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	345049	A. BUILDING _____ B. WING _____	C 03/22/2023

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F 000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted from 3/21/23 through 3/22/23. Event ID# 5OZQ11. The following intakes were investigated: NC00199721, NC00194221, NC00197814 , NC00194508, NC00198307, NC00197392 , NC00199599 and NC00199185. 3 of the 23 complaint allegations resulted in deficiency. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity G. Non-noncompliance began on 2/25/23. The facility came back in compliance effective 3/17/23.	F 000		
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 observation, record review, and resident, staff, Nurse Practitioner and Medical Director interviews the facility failed to prevent a fall from bed during incontinence care. Nurse Aide #2 raised the bed to waist level to provide care and Resident #4 rolled off the bed to the floor after being turned on to her side. Resident #4 reported pain in her right thigh and denied hiting her head. Two days after the fall Resident #4 was sent to the hospital for evaluation due to tenderness on the right side of her head and	F 689	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/05/2023

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temporary amnesia. A Computed Tomography (CT) of the head (a noninvasive medical exam or procedure that uses specialized X-ray equipment to produce cross-sectional images) was completed and noted a small subdural hematoma (collection of blood outside the brain). No surgical intervention was required. This was for 1 of 3 residents reviewed for accidents (Resident #4).

The findings included:

Resident #4 was admitted to the facility on 6/25/15 with diagnoses that included epilepsy (a seizure disorder), hemiplegia affecting the left non dominant side, and glaucoma.

The quarterly Minimum Data Set (MDS) dated 12/19/22 indicated Resident #4's cognition was intact. She had no behaviors and no rejection of care. Resident #4 required extensive assistance with 1 staff for bed mobility and the extensive assistance of 1 staff for toileting. Resident #4 had impairment of range of motion on one side upper and lower extremity and was always incontinent of bladder and bowel. Resident #4 was coded as no falls since prior assessment.

Review of a physician's progress note dated 2/21/23 revealed Resident #4 had a critical hemoglobin at 6.8 on 2/10/23. She was admitted to the hospital for further workup due to chronic history of bleeding.

A care plan initiated 6/7/2015 and last reviewed 2/27/23 revealed a focus that Resident #4 was at risk for falls related to stroke with left hemiplegia (paralysis) and was non ambulatory. The interventions included cue Resident #4 for safety awareness.

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An incident report dated 2/25/23 and written by Nurse # 5 indicated Nurse #5 was called to Resident #4's room by Nurse Aide #2. Resident #4 was lying on her back on the floor. Resident #4 had fallen from the bed onto the floor. Resident #4 complained that the top of her thigh where the brief closed was hurting. She was assessed by Nurse #5 and assisted back to bed by 2 staff. The Nurse Practitioner (NP) and Responsible Party were notified and made aware of the incident. The NP instructed the nurse to continue neurological checks and monitor the resident.

An interview was conducted with Nurse Aide #2 on 3/21/23 at 3:36 PM. NA #2 stated she was completing her final care round for her shift on 2/25/23 and she went in to provide incontinence care to Resident #4. NA #2 explained she raised the bed to waist level and rolled the resident away from her on to the resident's left side. NA #2 stated Resident #4 only required one person to assist with turning to provide incontinence care. NA #2 stated she recalled an assist bar on the right side of the bed but none on the left. NA #2 stated Resident #4 was able to use the assist bar to help with turning but did not during this interaction. NA #2 stated when she reached towards the foot of the bed to retrieve a brief Resident #4 continued to roll on the floor. NA #2 stated she moved to the side of the bed where Resident #4 was laying and observed her crying a little. NA #2 stated Resident #4 complained of pain to her right groin but denied that her head hurt.

A nursing progress note dated 2/25/23 and written by Nurse #5 revealed Nurse Aide (NA) #2

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stated that as she rolled Resident #4 over to her left side and put brief under her, Resident #4 had a little more leeway in front of her, but she continued to roll off the bed. Resident #4 landed on her left side and rolled onto the floor on her back. NA #2 then made Nurse #5 aware of the situation. On visual assessment Resident #4 was on her back on the floor with her head pointing to the wall. She was not able to move all extremities due to decreased mobility. Nurse #5 manipulated the resident limbs. Resident #4 complained of pain in the right thigh in brief area. Resident #4 and NA #2 stated that the resident did not hit her head. Nurse #4 stated Resident #4 had a knot on the back of her head on the right side. Neurological assessments were initiated.

An interview was conducted with Nurse #5 on 3/21/23 at 4:05 PM. Nurse #5 stated she was assigned to Resident #4 on 2/25/23 when she sustained a fall. Nurse #5 stated she was notified by NA #2 that Resident #4 had rolled out the bed onto the floor. Nurse #5 stated Resident #4 was laying on the floor on her back with her head towards the wall when she entered the room. Nurse #5 stated she assessed Resident #4 and felt a knot on the back of her head. Nurse #5 stated she was unsure if the knot was new or had already been there. Nurse #5 stated Resident #4 denied hitting her head and denied any tenderness to area when touched. Nurse #5 stated Resident #4 was cognitively intact and able to make her needs known. Nurse #5 stated she initiated neurological checks and notified the Nurse Practitioner. Nurse #5 stated no new orders were received and she was instructed to continue neurological checks monitor Resident #4 and report any changes.

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A review of the neurological assessments (a test of the mental status, motor function, cranial nerves, pupillary responses, reflexes, and vital signs) dated 2/25/23 at 6:30 AM through the assessment completed on 2/26/23 at 8:36 PM indicated no concerns with Resident #4's condition.

Review of a nurse progress note dated 2/25/23 at 11:26 PM revealed Resident #4 was alert and responsive. Her neurological checks were within normal limits and there were no signs or symptoms of distress.

Review of a nurse progress note dated 2/26/23 at 10:12 PM revealed Resident #4 had no signs or symptoms of distress. Resident #4 denied any pain or discomfort and neurological checks were within normal limits.

Review of a nurse progress note dated 2/27/23 at 7:18 AM revealed Resident #4 had slept through the night without complaint of pain or discomfort after fall.

Review of a nurse progress note entered by Nurse #6 dated 2/27/23 at 3:15 PM revealed Resident #4 was alert and responsive status post fall. Resident continued as needed acetaminophen (a pain medication) for generalized pain with effective results.

An interview was conducted with Nurse #6 on 3/21/23 at 4:28 PM. Nurse #6 stated she was the nurse assigned to Resident #4 on 2/27/23. Nurse #6 stated Resident #4 was alert and oriented X 3 and did not complain of any pain during the time that she cared for her. The nurse stated Resident #4 was unable to recall the fall. During the

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interview Nurse #6 revealed Resident #4 was seen by the NP for follow-up after a fall. Nurse #6 further stated Resident #4 was sent to the hospital at her Resident Representative's request due to her concern that Resident #4 could not recall the fall.

A Nurse Practitioner visit note dated 2/27/23 revealed Resident #4 was seen for new complaint of weakness, tremors, and poor appetite. Resident #4 had a mechanical fall on 2/25/23. There was no visible injury, however Resident #4 was unable to recall that she had fallen. The note indicated Resident #4 was cognitively at her baseline status during the examination. The Responsible Party (RP) was notified by the nurse practitioner of her assessment, and the note stated that Resident #4 ' s temporary amnesia (memory loss) was highly likely from the recent fall. The nurse practitioner offered to send Resident #4 to the hospital to get a head CT to rule out any head injury. The RP indicated that she wanted a head CT and Resident #4 was sent out to the emergency department for further evaluation.

Review of a physician's order dated 2/27/23 revealed an order Xray right hip 2 view, left hip 2 view for complaint of pain.

Review of the Xray results dated 2/27/23 for right hip and left hip revealed there were no fractures (cracking or breaking of the bone).

An interview was conducted on 3/21/23 at 4:27 PM. The Nurse Practitioner (NP) stated she was notified by her on call team on 2/25/23 that Resident #4 had fallen and there were no changes in her neurological status. NP stated

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Resident #4 complained of a little tenderness on the right side of her head when she examined her on 2/27/23. The NP stated Resident #4 denied any nausea/vomiting and no complaint of a headache. The NP stated that she spoke with Resident #4 ' s RP about the temporary amnesia and she was very concerned. The NP stated she sent Resident #4 to the hospital for a CT scan, and she was admitted.

A nursing note entered by Nurse #6 dated 2/27/23 revealed an order was received to send Resident #4 to the emergency room for head CT post fall and RP was made aware.

The hospital discharge summary dated 3/3/23 indicated Resident #4 was seen in the emergency department on 2/27/23 after a fall on 2/25/23 and found to have a small subdural hematoma, acute on chronic anemia and acute kidney injury. The CT dated 2/27/23 revealed Resident #4 had an 8mm (millimeter) in width right subdural hematoma. Resident #4 was evaluated by neurology and no surgical interventions were recommended. A repeat brain CT conducted on 2/28/23 revealed no changes to the size of the right subdural collection. Resident #4 was to follow up with neurology as an outpatient for monitoring. The hospital records indicated Resident #4 remained in the hospital from 2/27/23 to 3/2/23 when she was discharged back to the facility. Resident #4 was alert, oriented and stable. There was no mention of tremors during Resident #4's hospital stay and her activity level was as tolerated.

A nursing progress note dated 3/2/23 revealed Resident #4 was readmitted to the facility following a hospital stay for a fall resulting in a

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subdural hematoma.

An observation of incontinence care was conducted on 3/21/23 at 10:42 AM with NA #4 that was caring for Resident #4. The NA turned Resident #4 towards her during the observation and Resident #4 was able to hold on to the assist bar to remain on her left side. The were no concerns with the observation.

During an interview with Resident #4 on 3/21/23 at 2:10 PM she revealed she could not remember the fall but denied she had any pain from the fall.

During an interview with the Medical Director on 3/21/23 at 4:15 PM revealed that he was made aware that Resident #4 had fallen from the bed and ended up with subdural hematoma. The Medical Director stated there was no real way to tell if the hematoma came from the fall or happened spontaneously with Resident #4's chronic history of bleeding. The Medical Director stated that Resident #4 was hemodynamically stable from a nursing point of view, and she was alert and oriented X 3 (alert to person, place and time) plus she had passed her neurological assessments. The Medical Director stated Resident #4 had no complaints or changes that would have prompted staff to send her out to the hospital prior to the NP's assessment.

During an interview with the Director of Nursing (DON) on 3/21/23 at 4:53 PM, she stated that she had been notified of Resident #4 ' s fall by text on 2/25/23. The DON stated the facility initiated neurological checks and monitored Resident #4 for changes in condition. The DON stated an x-ray was conducted of Resident #4's right and left hips on 2/27/23 due to her complaint of

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tenderness in the groin area. The DON stated the results of the hip x-rays were both negative. The DON stated Resident #4 was cognitively at her baseline when she saw her on the morning of 2/27/23.

An interview was conducted with the Administrator on 3/22/23 at 12:49 PM. The Administrator stated that upon learning of Resident #4's fall, an investigation was launched. The Administrator stated the root cause of Resident #4 ' s fall was the lack of an assist bar. The Administrator stated Therapy was involved and all residents that required assist bars were evaluated and assist bars were placed by maintenance. The Administrator stated she contacted Resident #4's responsible party about the results of the investigation and explained to her what additional steps would be followed. The Administrator stated she did not notice any tremors (shaking movements) during her interactions with Resident #4 on 2/26/23 and 2/27/23. The Administrator stated Resident #4 did not complain of any pain to her during her interactions on 2/26/23 and 2/27/23.

The facility provided the following corrective action plan with a completion date of 3/17/23.

1.On 2/27/23 Resident #4 was sent to the emergency room per family request. The interdisciplinary team (IDT) reviewed the fall and implemented the following post fall interventions: scoop mattress and therapy screen. The care plan was reviewed and updated.

2.All residents that required assist bars for bed mobility were identified to be at risk.

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On 3/13/21 a facility observation was conducted by the IDT to determine residents with assist bars on their bed. Any resident determined to have assist bars will be reviewed by IDT to establish appropriate necessity.

On 3/13/23, an audit was completed by Nursing Management to review side rail evaluations in Point Click Care to determine residents who were identified as needing assist bars to assist in mobility. These residents care plan/Kardex was reviewed to reflect use of assist bars/

3.On 3/11/23, education was initiated by the SDC with all Nursing Staff on turning and repositioning of residents to ensure when turning a resident on their side turn the resident towards yourself. Do not turn a resident away from you. Additionally, education was provided on ensuring the Kardex was reviewed

prior to performing care. The education will be included on new hire orientation for all newly hired nursing staff.

Effective 3/11/23, Therapy in collaboration with Nursing Management will ensure side rail evaluations are completed quarterly on those residents identified as requiring assist bars.

4. On 3/11/23, reviews were initiated by Clinical Leadership to perform observations during ADL care to assess bed mobility and turning/repositioning. Re-education will be provided for any identified concerns observed during the observation. Observations will be conducted with (5) Nurse Aides weekly for 8 weeks or until pattern of compliance is maintained.

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F 689	Continued From page 10 Effective 3/11/23, observations will be made by Administrator or designee of 5 residents with assist bars ensuring that assist bar is present, location of, and it is on the care plan. Effective 3/11/23, during clinical meeting, therapy will provide any therapy/nursing communication forms for any resident including new admissions) who have been evaluated for the need for assist bars. Any resident evaluated for the need for assist bars will have assist bars placed by maintenance, Care Plan and Kardex will be reviewed and updated by MDS nurse. Audit results will be reported to the QAPI Committee by the Administrator and Director of Nursing monthly for a minimum of 2 months or until a pattern of compliance is established. DON and Administrator is responsible for implementing acceptable plan of correction. The corrective action plan was verified through record review of the education logs, audit reports of the event reporting, audits of the care plan and Kardex, audits of the side rail screen and an observation of incontinent care for Resident #4. Based on the observations and record review the facility ' s compliance date of 3/17/23 was verified.	F 689		