 10/01/2022 and had cumulative diagnoses some of which included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness or inability to move one side of the body) affecting right non-dominate side, and cerebral infarction. Documentation on a health status note in the medical record of Resident #1 dated 1/29/2023 at 11:20 AM written by Nurse #6 stated, "Resident unresponsive during medication administration, Nurse alert, to find resident breathing heavily eyes rolling episode lasted 2 minutes. [Nurse Practitioner name] informed order send to ER (emergency room) for evaluation follow up for previous fall injury to head right side. Seizure activity. [Resident representative] informed [name]." Nurse #6 was interviewed on 2/17/2023 at 9:45 AM. Nurse #6 revealed that on 1/29/2023 Resident #1 did take his medications at around 9:00 AM but he did not seem like himself. Nurse #6 stated she checked on Resident #1 again on 1/29/2023 at around 11:00 AM and his eyes were rolled back in his head, shaking, and not responding to questions. Nurse #1 stated she	F 609	WHAT WE DID FOR RESIDENT INVOLVED: Resident #1 was seen in Orthopedic office on 1-31-23 and placed in leg brace. Pain management of Oxycodone 5mg every 6 hours as needed was ordered. CP was updated to include use of a bariatric bed, upper side rails to the bed to assist in bed mobility and the use of two-person assistance with ADL care. 24-hour report was sent to the State agency on 2-27-23 OTHERS THAT HAVE THE POTENTIAL TO BE AFFECTED All other residents in the facility have the potential to be affected by the alleged deficient practice. All X-ray reports obtained for the last 60 days will be reviewed by the DON/Designee by 3/6/2023 to evaluate for potential injury of unknown origin. A 100% skin check will be conducted by the nursing leadership by 3/6/2023 to evaluate for any bruising, swelling, scratches or skin injury that may signify an injury of unknown origin. Any noted area of concern will be reported to the State as per regulation and an investigation will be initiated. The Regional Staff Development Director reviewed the past 3 month of Reportable incidents that the facility sent to the state for timeliness of reporting. SYSTEMIC CHANGES:	

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Continued From page 2

contacted the Nurse Practitioner, and an order was received to send Resident #1 to the ER. Nurse #1 revealed Resident #1 was returned to the facility from the emergency department on 1/29/2023 with his left foot wrapped and a diagnosis of fractures of the left tibia and fibula. Nurse #1 also revealed that at that time it was noted Resident #1 had a swollen right leg.

The Assistant Director of Nursing (ADON) was interviewed on 2/17/2023 at 11:44 AM. The ADON explained that along with Nurse #6 she was helping to assess Resident #1 when he returned from the hospital on 1/29/2023. The ADON further explained that the hospital had only x-rayed the left leg of Resident #1 and had not x-rayed the right leg. The ADON confirmed the right leg appeared swollen and was painful to the touch when Resident #1 was removed from the gurney onto his bed. The ADON explained that a mobile x-ray was called to the facility to take x-rays of the right leg. The ADON stated the mobile x-rays showed that Resident #1 had a fracture of the right leg and Resident #1 was subsequently sent back to the hospital for evaluation. The ADON stated Resident #1 returned to the facility with a splint on his upper right leg at the knee. The ADON explained an orthopedic appointment was made the following day for Resident #1.

Documentation on a mobile imaging report dated 1/30/2023 revealed in the findings Resident #1 had an "old fracture of the proximal fibula (calf bone near knee). There is a fracture of the distal tibia (shin bone) with minimal healing."

Documentation on an Orthopedic consultation dated 1/31/2023 revealed Resident #1 was

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The Regional Staff Development Director provided education to the Administrator, DON and ADON on 3-1-23 about what should be reported to the state agency and timeframes involved in reporting what types of abuse. The DON/designee educated 100% of facility staff, to include agency employees on the components of abuse and neglect and reporting requirements through 3/06/23. No staff will be allowed to work with residents prior to the education being provided. The facility will ensure all new hires have abuse training on hire, annually and as needed for allegations or incidents.

MONITORING:
The facility nurses will conduct weekly skin audits of all residents in the facility x 4 weeks (3/6/23 through 4/14/23) for any new areas that may constitute an injury of unknown origin. If any identified areas of concern result from the audits the staff will initiate reportable to the State agency per regulation, the Chief Clinical officer and the corporate consultant will be notified. All internal incident reports and grievances will be reviewed daily by the DON/designee x 4 weeks (through 4/14/23) to evaluate for facility need to report alleged abuse, injury of unknown origin, neglect or misappropriation of property. If any identified areas of concern result from the audits the staff will initiate reportable to the State agency per regulation, the Chief Clinical officer and the corporate consultant will be notified.

MONITORING/SUSTAIN COMPLIANCE

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F 609	Continued From page 3 experiencing pain in both legs after a fall at the facility and had a healing displaced tibia/fibula fracture shaft fracture on the right side estimated to be 6 to 8 weeks old. Resident #1 was to be kept in a knee immobilizer on the right side. The documentation noted Resident #1 did not recall another injury to his legs. An interview was conducted with the facility Administrator on 2/24/2023 at 1:45 PM. The facility Administrator confirmed Resident #1 was residing in the facility 6 to 8 weeks ago when the fracture of right leg was estimated to have occurred. The Administrator stated the facility had not reported the injury of unknown origin to the state agency and had not yet started an investigation into the fractures sustained on the right leg of Resident #1. The Administrator explained that shortly after it was discovered Resident #1 had fractures in both legs he had another hospital admission that took him from the facility for 8 days and it was just a lot going on for this resident.	F 609	The results of the audit will be brought through the facilities monthly QAPI meeting monthly x 3 months (March, April and May) to evaluate the need for resolution or need for continued monitoring.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, physician assistant interview, and physician	F 689	WHAT WE DID FOR RESIDENT INVOLVED:	3/7/23

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F 689	Continued From page 4 interview the facility failed to provide care in a safe manner resulting in a hematoma and a left ankle fracture for one (Resident #1) of three residents reviewed for accidental falls. Findings included: Resident #1 had cumulative diagnoses some of which included epilepsy (seizure disorder), hemiplegia (paralysis of one side of the body) and hemiparesis (weakness or inability to move one side of the body) affecting right non-dominate side, and cerebral infarction. Resident #1 had a current physician's order initiated on 10/19/2022 for 500 milligrams of Keppra to be administered as one tablet two times a day for a seizure disorder. Documentation on the medication administration record revealed Resident #1 received the seizure medication as ordered for the month of January 2023. Documentation on a quarterly Minimum Data Set assessment dated 11/11/2022 revealed Resident #1 had severe cognitive impairment, was coded as requiring extensive assistance of one for bed mobility and total dependence on one for bathing. Resident #1 was also coded as having range of motion impairment on one side of upper and lower extremities with incontinence of both bowel and bladder. Documentation on the care plan dated 12/9/2022 had a focus area for a resident care guide. Some of the interventions listed were, "aide of 1 or 2 people" and "no side rails." Documentation in a late entry health status note written by Nurse #1 dated 1/25/2023 at 5:21 AM stated, "Staff was washing up resident, when she	F 689	Resident #1 was seen in Orthopedic office on 1-31-23 and placed in leg brace. Pain management of Oxycodone 5mg every 6 hours as needed was ordered. CP was updated to include use of a bariatric bed, upper side rails to the bed to assist in bed mobility and the use of two-person assistance with ADL care. OTHERS THAT HAVE THE POTENTIAL TO BE AFFECTED All other residents in the facility that have had a fall have the potential to be affected by the alleged deficient practice. All internal incident reports for falls in the last 30 days will be reviewed by the DON for any injury noted, if noted area of concern on the incident report the DON/designee will conduct a thorough skin check of the resident involved for any delayed injury noted. SYSTEMIC CHANGES: The DON/designee educated 100% of facility nursing staff, to include agency employees on Supervision to prevent accident/incidents to include notification of change in condition that may increase risk for accident/injury. Education will be provided through 3/6/23 and staff will not be permitted to work with residents until training is completed. Education was provided by the DON/designee to all nursing staff, to include agency employees on post fall/incident monitoring of residents for delayed injury and/or change in condition. Education will be provided through 3/6/23 and staff will not be permitted to work with	

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turned him over to change his bedding he fell on the floor. 911 was called and resident was taken to the hospital for evaluation. Family and [Medical Doctor] aware."

Nurse #1 was interviewed on 2/16/2023 at 12:39 PM. Nurse #1 described the following events and actions taken on 1/25/2023 when Resident #1 fell out the bed. Nurse #1 stated that at approximately 4:40 AM NA #1 came running down the hall calling her to come quick because Resident #1 fell out of the bed. Nurse #1 ran down the hall to the room of Resident #1 to find him on the floor next to the bed face down. Nurse #1 explained she asked Resident #1 if he was okay. Resident #1 was talking but was complaining of being in pain. Nurse #1 stated she immediately went to get more help and found two more nurses to assist her because Resident #1 was a large person and therefore a lot of help was needed. Nurse #1 explained that every time Resident #1 was touched he complained of pain and complained of leg pain. Nurse #1 did not think it was a good idea to move Resident #1 because of his complaints of pain. Nurse #1 asked one of the other nurses in the room to go call 911. Nurse #1 stated she tried to get the vital signs for Resident #1 but was only able to get his temperature because he was laying face down. Nurse #1 stated her concern was that Resident #1 might have broken something and more damage could have occurred if he was moved. Nurse #1 revealed that EMS (emergency medical services) arrived quickly and requested the use of a mechanical hydraulic lift pad and mechanical hydraulic lift to move Resident #1 to the stretcher. Nurse #1 revealed with the assistance of the facility nurses, the EMS staff were able to get Resident #1 on the stretcher to take him to the

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residents until training is completed.

MONITORING:
All internal incident reports for falls for the last 30 days will be reviewed by the DON for any injury noted, if noted area of concern on the incident report the DON/designee will conduct a thorough skin check of the resident involved for any delayed injury noted.
All incidents/accidents will be reviewed by the clinical leadership team daily during stand-up meetings for appropriate interventions and care plan updates. The residents that sustain incidents will be monitored, utilizing an audit tool, for three days post incident for the next 60 days to evaluate for any delayed injury related to the incident in question. Any noted areas of concern from the audits will be reported to the appropriate entities in a timely manner.

MONITORING/SUSTAIN COMPLIANCE
The results of the audit will be brought through the facilities monthly QAPI meeting monthly x 3 months (March, April and May) to evaluate the need for resolution or need for continued monitoring.

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hospital. Nurse #1 stated that as soon as Resident #1 was leaving with EMS, she called the on-call physician assistant and the responsible party for Resident #1.

Nurse Aide (NA) #1 was interviewed on 2/16/2023 at 1:34 PM. NA #1 explained the following events and actions taken on 1/25/2023 when Resident #1 fell out of bed. NA #1 revealed she was very familiar with Resident #1 and had bathed him on her own many times. NA #1 stated she was giving Resident #1 a bath, had completed the bath, and had started to change the sheets. NA #1 stated Resident #1 was positioned on his left side and he had his left hand hanging on to the head of the bed. NA #1 revealed she went to the foot of the bed to get the pad on correctly and fit the sheet around the mattress when Resident #1 rolled out of the bed onto the floor, and she could not catch him. NA #1 explained Resident #1 was a big man who, "just tipped over before I could get around the bed to catch him." NA #1 further explained Resident #1 tried to grab the nightstand next to his bed, but he just fell right on his face on the floor. NA #1 said she ran to get the nurse at the end of the hall. NA #1 explained she helped to clean up Resident #1 and stayed with him and the nurses until EMS arrived.

Documentation in an emergency department note dated 1/25/2023 revealed the emergency department performed a left knee x-ray, CT (computed Tomography) scan of the cervical spine, and a CT scan of the head of Resident #1. Degenerative changes were noted on the left knee x-ray, degenerative changes on the CT of the cervical spine, and old cerebral infarcts noted on the head CT scan. The discharge assessment in the emergency room stated, "Patient awake,

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alert and oriented x 3. No cognitive and/or functional deficits noted. Patient verbalized understanding of disposition instructions. Patient awake and alert."

Documentation in a health status note dated 1/25/2023 at 9:05 AM written by Nurse #2 stated, "Assessed resident upon return room from [hospital]. Resident appeared shaken from fall. Visibly shaken, shoulders vibrating. Placed on list for visit from provider today. denies pain at this time. bed in low position, call bell in reach."

Nurse #2 was interviewed on 2/16/2023 at 3:21 PM and revealed she was the unit manager. Nurse #2 stated she went to assess Resident #1 as soon as he came back from the hospital on 1/25/2023. Nurse #2 stated Resident #1 was not complaining of pain when he returned to the facility but appeared visibly shaken and trembling. Nurse #2 stated she made sure the physician saw Resident #1 after he returned from the hospital on 1/25/2023.

Documentation in a physician progress note dated 1/25/2023 stated in part under the plan portion of the note, "Reassured him that he "is not going to die." He checked out ok at the ER. Will order Ativan 0.5 mg (milligrams) [twice a day] for chronic anxiety and tremor ... ...Apparently, he fell hard and hit his head and was shaken from the fall."

Resident #1 had a physician's order initiated on 1/26/2023 for 0.5 milligrams of Ativan to be administered as one tablet by mouth two times a day for anxiety. Documentation on the Medication Administration Record for January 2023 revealed Resident #1 received Ativan as ordered beginning

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on 1/26/2023.

An interview was conducted with NA #5 on 2/17/2023 at 10:30 AM. NA #5 confirmed she was very familiar with Resident #1 working on the 7:00 AM to 3:00 PM shift on the hallway he resided. NA #5 confirmed she was assigned to care for Resident #1 on 1/27/2023 and 1/28/2023. NA #5 stated that in the days after his fall Resident #1 did not complain of acute pain to her and his legs were not swollen or appear injured. NA #5 stated after the fall on 1/25/2023, Resident #1 stopped feeding himself and he seemed, "out of it." NA #5 stated that at the time of the interview Resident #1 was doing a little better in that he was again able to feed himself, but he was not back 100% verbally.

Documentation on a health status note dated 1/29/2023 at 11:20 AM written by Nurse #6 stated, "Resident unresponsive during medication administration, Nurse alert, to find resident breathing heavily eyes rolling episode lasted 2 minutes. [Nurse Practitioner name] informed order send to ER (emergency room) for evaluation follow up for previous fall injury to head right side. Seizure activity. [Resident representative] informed [name]."

Documentation on an emergency room notes from the hospital dated 1/29/2023 revealed Resident #1 arrived in the emergency room at 11:44 AM. The documentation under the exam portion revealed Resident #1 was complaining of leg pain and assessed as having pain and swelling in his left lower leg, left ankle, left foot, with increased tenderness to internal rotation of the left lower leg. The exam portion also revealed Resident #1 was assessed as having right lower

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F 689	Continued From page 9 ankle and foot swelling and edema. X-rays of the pelvis, left tibia and fibula, left foot, and left ankle were taken in the emergency room. Resident #1 was discharged back to the facility on 1/29/2023 with a diagnosis of nondisplaced facture of lateral malleolus of left fibula (ankle fracture just above the ankle joint) and a fracture of lower end of left tibia (shin bone fracture near the ankle). Nurse #6 was interviewed on 2/17/2023 at 9:45 AM. Nurse #6 explained she was the nurse who was on the hallway assigned to care for Resident #1 when he returned from the hospital on 1/25/2023, working the 7:00 AM to 7:00 PM shift. Nurse #6 revealed Resident #1 was "not his normal self" in that he was quiet and shaking with nervousness. Nurse #6 stated Resident #1 did not complain of pain, but he had a "huge protruding lump on the right side of his head." Nurse #6 explained she performed an assessment of Resident #1 when he returned on 1/25/2023 from the ER and did not note any pain or swelling to his legs at that time. Nurse #6 stated she did not receive any reports from the nurse aides of any pain or swelling in the legs of Resident #1 in the days after the fall. Nurse #6 revealed that on 1/29/2023 Resident #1 did take his medications at around 9:00 AM but he did not seem like himself. Nurse #6 stated she checked on Resident #1 again on 1/29/2023 at around 11:00 AM and his eyes were rolled back in his head, shaking, and not responding to questions. Nurse #1 said she knew Resident #1 had a diagnosis of a seizure disorder and she had concern perhaps something was missed when he was sent to the hospital for assessment after the fall on 1/25/2023. Nurse #1 revealed Resident #1 had not had any seizure activity in the last few years since she had been coming to the facility as	F 689		

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an agency nurse. Nurse #1 stated she contacted the Nurse Practitioner, and an order was received to send Resident #1 to the ER. Nurse #1 revealed Resident #1 was returned to the facility from the emergency department on 1/29/2023 with his left foot wrapped and a diagnosis of fractures of the left tibia and fibula. Nurse #1 also revealed that at that time it was noted Resident #1 had a swollen right leg.

Documentation on an orthopedic consultation dated 1/31/2023 revealed Resident #1 had a fracture of the left lower tibia and fibula and a right sided tibia/fibula fracture of 6 to 8 weeks of age with minimal healing.

Documentation on a physician's progress note for Resident #1 dated 2/1/2023 stated, "He had a fall on 1/25/23 and went to ER. He had a hematoma on right forehead, no other findings noted, no changes made. He was then sent back to the ER on 1/29/23 due to "seizure like activity" and recent fall. He was [diagnosed] with left Tibia/Fibula fracture, splinted, and sent back to the facility for [follow up] with [Orthopedics]. Staff reported [right lower extremity] pain as well and hospital reported that they did not x-ray the right lower extremity. X-ray showed fracture and he was sent to ER on 1/30/23 and diagnosed with distal femur fracture (right) and put in knee immobilizer. He has oxycodone 5 [milligrams] [every] 6 hours [as needed] for pain."

An interview was conducted with the Director of Nursing (DON) on 2/16/2023 at 12:21 PM. After an investigation into the fall of Resident #1 a discussion was held in the morning meeting discussing the fall the next day (1/26/2023). The DON stated the facility ordered a bariatric bed for

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Resident #1 and put upper side rails on his bed so he could grab onto them during care. The DON also stated education materials were distributed to all the nursing staff on 1/26/2023 letting everyone know Resident #1 required 2 people for the provision of activities of daily living and repositioning as well as to let nursing administration know if a bed was too small or side rails were needed. The DON confirmed the care plan was updated at that time to reflect 2 people were needed for the provision of care for Resident #1 and the use of side rails for mobility.

An interview was conducted with the facility Administrator on 2/17/2023 at 11:30 AM who indicated the cause of the fall for Resident #1 was poor positioning of the resident during care. The Administrator elaborated and stated that although Resident #1 was a large man, the bed he was in prior to the fall was big enough for him and he did not need side rails. The Administrator reiterated that if Resident #1 had been positioned correctly he would not have fallen. The Administrator stated NA #1 was retrained in positioning of residents and a four-point plan was being initiated to make sure all staff are trained in positioning of residents to prevent further occurrence of this type of accident.

An interview was conducted with the facility physician assistant (PA #1) on 2/23/2023 at 2:40 PM. PA #1 stated on 1/25/2023 the hospital took a CT (computerized tomography) scan of the head of Resident #1 and reported to the facility there were no abnormalities such as a brain bleed. PA #1 further explained the stress of the fall and the fracture put Resident #1 at continued risk for break through seizure activity despite being on medication for seizures. PA #1 stated

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F 689	Continued From page 12 she was not sure if the seizure-like activity Resident #1 had was an actual seizure on 1/29/2023 because she was not there to witness it. PA #1 elaborated to say the hospital did not report to the facility on 1/29/2023 Resident #1 had a seizure and there was no treatment or medication changes made as a result of the seizure-like activity on 1/29/2023. An interview was conducted with the physician (MD #1) for Resident #1 on 2/27/2023 at 11:26 AM. MD #1 stated Resident #1 was on medication for seizures and he had not known him to have any seizure activity while he was a resident in the facility. MD #1 revealed he doubted Resident #1 had a seizure on 1/29/2023. MD #1 further revealed Resident #1 was a very debilitated resident who was hard to assess. MD #1 stated Resident #1 would have been in a postictal state for a period if he had a seizure and there was not enough of a description in the nursing notes to prove he had a seizure. (A postictal state is a period that begins when a seizure subsides and ends when a patient returns to baseline. It typically lasts between 5 and 30 minutes.)	F 689		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:	F 867		3/7/23

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§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

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F 867	Continued From page 14 §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e).	F 867		

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F 867	Continued From page 15 Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, and record review the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification survey completed 11/18/2022. This was for one repeat deficiency in the area of supervision to prevent accidents that was originally cited on 11/18/2022 during a recertification survey. The continued failure of the facility during two federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The findings included:	F 867	WHAT WE DID FOR RESIDENT INVOLVED: Facility held an Ad-HOC QAPI on 3-1-23 with the Regional Staff Development Director in attendance. OTHERS THAT HAVE THE POTENTIAL TO BE AFFECTED All residents have the potential to be affected by the alleged deficient practice. SYSTEMIC CHANGES: The Chief Clinical Officer/designee will review the last 6 months of facility QAPI meetings for signs of Program feedback,	

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F 867	Continued From page 16 This citation is cross referenced to: F689:During the complaint investigation completed 2/17/2023 the facility failed to provide care in a safe manner resulting in a hematoma and a left ankle fracture for one (Resident #1) of three residents reviewed for accidental falls. During the recertification survey completed 11/18/2022 the facility failed to provide a hazard free environment by leaving an electrical outlet uncovered with exposed wires for 1 of 6 residents reviewed for accidents. An interview was conducted with the Assistant Director of Nursing (ADON) on 2/17/2023 at 11:44 AM. The ADON stated that the facility did have a quality assurance process for reviewing falls in the facility and monitoring accidents. The ADON stated the facility did research into what happened, made sure interventions were in place, follow-up on interventions, and the resident was made into a focus resident so that staff can be kept updated. The facility Administrator was interviewed on 2/17/2023 at 11:30 AM. The facility Administrator stated that the facility recently had a Quality Assurance Performance Improvement meeting and all of the citations from the most recent recertification survey were discussed to include F689 supervision to prevent accidents. The Administrator revealed the monitoring tools for F689 were discussed but the most recent accident with Resident #1 was not documented as discussed.	F 867	data systems and monitoring per state regulation/guidelines. The Corporate Staff Development Director will provide education to the QAPI committee on the QAPI/QAA system on 3-1-23. The DON/designee will educate all staff through 3-6-23 on QAPI/QAA and what the performance improvement plans that the facility currently has in place. MONITORING: The Nursing consultant/corporate designee will review the monthly QAPI/QAA meeting minutes monthly x 4 months to ensure ongoing compliance with state regulations for an effective QAPI system. MONITORING/SUSTAIN COMPLIANCE The results of the audit will be brought through the facilities monthly QAPI meeting monthly x 3 months (March, April and May) to evaluate the need for resolution or need for continued monitoring.	