STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 survey team entered the facility on 6/27/23 to conduct a complaint investigation through 6/30/23. The survey team reentered the facility on 7/5/23 to conduct a partial extended survey and investigate another complaint and exited remotely on 7/6/23. Therefore, the survey exit date was changed to 7/6/23. The following intakes were investigated NC 198871; NC 200846; NC 203562; NC 203984 NC 204071; and NC 204224. Six of twelve complaint allegations resulted in deficiency. Intakes NC 203562, NC 204071, and NC 204224 resulted in immediate jeopardy. Past-noncompliance was identified at: Past-noncompliance was identified at: CFR 483.10 at tag F580 at a scope and severity J CFR 483.25 at tag F684 at a scope and severity J CFR 483.25 at tag F689 at a scope and severity J The tags F684 and F689 constituted Substandard Quality of Care. Non-compliance for F689 began on 3/2/23 and the facility corrected the deficiency on 3/8/23. Non-compliance began for F580 and F684 on 5/21/23 and the facility came back in compliance effective 6/9/23. A partial extended survey was conducted.	F 000		
F 580 SS=J	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,	F 580		

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

Electronically Signed | 07/21/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

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F 580	Continued From page 1	F 580		

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 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

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F 580	Continued From page 2 §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 record review, staff interview, Physician Assistant interview, Physician interview, and hospice staff interview the facility failed to notify the physician of bruising to Resident #2's right hip and thigh that was identified on 5/21/23 by Nursing Assistant (NA) #1 and Nurse #3 two days following a fall (5/19/23). The bruising continued through 5/31/23 and was accompanied by swelling. On 5/31/23 the resident also showed signs of pain. On 5/31/23 the resident was admitted to the hospital with a comminuted and angulated hip fracture (a comminuted fracture is when the bone is broken into more than two pieces, and an angulated fracture is where the ends of the bone fragments are at an angle to each other) and significant bruising from the right hip to thigh hip fracture. This was for one (Resident # 2) of seven residents reviewed for physician notification following falls with injury. The findings included: Resident # 2 was admitted to the facility on 12/23/21. Resident # 2's significant change Minimum Data Set assessment, dated 3/7/23, coded the resident as moderately cognitively impaired. On 5/19/23 at 7:24 PM Nurse #1 noted the following in Resident # 2's record. The resident had been observed on the floor, was assessed	F 580	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 580	Continued From page 3	F 580		

for injuries with no apparent injuries found. Range of motion was performed on all extremities. A voice mail was left for the physician.

Nurse #1 was interviewed on 6/29/23 at 2:30 PM and reported the following. Resident #2 had been at the nursing station when she fell on 5/19/23. No one had seen the resident fall, and she was called to assess the resident and found no signs of injury. The resident was transferred to the bed after the fall by pivoting her, and the resident transferred without any problems. She removed her clothes and did not find any bruises or injury. Following the date of 5/19/23 no one had mentioned to her that Resident #2 had a bruise on the days on which she cared for her.

NA #1 was interviewed on 6/29/23 at 6:55 AM and reported the following. She had worked a double shift beginning on 5/20/23 on second shift and lasting until 5/21/23 at the end of third shift. The resident had no bruising during her check up until 6:00 AM. At that time, she saw a discolored, round reddish area on the right side of her leg. The resident did not complain of pain. She told Nurse #3.

On 6/27/23 at 3:00 PM the Administrator and Corporate Nurse Consultant were interviewed and reported Resident # 2's bruise was first observed on 5/21/23 and assessed by Nurse #3. The facility presented an investigative file for Resident # 2's bruise and fracture, which included staff member's statements.

Review of Nurse #3's statement, which was in the facility's investigative file, revealed on 5/21/23 the resident's NA (NA #1) had told him about the bruise. He assessed the bruise, found it to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

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F 580	Continued From page 4	F 580		

dark red on her right thigh, and larger than his hand.

Nurse #3 was interviewed on 6/27/23 at 4:50 PM and reported the following. It was close to the end of the shift when NA #1 reported a bruise on Resident #2's right thigh on 5/21/23. He assessed it, found it to be on the anterior part of her thigh and to be a large bruise. He thought it was related to her fall on 5/19/23. It was the first time he had seen it. Resident #2 was moving her legs and did not seem to be in pain. He took her vital signs to make sure it was not related to a bleeding problem and felt it should be something that should be monitored but did not tell the physician. The resident's vital signs were stable. The resident could not answer any questions related to the bruise.

The facility's investigational summary indicated the following information for 5/22/23:
- NA #6 observed a dark purple bruise to Resident's right hip during care and reported it to the nurse. He provided her incontinent care and transferred the resident via stand pivot. Resident #2 did now show signs of pain and her legs were straight.

NA #6 was interviewed on 6/28/23 at 1:53 PM and reported the following. The resident seemed to bear weight on 5/22/23 when he transferred her. NA #6 recalled he talked to a nurse about the bruise.

On 5/23/23 at 6:49 AM Nurse #2 noted in a nursing note that Resident #2 had a "bruise to right hip/thigh." There was no notation of further assessment or that the physician was updated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

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TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 580	Continued From page 5	F 580		

On 5/23/23 Resident #2 was seen by her physician who noted the following. "Patient noted to have a change in mental status. Patient is awake and alert and sitting up in wheelchair however appears glazed and withdrawn. Patient is less talkative and not reaching for things. She was unable to fully participate with OT [occupational therapy]. No acutes signs of pain to her arms and legs on passive range of motion." The physician further noted that she would order labs for the resident. The physician made no notation that she had been informed of a bruise to the resident's hip/thigh.

The facility's investigational summary indicated the following information for 5/24/23 and 5/26/23:
- 5/24/23: The resident was observed by the Physician Assistant (PA) at nursing station. Resident appeared lethargic and was leaning to the side. Resident was looking at PA but did not talk as she normally did.
- 5/24/23: NA #7 noted at 11:00 PM resident was observed in bed awake with bruising noted to her right hip. She was unable to remember the color but remembered it was significant. There were no signs of pain. The bruise was reported to a nurse.
- 5/26/23 indicated NA #6 observed bruise that was light purple with yellow on the front and darker purple towards the side. The bruise was similar in size as noted by NA on 5/22/23. Bruising again was reported to the nurse.

On 5/26/23 at 6:52 AM Nurse #2 made a notation that Resident # 2 had a "right thigh/hip bruise." There was no notation that the physician was updated.

On 5/27/23 an admission Hospice Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 580	Continued From page 6	F 580		

electronically signed an admission assessment for Resident #2 for a start of service date on 5/25/23. The hospice nurse noted the following. "Patient's right thigh, anterior and lateral are covered in black and blue bruises. The lateral portion of thigh/hip swelling about 1/3 the size of her left thigh. No interventions. No pain, anxiety or shortness of breath on exam." The hospice nurse noted the resident should be non-weight bearing on the hospice care plan.

The facility's investigational summary indicated the following information for 5/28/23, 5/29/23, and 5/30/23:
- 5/28/23: The NA noted a bruise on Resident #2's right thigh that was purple with yellowish colors. She did not report the bruise as she thought if most like came from a fall.
- 5/29/23: An NA indicated a bruise was noted on Resident #2's right leg from her hip to her knee. Her right leg was bent with her knee towards the left side of the bed. There were no complaints of pain.
- 5/30/23: At approximately 8:00 AM, NA #3 noted the resident's right leg was turned and bent with dark purple bruising from her hip to her thigh. NA #3 indicated he reported to the nurse who responded that the resident had fallen previously, and it probably took a while for the bruising to "come up". NA #3 slowly straightened Resident #2's leg and then proceeded to provide bathing, incontinent care, and dressing. He then transferred Resident #2 via stand pivot transfer. The resident was noted to favor the right leg and she was leaning more to the left. Once seated in the wheelchair, NA #3 noted her right leg did not seem as if it was turned like it was before. There were no signs or symptoms of pain.
- 5/30/23: At approximately 11:30 AM the Hospice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

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TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

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F 580	Continued From page 7	F 580		

NA took the resident to her room to lay her down. She positioned the chair next to the bed and then picked the resident up to move her to the bed. The Hospice NA indicated Resident #2 was able to bear some weight but stated she basically lifted the resident. The resident did not show any signs or symptoms of pain when transferred. Once in bed the Hospice NA noticed Resident #2's right leg was turned in and bent and her left leg was straight. She indicated she asked facility about Resident #2's leg and was informed by staff that she had fallen several days ago.

NA #3 was interviewed on 6/28/23 at 2:35 PM and reported the following. When he first cared for her on the morning of 5/30/23, her right leg seemed to be in an awkward position when compared to the left. He took precautions and straightened it. It did not seem to cause her pain. When he pivoted her to the wheelchair, she seemed to put more weight on her left leg than her right leg. After she was in the wheelchair, he noticed she was leaning forward and that was the first day he had noted her to do that. Later a hospice NA came and put her in bed. He had talked to the nurse on the hall about her leg being bent.

The Hospice NA was interviewed on 6/28/23 at 12:12 PM and reported the following. When she arrived, she found Resident #2 in her wheelchair, and she was leaning forward so that her head was facing downward. When she transferred Resident #2 on 5/30/23 she (the NA) did about 80% of the work. The resident did not bear all her weight. When she got Resident #2 back in bed, she noticed her leg was bent. It was bent so that "the knee was inward, and the bottom of her leg was outward." The bruise covered her hip and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 580	Continued From page 8	F 580		

most of her upper thigh. She did not tell the facility nurse or the Hospice Nurse because NA #3 already knew about it.

The facility's investigational summary indicated the following information for 5/31/23:
- At approximately 11:00 AM the NA reported to the hall nurse that Resident #2 had a change in condition. While providing care it was noted NA that Resident #2 had bruising to her right hip and thigh and signs of pain to right hip. The nurse assessed the resident. The nurse observed purple bruising to the right hip and right thigh. Bruising showed signs of fading. Resident #2 was noted with facial grimacing and furrowing of eyebrows indicating pain. This nurse noted internal rotation of right hip. The PA was in the facility and was notified by the nurse to assess the resident.
- The PA noted Resident #2 had progressive decline which included change in mental status, increased lethargy, and overall withdrawal. She was less engaged, not verbally responding to questions and had decreased oral intake. She was noted with moderate soft tissue swelling with significant bruising noted lateral aspect right thigh. The right leg was in an angulated position. Attempted to gently straighten leg and Resident #2 demonstrated discomfort by wincing. When questioned about pain there was no verbal response.

On 5/31/23 the Physician Assistant saw Resident #2 and noted the following. "Patient with significant swelling and bruising right hip history of fall on 5/19/23. She is wheelchair dependent, non-ambulatory patient seen lying in bed with right leg angulation highly suspicious for right hip fracture, stat x-ray of right hip was ordered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 580	Continued From page 9	F 580		

however due to time delay in obtaining imaging decision was made to transfer to (hospital) for further evaluation."

A review of hospital records for the date of 5/31/23 included a digital photograph of Resident # 2's hip and thigh which had become part of her hospital medical record. Review of the medical record photograph revealed the right hip was a yellowish color and the anterior thigh down to the knee was predominantly a dark purplish color. The hospital physician noted Resident # 2 had "significant bruising in multiple stages of healing and internal rotation of right hip." An x-ray was completed showing a comminuted and severely angulated fracture of the right hip. (A comminuted fracture is when the bone is broken into more than two pieces, and an angulated fracture is where the ends of the bone fragments are at an angle to each other). Hospice services were continued for the resident, and she did not undergo surgery.

According to the facility's schedules, following the time Resident #2's bruise had been found on 5/21/23, Nurse #2 had cared for Resident #2 on 5/21/23, 5/22/23. 5/23/23, 5/24/23, 5/25/23, 5/26/23, 5/27/23, 5/28/23, 5/29/23, and 5/30/23. Nurse #2 was interviewed on 6/28/23 at 6:44 AM and reported the following. She recalled another nurse telling her about the bruise and that the resident had fallen before it was found. She did not talk to the physician about the bruise because she thought a facility manager already knew about the bruise. She never saw that Resident #2's leg was deformed. The resident never appeared in pain when she cared for her, and her legs appeared symmetrical. When she had looked at the bruise, there was never any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 580	Continued From page 10	F 580		

indication the resident's leg was fractured.

According to the schedule sheets, Nurse #4 had cared for Resident #2 on 5/25/23, 5/26/23, 5/30/23, an 5/31/23. Nurse #4 was interviewed on 6/27/23 at 4:00 PM and again on 6/29/23 at 1:45 PM. Nurse #4 reported the following. The only way she knew about Resident #2's fall was because she had read the resident's record. When the NA told her on 5/30/23 she did not recall him saying anything about the resident's leg being bent. If he had done so, she would have told the Director of Nursing (DON) right away. It had also not been reported to her that Resident #2 was leaning in her wheelchair before they laid her back down on 5/30/23. She had been busy and not seen that herself. On 5/31/23 she was called into the room by a NA and Resident #2's hip looked like it was out of place. She immediately let the DON know and the Physician Assistant came in to look at her. It was validated with Nurse # 4that she had not spoken to the Physician or the Physician Assistant prior to 5/31/23 about the bruise or the leg being bent.

The Physician Assistant (PA) was interviewed on 6/28/23 at 1:20 PM and reported the following. She is at the facility every Wednesday and the physician is at the facility every Tuesday and Friday. She had not been told of a bruise before 5/31/23. When she had been in the facility on the previous Wednesday (5/24/23, Resident # 2 just looked tired. The physician had seen her the previous day on 5/23/23 and they thought something metabolic might be occurring. Labs had been ordered. She was declining and placed on hospice that week. On Wednesday (5/31/23) she was in route to the facility when she received a call that her hip looked awkward. She ordered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 580	Continued From page 11	F 580		

an x-ray while in route. When she arrived, she assessed Resident # 2 and found that while at rest, Resident # 2 appeared comfortable. With range of motion, she winced. The hip appeared angulated. The exact time the x-ray was to be completed could not be estimated, and therefore she talked to hospice and the decision to send her to the hospital was made. She knew Resident # 2 had fallen on 5/19/23 and no injury had been identified on that date, but felt something might have happened on 5/19/23 that progressed with time.

Resident # 2's physician was interviewed on 6/29/23 at 4:00 PM and reported the following. On Tuesday (5/23/23) she had seen Resident # 2 because therapy had said she was not acting like herself. The resident was very out of it and was not reaching for things. She saw her at the nursing station. She was able to move her wheelchair. She (the physician) was aware Resident # 2 had fallen and checked her range of motion. The resident did not wince with range of motion. She had not been told anything about a bruise. If she had been notified of this, then she would have taken Resident # 2 back to her room, laid her down, and examined the bruise. On 5/23/23 Resident # 2 was not hospice yet, and she probably would have ordered an x-ray on that day also. Since she was not acting herself, she decided to order labs. Later, the resident became hospice because she had a long history of progressively declining. On 5/26/23 she did not see Resident # 2. The plan at that point was not to be aggressive with the resident's care. She had not been told anything about the bruise before 5/31/23. She had never known that hospice had recommended she be non-weight bearing. They did not get paperwork from hospice until after

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 580	Continued From page 12	F 580		

Resident # 2 was discharged from the facility.

On 6/30/23 at 1:30 PM the facility Administrator was informed of immediate jeopardy. The Administrator presented a corrective action plan.

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

Resident #2 is alert to self. A Brief Interview for Mental Status (BIMS) score could not be obtained due to cognition. Diagnoses include but not limited to Progressive Supranuclear Ophthalmoplegia (unable to move eyes at will in all directions), history of Cerebral Infarction (stroke) affecting right side, Glaucoma (increased pressure behind the eyes), Convulsions (seizures), aphasia (difficulty communicating), Dysphagia (difficulty swallowing), Major Depressive Disorder, Dementia with behaviors, Abnormalities of gait and mobility (difficulty walking), history of repeated falls, Nontraumatic subarachnoid hemorrhage (bleeding on the brain not caused by injury), polyneuropathy (muscle and nerve pain), ataxia, (impaired balance), Fibromyalgia (muscle pain), displaced simple history of fracture of bone between hip and knee, history of fracture of nasal bones, Age-related Osteoporosis (weakening of bones) and Osteopenia (softening of the bones), Adult Failure to Thrive. On 5/19/23 at 1:20 pm, staff observed the resident on the floor. The nurse assessed the resident for injuries, and the resident could move all extremities with no apparent pain. After the resident was transferred to the chair, the nurse completed a head-to-toe assessment with no bruising noted. The nurse attempted to notify the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 580	Continued From page 13	F 580		

on-call physician and left a voicemail. The nurse notified the resident representative of the fall. On 5/21/23 at 6:00 am, the Nursing Assistant (NA) observed a large bruise on the top inner thigh and notified the nurse. The nurse assessed the resident and noted a dark red bruise on the right thigh, larger than a hand. The physician was not notified of the newly identified bruise. On 5/23/23, the resident was seen by the physician for a change in mentation. The provider notes the resident was observed sitting up in a wheelchair by the nursing station with (1) No acute injuries noted from the fall on 5/19/23, (2) No signs of pain or discomfort, (3) No wincing on exam of arms, and legs (4) Resident manipulated wheelchair backward using both feet without complaints of pain (5) Cooperative, Frail, in no apparent distress, sitting up in a wheelchair, awake and alert, not speaking, appears withdrawn. A complete blood count (CBC), comprehensive metabolic panel (CMP), and urine/urine culture were ordered. On 5/25/23 the provider started an antibiotic for a possible urinary tract infection (UTI). On 5/25/23 at 6:33 pm, the resident was admitted to hospice services with a visit by the hospice nurse. From 5/21/23-5/30/23, multiple facility staff observed bruising to the resident's right thigh. Staff had not reported the bruising to the physician. However, the resident exhibited no complaints of pain or swelling during care nor stand and pivot transfers. On 5/31/23 at approximately 11:00 am, the NA reported to the hall nurse that the resident had bruising to the right hip and thigh and signs of pain to the right hip while providing care. The nurse assessed the resident and observed fading purple bruising to the right hip and thigh with internal rotation. The resident was noted with facial grimacing and furrowing of eyebrows indicating pain. The nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 580	Continued From page 14	F 580		

notified the provider. The provider assessed the resident and ordered a STAT (immediately) x-ray. On 5/31/23 at 2:45 pm, the resident was transferred to the hospital by emergency services due to the length of time to obtain an in-house x-ray. The resident was admitted to the hospital with a diagnosis of a right femur fracture. The Administrator initiated an investigation for injury of unknown origin to include notification of police, Adult Protective Services (APS), and state reporting per facility protocol.

-Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

On 5/31/23, the Unit Manager completed a 100% skin audit of residents to identify all residents with signs and symptoms of a fracture, new bruising, pain, and/or deformity of extremities. There were no additional concerns identified.
On 6/2/23, the administrative nurses including the Minimum Data Set Nurse (MDS), Director of Nursing, Staff Development Coordinator (SDC) and Unit Managers completed an audit of all residents to determine if the resident was experiencing a change in condition, with no additional concerns identified.
On 6/2/23, the administrative nurses including the Minimum Data Set Nurse (MDS), Director of Nursing, Staff Development Coordinator (SDC) and Unit Managers reviewed progress notes for the past 14 days to determine if a resident exhibited a change in condition, including signs/symptoms of a fracture, pain, or bruising, and ensure the practitioner was notified timely.
The Director of Nursing will address all areas of concern identified during the audit, including the physician's notification for further instruction. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 580	Continued From page 15	F 580		

audit was completed by 6/8/23.

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

On 6/2/23, An in-service was initiated by the administrative nurses to include the Minimum Data Set Nurse (MDS), Director of Nursing, Staff Development Coordinator (SDC), and Unit Managers with all nurses regarding (1) Notification of Changes with emphasis on (a) a prompt complete assessment of a resident's slight or subtle changes with physician notification will ensure adequate management of the resident's acute illness or exacerbation of a chronic illness. (b) notification of physician with any change in resident condition to include but not limited to new bruising, pain, and deformity of extremity after a fall with documentation in the electronic record (2) Signs and Symptoms of a Fracture with emphasis on signs and symptoms of a fracture to include but not limited bruising, swelling over a bone or pain, assessment of the resident, and immediate notification of the physician with documentation in the electronic record. In-services will be completed by 6/8/23. After 6/8/23, any nurse who has not worked or received the in-service will receive it prior to the next scheduled work shift. All newly hired nurses will be in-service during orientation regarding Notification of Changes, and Signs and Symptoms of a fracture.

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and

Monitoring actions began on 5/31/23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 580	Continued From page 16	F 580		

15 residents' charts, including charts of residents with recent falls, new or worsening bruising and residents receiving hospice services will be reviewed by the Unit Managers weekly x 4 weeks, then monthly x 1 month utilizing the Notification Audit Tool. This audit is to ensure the physician was notified of changes in condition and changes related to new bruising, pain, and deformity of extremities for further recommendations and to ensure the coordination of care with hospice services. The Unit Managers will address all areas of concern identified during the audit, including assessment of the resident, notification of the physician of changes, and staff re-training. The DON will review the Notification Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern are addressed.

The DON will present the findings of the Notification Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee, including but not limited to the Administrator, Director of Nursing, Maintenance Director, Dietary Manager, Activities Director, Social Worker, Therapy Director, and MDS Director and Medical Director monthly for 2 months. The QAPI Committee will meet monthly for 2 months to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.

Date of corrective action completion: 6/9/23

The facility's corrective action plan was validated by the following.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 580	Continued From page 17 On 6/27/23 and beginning at 9:05 AM a tour of all facility halls was made. Multiple residents were interviewed at this time. The residents did not report any medical problems that had not been brought to the physician's attention and addressed. Multiple residents, who had sustained falls, were placed on a sample. There was documentation the physician had been notified of any injuries related to falls sustained by other sampled residents. The facility presented documentation they had completed their audits and inservices as noted in their corrective action plan. Multiple staff members were interviewed during the survey dates and validated they had attending inservice training as outlined in the facility's corrective action plan. On 6/30/23 the facility's correction date of 6/9/23 was validated.	F 580		
F 684 SS=J	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:	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 684	Continued From page 18 Based on record review, staff interview, Physician Assistant interview, Physician interview, and hospice staff interviews the facility failed to communicate effectively to ensure comprehensive assessment and care were provided to address bruising to Resident #2's right hip and thigh that was first identified on 5/21/23 by Nursing Assistant (NA) #1 and Nurse #3 two days following a fall (5/19/23). The facility continued to transfer the resident via stand pivot method with weight being placed on the right leg and on 5/30/23 NA #3 noted the resident's right leg was in an awkward position and he straightened it. The resident was admitted to the hospital on 5/31/23 with a comminuted and angulated hip fracture (a comminuted fracture is when the bone is broken into more than two pieces, and an angulated fracture is where the ends of the bone fragments are at an angle to each other) and significant bruising from the right hip to thigh. This was for one (Resident # 2) of seven residents reviewed for care following falls and injuries. The findings included: Resident #2 was admitted to the facility on 12/23/21. The resident's diagnoses, in part, included supranuclear palsy (a progressive neurogenerative disease), stroke, polyneuropathy, dementia, aphasia (the loss of ability to comprehend and express speech due to brain damage), and ataxia (poor muscle control causing problems with balance and walking). Resident #2's significant change Minimum Data Set assessment, dated 3/7/23, coded the resident as moderately cognitively impaired and as needing extensive assistance with transfers and hygiene needs. She was not assessed to be ambulatory. The resident also was assessed to	F 684	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 684	Continued From page 19	F 684		

have a history of falls with major injury on the assessment. The resident was not on an anticoagulant.

Resident #2's care plan, updated on 5/19/23, noted the resident had a history of falls with fracture. The care plan included multiple interventions which included but were not limited to keeping a fall mat by the resident's bed and encouraging her to be out of her room.

On 5/19/23 at 7:24 PM Nurse #1 noted the following in Resident #2's record within a nursing note. The resident had been observed on the floor, was assessed for injuries with no apparent injuries found. Range of motion was performed on all extremities. A voice mail was left for the physician.

Review of Nurse #1's statement, which was in the facility's investigative file, indicated she assessed Resident #2 following the 5/19/23 fall and the resident was able to move all her extremities without pain. She had removed the resident's clothes, examined her skin, and found no bruising on 5/19/23.

Nurse #1 was interviewed on 6/29/23 at 2:30 PM and reported the following. Resident #2 had been at the nursing station when she fell on 5/19/23. No one had seen the resident fall, and she was called to assess the resident and found no signs of injury. The resident was transferred to the bed after the fall by pivoting her, and the resident transferred without any problems. She removed her clothes and did not find any bruises or injury. Following the date of 5/19/23 no one had mentioned to her that Resident #2 had a bruise on the days on which she cared for her.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 684	Continued From page 20	F 684		

During an interview on 6/27/23 at 3:00 PM the Administrator and Corporate Nurse Consultant were interviewed and reported there was an investigative file for Resident #2 related to a bruise which was first observed on 5/21/23 and assessed by Nurse #3. The facility presented an investigative file which included staff member's statements.

NA #1 was interviewed on 6/29/23 at 6:55 AM and reported the following. She had worked a double shift beginning on 5/20/23 on second shift and lasting until 5/21/23 at the end of third shift. The resident had no bruising during her check up until 6:00 AM. At that time, she saw a discolored, round reddish area on the right side of her leg. The resident did not complain of pain. She told Nurse #3.

Review of Nurse #3's statement, which was in the facility's investigative file, revealed on 5/21/23 the resident's NA (NA #1) had told him about the bruise. He assessed the bruise, found it to be dark red on her right thigh, and larger than his hand.

Nurse #3 was interviewed on 6/27/23 at 4:50 PM and reported the following. It was close to the end of the shift when NA #1 reported a bruise on Resident #2's right thigh on 5/21/23. He assessed it, found it to be on the anterior part of her thigh and to be a large bruise. He thought it was related to her fall on 5/19/23. It was the first time he had seen it. Resident #2 was moving her legs and did not seem to be in pain. He took her vital signs to make sure it was not related to a bleeding problem and felt it should be something that should be monitored but did not tell the physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 684	Continued From page 21	F 684		

The resident's vital signs were stable. The resident could not answer any questions related to the bruise.

The facility's investigational summary indicated the following information for 5/22/23:
- NA #6 observed a dark purple bruise to Resident's right hip during care and reported it to the nurse. He provided her incontinent care and transferred the resident via stand pivot. Resident #2 did now show signs of pain and her legs were straight.

NA #6 was interviewed on 6/28/23 at 1:53 PM and reported the following. The resident seemed to bear weight on 5/22/23 when he transferred her. He did recall that he had talked to a nurse about the bruise.

According to the staffing schedule, NA #1 cared for Resident #2 again on 5/22/23 and 5/23/23. During the interview with NA # 1 on 6/29/23 at 6:55 AM NA # 1 reported during the times she cared for her, the resident liked to stretch out her leg and did not keep her leg in an awkward position. NA # 2 did not recall working with Resident # 2 following 5/23/23.

On 5/23/23 at 6:49 AM Nurse #2 noted in a nursing note that Resident #2 had a "bruise to right hip/thigh." There was no notation of further assessment or that the physician was updated.

On 5/23/23 Resident #2 was seen by her physician who noted the following. "Patient noted to have a change in mental status. Patient is awake and alert and sitting up in wheelchair however appears glazed and withdrawn. Patient is less talkative and not reaching for things. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 684	Continued From page 22	F 684		

was unable to fully participate with OT [occupational therapy]. No acutes signs of pain to her arms and legs on passive range of motion." The physician further noted that she would order labs for the resident.

The facility's investigational summary indicated the following information for 5/24/23:
- The resident was observed by the Physician Assistant (PA) at nursing station. Resident appeared lethargic and was leaning to the side. Resident was looking at PA but did not talk as she normally did.
- NA #7 noted at 11:00 PM resident was observed in bed awake with bruising noted to her right hip. She was unable to remember the color but remembered it was significant. There were no signs of pain. The bruise was reported to a nurse.

On 5/24/23 at 12:23 PM the Administrator made a notation in the progress notes that she had spoken to Resident #2's responsible party and he was interested in pursuing hospice services for Resident #2.

On 5/25/23 at 6:33 PM the Administrator made a notation in the record in the progress notes that Resident #2 had been admitted to hospice services for cerebrovascular disease.

On 5/26/23 at 6:52 AM Nurse #2 made a notation within a nursing note that Resident #2 had a "right thigh/hip bruise." There was no notation of further assessment or that the physician was updated.

The facility's investigational summary indicated the following information for 5/26/23. NA #6 observed bruise that was light purple with yellow

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 684	Continued From page 23	F 684		

on the front and darker purple towards the side. The bruise was similar in size as noted by NA on 5/22/23. Bruising again was reported to the nurse.

During an interview with NA #6 on 6/28/23 at 1:53 PM he indicated he cared for Resident #2 on 5/26/23 and on that day she had a fever, and he was concerned about the bruise as well. Therefore, he did not get her up on 5/26/23. Her leg was straight, and he took care to push a brief up under her rather than turning her completely from side to side.

The facility's investigational summary indicated the following information for 5/27/23 indicated NA #8 observed the bruise to Resident #2's right leg. Resident did not get out of the bed and was not eating like usual self. Resident #2's roommate informed NA # 8 that the resident had fallen. She indicated Resident #2's right leg seemed more bent and the left leg was straight. NA # 8 asked the resident if she was in pain and the resident did not respond. She indicated the resident did not move around in bed as usual. NA #8 had not reported the bruising or other changes due to being told the resident had fallen previously.

On 5/27/23 an admission Hospice Nurse electronically signed an admission assessment for Resident #2 for a start of service date on 5/25/23. The Hospice Nurse noted the following. The resident was "lethargic. Not oriented to person place, time, or situation. Aphasic. Makes eye contact at times but mostly stares into the distance. Right at the end of the visit she let out an audible, unintelligible sound." The Hospice Nurse further documented, "Patient's right thigh, anterior and lateral are coved in black and blue

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 684	Continued From page 24	F 684		

bruises. The lateral portion of thigh/hip swelling about 1/3 the size of her left thigh. No interventions. No pain, anxiety or shortness of breath on exam." The Hospice Nurse noted the resident should be non-weight bearing on the hospice care plan.

The Hospice Nurse, who had signed the admission hospice assessment on 5/27/23 was interviewed on 6/29/23 at 2:45 PM and reported the following. During her admission assessment, Resident #2 was in bed. Resident #2's right hip was swollen and 1/3 size larger than her left hip. She had a black and blue bruise which was on her hip, anterior thigh, and lateral thigh. She was not exhibiting pain or anxiety. She had reviewed the record and saw that Resident #2 had been seen by her facility physician with no further work up by the physician. She interpreted that to be that there was to be none since the resident was hospice. She had talked to Nurse #4 while in the facility.

The facility's investigational summary indicated the following information for 5/28/23, 5/29/23, and 5/30/23:
- 5/28/23: The NA noted a bruise on Resident #2's right thigh that was purple with yellowish colors. She did not report the bruise as she thought if most like came from a fall.
- 5/29/23: An NA indicated a bruise was noted on Resident #2's right leg from her hip to her knee. Her right leg was bent with her knee towards the left side of the bed. There were no complaints of pain.
- 5/30/23: At approximately 8:00 AM, NA #3 noted the resident's right leg was turned and bent with dark purple bruising from her hip to her thigh. NA #3 indicated he reported to the nurse who

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 684	Continued From page 25	F 684		

responded that the resident had fallen previously, and it probably took a while for the bruising to "come up". NA #3 slowly straightened Resident #2's leg and then proceeded to provide bathing, incontinent care, and dressing. He then transferred Resident #2 via stand pivot transfer. The resident was noted to favor the right leg and she was leaning more to the left. Once seated in the wheelchair, NA #3 noted her right leg did not seem as if it was turned like it was before. There were no signs or symptoms of pain.
- 5/30/23: At approximately 11:30 AM the Hospice NA took the resident to her room to lay her down. She positioned the chair next to the bed and then picked the resident up to move her to the bed. The Hospice NA indicated Resident #2 was able to bear some weight but stated she basically lifted the resident. The resident did not show any signs or symptoms of pain when transferred. Once in bed the Hospice NA noticed Resident #2's right leg was turned in and bent and her left leg was straight. She indicated she asked facility about Resident #2's leg and was informed by staff that she had fallen several days ago.

Review of the facility's investigative file revealed NA #3 had been assigned to care for Resident #2 on the 7:00 AM to 3:00 PM shift on 5/30/23. The following information appeared in NA #3's statement. When he was bathing and dressing the resident, her right leg was turned and bent. There was dark purple bruising from her hip to her thigh. He told Resident #2's nurse who in turn told him Resident #2 had fallen and it "probably took a while for the bruising to come up." He then slowly straightened Resident #2's leg and proceeded with care. When he transferred her to the chair, she seemed to be "favoring her right leg and leaning more to her left." He took her to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 684	Continued From page 26	F 684		

the nursing station to sit and later that morning noticed she was leaning forward in her wheelchair. The hospice NA came and placed her in the bed.

NA #3 was interviewed on 6/28/23 at 2:35 PM and reported the following. When he first cared for her on the morning of 5/30/23, her right leg seemed to be in an awkward position when compared to the left. He took precautions and straightened it. It did not seem to cause her pain. When he pivoted her to the wheelchair, she seemed to put more weight on her left leg than her right leg. After she was in the wheelchair, he noticed she was leaning forward and that was the first day he had noted her to do that. Later a hospice NA came and put her in bed. He had talked to the nurse on the hall about her leg being in an awkward position, and he felt sure the nurse had checked her.

Review of the facility's investigative file revealed a statement from the Hospice NA who had cared for Resident #2 on 5/30/23. The statement read, "On 5/30/23 I got to the facility around 10:30 AM. [Resident #2] was sitting at the nurse's station bent over with her eyes open. I asked [NA #2] about her care and whether she always leaned like that. She told me that [Resident #2] was a pivot transfer and that she did not always lean like that. The hospice nurse was also at the nurse's station at this time and did not say anything about her care. I asked if I should leave her there or lay her down. I took her to the room to lay her down. I positioned her chair next to the bed and then picked her up to move her to the bed. (Resident #2) was able to bear some weight, but I basically lifted her. [Resident #2] did not show any signs and symptoms of pain when I transferred her. I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 684	Continued From page 27	F 684		

then held her and lifted her legs into the bed while turning her. I noticed her right leg was turned in and bent and her left leg was straight. I went and got [NA#3] to help pull her up in bed. When we got her pants off, I saw a bruise on her right leg from her hip to her knee. I asked [NA # 3] about her leg and he told me that she had fallen several days ago.

The Hospice NA was interviewed on 6/28/23 at 12:12 PM and reported the following. When she arrived, she found Resident #2 in her wheelchair, and she was leaning forward so that her head was facing downward. When she transferred Resident #2 on 5/30/23 she (the NA) did about 80% of the work. The resident did not bear all her weight. When she got Resident #2 back in bed, she noticed her leg was bent. It was bent so that "the knee was inward, and the bottom of her leg was outward." The bruise covered her hip and most of her upper thigh. She did not tell the facility nurse or the Hospice Nurse because NA #3 already knew about it.

The facility's investigational summary indicated the following information for 5/31/23:
- At approximately 11:00 AM the NA reported to the hall nurse that Resident #2 had a change in condition. While providing care it was noted by NA that Resident #2 had bruising to her right hip and thigh and signs of pain to right hip. The nurse assessed the resident. The nurse observed purple bruising to the right hip and right thigh. Bruising showed signs of fading. Resident #2 was noted with facial grimacing and furrowing of eyebrows indicating pain. This nurse noted internal rotation of right hip. The PA was in the facility and was notified by the nurse to assess the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 684	Continued From page 28	F 684		

- The PA noted Resident #2 had progressive decline which included change in mental status, increased lethargy, and overall withdrawal. She was less engaged, not verbally responding to questions and had decreased oral intake. She was noted with moderate soft tissue swelling with significant bruising noted lateral aspect right thigh. The right leg was in an angulated position. Attempted to gently straighten leg and Resident #2 demonstrated discomfort by wincing. When questioned about pain there was no verbal response.

On 5/31/23 the Physician Assistant saw Resident #2 and noted the following. "Patient with significant swelling and bruising right hip history of fall on 5/19/23. She is wheelchair dependent, non-ambulatory patient seen lying in bed with right leg angulation highly suspicious for right hip fracture, stat x-ray of right hip was ordered however due to time delay in obtaining imaging decision was made to transfer to (hospital) for further evaluation."

The Physician Assistant (PA) was interviewed on 6/28/23 at 1:20 PM and reported the following. She was at the facility every Wednesday and the physician was at the facility every Tuesday and Friday. She had not been told of a bruise before 5/31/23. When she had been in the facility on the previous Wednesday (5/24/23), Resident #2 just looked tired. The physician had seen her the previous day on 5/23/23 and they thought something metabolic might be occurring. Labs had been ordered. She was declining and placed on hospice that week. On Wednesday (5/31/23) she was in route to the facility when she received a call that the resident's hip looked awkward. She ordered an x-ray while in route. When she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 684	Continued From page 29	F 684		

arrived, she assessed Resident #2 and found that while at rest, Resident #2 appeared comfortable. With range of motion, she winced. The hip appeared angulated. The exact time the x-ray was to be completed could not be estimated, and therefore she talked to hospice and the decision to send her to the hospital was made. She knew Resident #2 had fallen on 5/19/23 and no injury had been identified on that date, but felt something might have happened on 5/19/23 that progressed with time.

A review of hospital records for the date of 5/31/23 included a digital photograph of Resident #2's hip and thigh which had become part of her hospital medical record. Review of the medical record photograph revealed the right hip was a yellowish color and the anterior thigh down to the knee was predominantly a dark purplish color. The hospital physician noted Resident #2 had "significant bruising in multiple stages of healing and internal rotation of right hip." An x-ray was completed showing a comminuted and severely angulated fracture of the right hip. (A comminuted fracture is when the bone is broken into more than two pieces, and an angulated fracture is where the ends of the bone fragments are at an angle to each other). Hospice services were continued for the resident, and she did not undergo surgery.

According to the facility's schedules, following the time Resident #2's bruise had been found on 5/21/23, Nurse #2 had cared for Resident #2 on 5/21/23, 5/22/23. 5/23/23, 5/24/23, 5/25/23, 5/26/23, 5/27/23, 5/28/23, 5/29/23, and 5/30/23. Nurse #2 was interviewed on 6/28/23 at 6:44 AM and reported the following. She recalled another nurse telling her about the bruise and that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 684	Continued From page 30	F 684		

resident had fallen before it was found. She did not talk to the physician about the bruise because she thought a facility manager already knew about the bruise. She never saw that Resident #2's leg was deformed. The resident never appeared in pain when she cared for her, and her legs appeared symmetrical. When she had looked at the bruise, there was never any indication the resident's leg was fractured.

Review of Nurse #1's statement revealed the following. She worked with Resident #2 on 5/22/23, 5/28/23, and 5/29/23. Nurse #1 was interviewed on 6/29/23 at 2:30 PM and reported no one had mentioned to her that Resident #2 had a bruise on the days on which she cared for her (5/22/23, 5/28/23, 5/29/23).

According to schedule sheets, NA #2 had cared for Resident #2 on 5/20/23, 5/23/23, 5/25/23 and 5/29/23 on the 7:00 AM to 3:00 PM shift. NA #2 was interviewed on 6/28/23 at 10:45 AM and reported the following. She thought it was around the time she was assigned to care for Resident #2 on 5/23/23 that the resident had a big, dark, blue bruise. It covered most of the top of her thigh. She asked another NA about the bruise, and they told her Resident #2 had fallen. She did not talk to a nurse about it. Resident #2 moved her leg okay, and she could stand and pivot the same as she usually did. She did not seem to be in pain, and the bruise was the only thing that seemed different about her.

According to schedule sheets, Nurse #4 had cared for Resident #2 on 5/25/23, 5/26/23, 5/30/23, and 5/31/23. A review of the facility's investigative file revealed a statement from Nurse #4 which noted the following information. A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 684	Continued From page 31	F 684		

hospice nurse had not talked to her about Resident #2's bruise. She had never been told in report about a bruise or a fall. She had read in the resident's record about a fall. On 5/30/23 an NA told her Resident #2 had a bruise and she told him it was probably due to the fall. She did not assess the bruise that day. On 5/31/23 two NAs came to her and reported Resident #2's hip looked swollen and as if it was out of socket. She reported this to the physician and the Director of Nursing.

Nurse #4 was interviewed on 6/27/23 at 4:00 PM and again on 6/29/23 at 1:45 PM. Nurse #4 reported the following. The only way she knew about the fall was because she had read the resident's record. When the NA told her on 5/30/23 she did not recall him saying anything about the resident's leg being bent. If he had done so, she would have told the Director of Nursing (DON) right away. It had also not been reported to her that Resident #2 was leaning in her wheelchair before they laid her back down on 5/30/23. She had been busy and not seen that herself. On 5/31/23 she was called into the room by a NA and Resident #2's hip looked like it was out of place. She immediately let the DON know and the Physician Assistant came in to look at her. She did not seem to be in a lot of pain.

Interview with the Director of Nursing on 6/30/23 at 12:46 PM revealed none of her staff had reported Resident #2's bruise to her before the morning of 5/31/23.

Resident #2's physician was interviewed on 6/29/23 at 4:00 PM and reported the following. Typically, Resident #2 could transfer with assistance, but she was non-ambulatory. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 684	Continued From page 32	F 684		

had some unusual spontaneous movements due to her neurological disease, but her legs were normally straight. On Tuesday (5/23/23) she had seen Resident #2 because therapy had said she was not acting like herself. The resident was very out of it and was not reaching for things. She saw her at the nursing station. She was able to move her wheelchair. She (the physician) was aware Resident #2 had fallen and checked her range of motion. The resident did not wince with range of motion. She had not been told anything about a bruise. If she had been notified of this, then she would have taken Resident #2 back to her room, laid her down, and examined the bruise. On 5/23/23 Resident #2 was not hospice yet, and she probably would have ordered an x-ray on that day also. Since she was not acting herself, she decided to order labs. Later, the resident became hospice because she had a long history of progressively declining. On 5/26/23 (the Friday she was routinely in the facility) she did not see Resident #2. The plan at that point was not to be aggressive with the resident's care. She had not been told anything about the bruise before 5/31/23. She had never known that hospice had recommended she be non-weight bearing. They did not get paperwork from hospice until after Resident #2 was discharged from the facility.

Interview with the Administrator on 6/30/23 at 11:40 AM revealed the facility received nothing from hospice related to their concern about Resident #2's hip or the hospice nurse's admission assessment until after Resident #2 was discharged from them.

On 6/30/23 at 1:30 PM the facility Administrator was informed of immediate jeopardy. The Administrator presented a corrective action plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 684	Continued From page 33 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #2 is alert to self. A Brief Interview for Mental Status (BIMS) score could not be obtained due to cognition. Diagnoses include but not limited to Progressive Supranuclear Ophthalmoplegia (unable to move eyes at will in all directions), history of Cerebral Infarction (stroke) affecting right side, Glaucoma (increased pressure behind the eyes), Convulsions (seizures), aphasia (difficulty communicating), Dysphagia (difficulty swallowing), Major Depressive Disorder, Dementia with behaviors, Abnormalities of gait and mobility (difficulty walking), history of repeated falls, Nontraumatic subarachnoid hemorrhage (bleeding on the brain not caused by injury), polyneuropathy (muscle and nerve pain), ataxia, (impaired balance), Fibromyalgia (muscle pain), displaced simple history of fracture of bone between hip and knee, history of fracture of nasal bones, Age-related Osteoporosis (weakening of bones) and Osteopenia (softening of the bones), Adult Failure to Thrive. On 5/19/23 at 1:20 pm, staff observed the resident on the floor. The nurse assessed the resident for injuries, and the resident could move all extremities with no apparent pain. After the resident was transferred to the chair, the nurse completed a head-to-toe assessment with no bruising noted. The nurse attempted to notify the on-call physician and left a voicemail. The nurse notified the resident representative of the fall. On 5/21/23 at 6:00 am, the Nursing Assistant (NA) observed a large bruise on the top inner thigh and notified the nurse. The nurse assessed the resident and noted a dark red bruise on the right thigh, larger than a hand. The physician was not	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 684	Continued From page 34	F 684		

notified of the newly identified bruise. On 5/23/23, the resident was seen by the physician for a change in mentation. The provider notes the resident was observed sitting up in a wheelchair by the nursing station with (1) No acute injuries noted from the fall on 5/19/23, (2) No signs of pain or discomfort, (3) No wincing on exam of arms, and legs (4) Resident manipulated wheelchair backward using both feet without complaints of pain (5) Cooperative, Frail, in no apparent distress, sitting up in a wheelchair, awake and alert, not speaking, appears withdrawn. A complete blood count (CBC), comprehensive metabolic panel (CMP), and urine/urine culture were ordered. On 5/25/23 the provider started an antibiotic for a possible urinary tract infection (UTI). On 5/25/23 at 6:33 pm, the resident was admitted to hospice services with a visit by the hospice nurse. From 5/21/23-5/30/23, multiple facility staff observed bruising to the resident's right thigh. Staff had not reported the bruising to the physician. However, the resident exhibited no complaints of pain or swelling during care nor stand and pivot transfers. On 5/31/23 at approximately 11:00 am, the NA reported to the hall nurse that the resident had bruising to the right hip and thigh and signs of pain to the right hip while providing care. The nurse assessed the resident and observed fading purple bruising to the right hip and thigh with internal rotation. The resident was noted with facial grimacing and furrowing of eyebrows indicating pain. The nurse notified the provider. The provider assessed the resident and ordered a STAT (immediately) x-ray. On 5/31/23 at 2:45 pm, the resident was transferred to the hospital by emergency services due to the length of time to obtain an in-house x-ray. The resident was admitted to the hospital with a diagnosis of a right femur fracture. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 684	Continued From page 35	F 684		

Administrator initiated an investigation for injury of unknown origin to include notification of police, Adult Protective Services (APS), and state reporting per facility protocol.

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

On 5/31/23, the Unit Manager completed a 100% skin audit of residents to identify all residents with signs and symptoms of a fracture, new bruising, pain, and/or deformity of extremities. There were no additional concerns identified.
On 6/2/23, the administrative nurses including the Minimum Data Set Nurse (MDS), Director of Nursing, Staff Development Coordinator (SDC) and Unit Managers completed an audit of all residents to determine if the resident was experiencing a change in condition, with no additional concerns identified.
On 6/2/23, the administrative nurses including the Minimum Data Set Nurse (MDS), Director of Nursing, Staff Development Coordinator (SDC) and Unit Managers reviewed progress notes for the past 14 days to determine if a resident exhibited a change in condition, including signs/symptoms of a fracture, pain, or bruising, and ensure the practitioner was notified timely.
The Director of Nursing will address all areas of concern identified during the audit, including the physician's notification for further instruction. The audit was completed by 6/8/23.
On 6/6/23, the Administrator, Medical Director and Director of Nursing reviewed with the Hospice Director all residents currently receiving hospice services to identify any concerns or changes in condition that had not been previously addressed. No additional concerns were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 684	Continued From page 36	F 684		

identified.

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

On 6/6/23, the Administrator, Medical Director and Director of Nursing met with Hospice Director regarding communication and timely reporting of resident acute changes. Beginning 6/7/23, all Hospice personnel will exit with the Unit Manager, Director of Nursing and/or Administrator following each visit to the facility to provide an update for any concerns or resident changes in condition.

On 6/2/23, An in-service was initiated by the administrative nurses to include the Minimum Data Set Nurse (MDS), Director of Nursing, Staff Development Coordinator (SDC), and Unit Managers with all nurses regarding (1) Notification of Changes with emphasis on (a) a prompt complete assessment of a resident's slight or subtle changes with physician notification will ensure adequate management of the resident's acute illness or exacerbation of a chronic illness. (b) notification of physician with any change in resident condition to include but not limited to new bruising, pain, and deformity of extremity after a fall with documentation in the electronic record (2) Signs and Symptoms of a Fracture with emphasis on signs and symptoms of a fracture to include but not limited bruising, swelling over a bone or pain, assessment of the resident, and immediate notification of the physician with documentation in the electronic record. In-services will be completed by 6/8/23. After 6/8/23, any nurse who has not worked or received the in-service will receive it prior to the next scheduled work shift. All newly hired nurses

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 684	Continued From page 37	F 684		

will be in-service during orientation regarding Notification of Changes, and Signs and Symptoms of a fracture.

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and

Monitoring actions began on 5/31/23.

15 residents' charts, including charts of residents with recent falls, new or worsening bruising and residents receiving hospice services will be reviewed by the Unit Managers weekly x 4 weeks, then monthly x 1 month utilizing the Notification Audit Tool. This audit is to ensure the physician was notified of changes in condition and changes related to new bruising, pain, and deformity of extremities for further recommendations and to ensure the coordination of care with hospice services. The Unit Managers will address all areas of concern identified during the audit, including assessment of the resident, notification of the physician of changes, and staff re-training. The DON will review the Notification Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern are addressed.

The DON will present the findings of the Notification Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee, including but not limited to the Administrator, Director of Nursing, Maintenance Director, Dietary Manager, Activities Director, Social Worker, Therapy Director, and MDS Director and Medical Director monthly for 2 months. The QAPI Committee will meet monthly for 2 months to determine trends and/or issues that may need

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 684	Continued From page 38 further interventions put into place and to determine the need for further frequency of monitoring. Date of corrective action completion: 6/9/23 The facility's corrective action plan was validated by the following. On 6/27/23 beginning at 9:05 AM a tour was made on all halls of the facility. Multiple residents were interviewed, and reported they were pleased with care and services. There were no residents who complained of a lack of medical attention. The facility presented documented evidence they had completed inservice training and audits noted in their corrective action plan. This documentation was reviewed during the survey dates. During the survey dates from 6/27/23 to 6/30/23, multiple staff members were interviewed and reported they had received training as noted in the facility's corrective action plan. This included staff members from different shifts. The Administrator presented documentation that a meeting was held with the medical director and all hospice organizations which provided care at the facility to assure all hospice residents needs were being met. On 6/30/23 the facility's correction date of 6/9/23 was validated.	F 684		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 689	Continued From page 39 §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, review of manufacturer's instructions, and staff interviews, the facility failed to ensure securement was according to manufacturer's recommendations to provide a safe van transport. Resident #50 slid out of a reclined high back wheelchair into a seated position on the floor of the van with his legs extended in front of him and the seatbelt was above his head. Resident #50 alerted the transportation driver he had fallen. The transportation driver stopped the van in the center turning lane of a well-traveled road in the afternoon with the hazard lights on and lifted the Resident back into the high back wheelchair in a "bear hug" motion. The transportation driver proceeded to take Resident #50 to his appointment, failing to report the incident to the facility. Resident #50 was not assessed for injuries from the incident until later in the day; Resident #50 complained of a bruise to the right under arm, a left forearm bruise, and right ankle pain. This was for 1 of 11 residents reviewed for supervision to prevent accidents. This incident had the high likelihood of serious harm, injury or death. Findings included: Review of 4-point wheelchair securement	F 689	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 689	Continued From page 40	F 689		

system's use and care manual not dated found on the manufacture's website included the following information: ensure shoulder and lap belts are adjusted as firmly as possible, but consistent with user comfort.

Resident #50 was admitted to the facility on 2/3/23 with cumulative diagnoses that included stroke and peripheral vascular disease (PVD).

Review of physician orders revealed that 50 milligrams (mg) of Tramadol HCl powder every 6 hours as needed for pain was ordered on 2/3/23.

Review of physician orders revealed that 650 mg of Tylenol three times daily as needed for pain was ordered on 2/7/23.

Resident #50's admission Minimum Data Set (MDS) dated 2/7/23 indicated he was moderately cognitively impaired. Resident #50 required the assistance of two staff members with transfers and was unable to walk. He had a wheelchair for mobility.

Review of an incident report dated 3/2/23 and completed by the Unit Manager revealed that on 3/2/23 the transportation driver stated Resident #50 slid out of the wheelchair on the transportation van during transport to an outside appointment. The report indicated a complete body assessment was performed on Resident #50 with no injuries noted, and he was provided pain medicine.

A skin inspection dated 3/2/23 was reviewed and revealed Resident #50 included, in part, the following new skin conditions: a bruise to the right under arm, a left forearm bruise, and right ankle

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 689	Continued From page 41	F 689		

pain.

Nurse's progress note written by the Unit Manager dated 3/2/23 at 3:27 PM showed Resident #50 complained of right leg pain. The Medical Director (MD) was notified and ordered immediate x-rays. As needed pain medication was provided to Resident #50.

Review of Resident #50's Medication Administration Records (MAR) for March 2023 showed he received Tylenol 650 milligrams (mg) ordered for severe pain on 3/2/23 at 8:00 PM for a pain level of 3 on a 0-10 pain scale where 0 is no pain and 10 is the highest pain level. Resident #50 also received tramadol on 3/2/23 for a pain level of 2 on a 0-10 pain scale. On 3/3/23, Resident #50 received Tylenol at 8:00 AM for a pain level of 3 and received tramadol on 3/3/23 for a pain level of 4.

Nurse's progress note written by the Unit Manager dated 3/2/23 at 5:30 PM revealed the mobile x-ray company was contacted.

Nurse's progress note written by the Unit Manager dated 3/2/23 at 5:46 PM showed Resident #50 refused to go to the emergency room (ER) for evaluation.

An interview was conducted with the Unit Manager on 7/5/23 at 11:47 AM. She revealed Resident #50 went out for a scheduled appointment on 3/2/23, and when he returned to the facility, he told another staff member (name unknown) that he had slid out of his wheelchair in the van. The Unit Manager stated she then notified the Administrator and performed a skin assessment with no visible injuries. She notified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 689	Continued From page 42	F 689		

the MD as well who had requested for him to be sent to hospital, but he refused. Resident #50 denied any pain or discomfort and appeared nervous after the incident.

Physician order dated 3/2/23 showed x-rays were ordered for the left/right hips, left thigh, right/left knees, and left/right lower legs.

Review of the x-ray results for the pelvis (both hips) dated 3/2/23 showed Resident #50 had no acute fractures or dislocation.

Review of the x-ray results for the right/left knees, left thigh, and right/left lower legs dated 3/3/23 showed Resident #50 had no acute fractures or dislocation.

MD note dated 3/3/23 showed Resident #50 was evaluated by the MD after he slid out from the wheelchair while on the transportation van. Resident #50 had complained of left knee pain and was offered to go to the hospital, but he declined. X-rays were ordered and performed in the facility. The note indicated Resident #50 had a small bruise noted on the right side of his forehead and bruising to his leg (no indication of which side).

An interview was attempted with the MD, but she was unavailable during the investigation.

Review of an investigation summary report created by the Administrator dated 3/3/23 showed at 1:05 PM Resident #50's high back wheelchair was in a reclined position at approximately a 45-degree angle. The shoulder strap did not fit snug to the resident due to the wheelchair being reclined, and the transportation driver did not sit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 689	Continued From page 43	F 689		

Resident #50 upright in the wheelchair. During transport at 1:30 PM, the transportation driver heard Resident #50 say "I'm down." At 1:31 PM, the transportation driver stopped the van in the middle lane of a busy road and applied the hazard lights. Resident #50 was at the base of the footrests with his back against the front of the wheelchair and his legs extended out in front. The transportation driver lifted him back into his wheelchair and continued to the appointment destination. At 2:45 PM, the transportation driver returned to the facility, returned Resident #50 to his room, and did not notify anyone of the incident on the van. At 3:00 PM, the Administrator, previous Director of Nursing (DON), and the Unit Manager met with the resident and his family to discuss the appointment. Resident #50 told them he slid out of his wheelchair on the van during transport. He was assessed for injuries with none noted. The Administrator called the transportation driver immediately to return to the facility. A reenactment of the incident was performed to show exactly what had occurred. There were not any other witnesses. At 3:30 PM, the Administrator ceased all future transportation appointments for the day and utilized an outside transportation company for any further travel. At 4:30 PM, the transportation driver returned to the facility, was provided education on reporting of incidents, and was suspended pending the investigation. A witness statement given by the transportation driver on 3/2/23 showed that Resident #50 was "in a reclined position during transport" and "remained in a reclined position during transport." A witness statement given by Nurse Aide (NA) #4 read on 3/2/23 at 11:30 AM Resident #50 was "adjusted in a high back wheelchair to a slightly reclined position. At approximately 12:00 PM, he was picked up for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 689	Continued From page 44	F 689		

transport."

Resident #50 was discharged from the facility on 3/28/23 and unable to be reached for an interview.

The transportation driver's witness statement dated 3/2/23 read: "I was transporting Resident #50 to his medical appointment. He was in a high back wheelchair in a reclined position. The wheelchair remained in a reclined position during transport. The seatbelt was secured around Resident #50's waist with straps beneath the arm rest. Resident #50 reported the seat belt position was comfortable. He was secured at the base of the wheelchair. During transport, Resident #50 yelled out "I'm down." I looked in the rear-view mirror. At that time, I was getting off highway 440. I stopped the van in the middle lane - hazards were applied. I went to the back of the van to see what was going on. Resident #50 was noted to have slid out of his wheelchair: his back was against the wheelchair and his bottom rested on the footrests. Both legs were extended out in front of his body. Resident #50 did not report he was in pain. I pulled him back up into the wheelchair. Once back in the wheelchair, I proceeded to take Resident #50 to his appointment, which was rescheduled. I returned him to the facility with still no reports of pain."

The transportation driver could not be reached for an interview because a contact phone number was not available, and he no longer worked at the facility.

An interview was conducted with NA #4 on 3/2/23 at 4:07 PM. She revealed that if Resident #50 sat up straight in the high back wheelchair, then he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 689	Continued From page 45	F 689		

would slide out of the chair. On 3/2/23, NA #4 indicated that Resident #50 was "just slightly reclined, not even halfway" in his wheelchair prior to transport.

An interview was conducted with Nurse #5 on 7/5/23 at 12:53 PM, who was assigned to Resident #50 on 3/2/23 from 7:00 AM - 7:00 PM; however, she could not recall the details of Resident #50 or the events on 3/2/23.

An interview was conducted on 7/5/23 at 11:50 A.M. with the Nurse Consultant. During the interview, the Nurse Consultant indicated that although the investigation summary noted Resident #50 was reclined at a 45-degree angle during transport, he was in fact reclined only slightly (15 degrees at the most).

An interview was conducted on 7/5/23 at 4:33 PM. During the interview, the Administrator indicated the transportation driver could have secured Resident #50 more safely and should have reported the incident to management immediately. Resident #50 told her on 3/2/23 that he had a seat belt on and slid from the wheelchair to the footrest of the wheelchair. No injuries were noted, and immediate x-rays were performed immediately following the incident with no injuries noted. Resident #50 declined to go to the hospital for evaluation. He told the Administrator that the transportation driver stopped the van and assisted the resident back into the wheelchair then continued to the scheduled appointment.

On 7/5/2023 at 4:15 P.M., the facility's Administrator was informed of the immediate jeopardy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 689	Continued From page 46	F 689		

The facility provided the following corrective action plan with a completion date of 3/8/22:

Resident #50 is alert and oriented with a Brief Interview of Mental Status (BIM) of 10. Diagnosis include Diabetes, hypertension (high blood pressure), Chronic Obstructive Pulmonary Disease (inflammation of the lungs that reduces air flow) , Ischemic Cardiomyopathy (enlarged heart), history of heart attack, Anemia, Cerebral Infarction (stroke), Coronary Artery Disease (blockage of major blood vessels), Hyperlipidemia (high levels of lipids/fat in the blood), Peripheral Artery Disease (narrowing blood vessels that reduces blood flow), deep vein thrombosis (blood clot), Hemiplegia (paralysis) and hemiparesis (partial weakness) affecting left side, and Aneurysm (ruptured blood vessel). Per the driver's report, on 3/2/2023, at approximately 11:00 am, the transportation driver arrived at the facility to transport resident to a medical appointment. The transportation driver lowered and secured the wheelchair ramp onto the ground. The transportation driver entered the facility and assisted Resident #50 by high back wheelchair onto the van wheelchair lift. The high back wheelchair was in a reclined position. The driver backed the wheelchair and resident onto the lift and into the van. The transportation driver secured the wheelchair/resident in the van by locking the brakes and placing/tightening the back-floor straps around the frame of the wheelchair on the back right and sides. The transportation driver then secured the front floor straps around the front frame of the wheelchair and tightened the straps. The transportation driver then placed the seat belt with the shoulder strap hooked to the lap belt through the arms of the wheelchair and fastened it around the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 689	Continued From page 47	F 689		

resident waist. The shoulder strap did not fit snugly to the resident due to the wheelchair being reclined. The transportation driver did not sit the resident upright in the chair. At approximately 1:30 pm, the transportation driver heard the resident yell, "I'm down." At 1:31 pm, the transportation driver stopped the van in the center turning lane of a well-traveled roadway with his hazard lights on. Upon entering the back of the van, the resident was positioned at the base of the footrests, with the resident's back against the front of the wheelchair, the resident's bottom was positioned on the leg rests, and the resident legs were extended in front of the resident. The seatbelt was positioned at the top of the resident's head. The transportation driver unbuckled the seatbelt and placed the resident back in the wheelchair. The resident denied pain or injury and was transported to the appointment. On 3/2/23, during a discussion with the resident, resident representative, Administrator, and Registered Nurse (RN) Unit Manager, Resident #50 reported he slid out of a wheelchair while being transported in the van. The Administrator immediately initiated an investigation. The Director of Nursing (DON) and Unit Manager assessed the resident with no identified concerns. The resident declined to go to the emergency room for further evaluation. The Medical Director was notified of the incident on the van. On 3/2/23, the van driver was suspended by the Administrator pending investigation.

On 3/2/23, at approximately 3:30pm, the facility Administrator stopped all resident wheelchair transport utilizing the facility's van. An alternate contracted van transport company was utilized until education and return demonstration could be completed with the facility van transport driver.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 689	Continued From page 48	F 689		

On 3/2/23 a root cause analysis was completed to identify root cause for van driver not securing a snug fit of the shoulder strap per manufacturer guidelines and why he did not immediately report to the facility and call Emergency Management Services. The transportation driver was trained on securing a resident during transport, as well as what to do if resident had fall on van. Training was performed 12/3/21, which included stopping van, putting hazard lights on, not moving the resident, notifying Emergency Medical Services (EMS) and the facility. Resident #50 utilized a mechanical lift for transfers with the assistance of one.

Resident #50 had therapy assessment completed on 2/3/23 that indicated resident was appropriate to transfer into upright wheelchair.

On 3/2/23, the Social Worker (SW) initiated resident questionnaires with all alert and oriented residents regarding medical transport to include: "Do you have any concerns related to medical transport? If yes, please explain." There were no additional concerns identified.

On 3/2/23, The DON and Unit Manager completed an audit of all incident reports for the past 30 days. This audit was to identify any other incidents during medical transport. There were no additional identified areas of concern.

On 3/2/23, the van including straps was inspected by the Maintenance Assistant with no identified concerns.

- Actions taken to alter the process or system failure to prevent a serious adverse outcome for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 49 occurring or recurring. On 3/2/23, the Administrator completed an in-service with the van driver regarding prompt notification to the facility regarding van incidents, procedure for van incidents, proper positioning of resident on van, and securing residents on van. The transportation driver was the only driver employed by the facility at the time of the event. The sister facility transportation driver is responsible for training newly hired facility van drivers to include return demonstration. On 3/7/23, a sister facility transportation driver completed training with return demonstration with the facility's van transport driver, Unit Manager, Housekeeping Supervisor, and the Maintenance Assistant on how to properly secure a resident during medical transport. The manufacturer's video was utilized for reviewing the appropriate technique of securing resident for medical transport. This in-service also included emphasis on (1) never position the lap belt over the abdominal area, over the wheelchair armrests, through the wheelchair arm rests or with the belt assembly twisted and (2) ensuring wheelchairs are not reclined during transport. - The procedure for monitoring the plan of correction. Monitoring actions began on 3/2/23. The Director of Nursing, Unit Managers, and/or Administrator will complete an audit of 5 facility wheelchair medical transports weekly x 4 weeks to ensure resident is secured properly and safely in the van prior to transport. The Administrator and/or DON will address all concerns identified	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 50	F 689		

during the audit to include but not limited to immediately stopping all medical transport for any concerns identified.

The Social Worker will complete 5 resident questionnaires weekly x 4 weeks utilizing the Resident Questionnaire Van Transport. This questionnaire is to identify any concerns related to van transport. The Administrator and/or DON will address all concerns identified during the questionnaires to include but not limited to immediately stopping all medical transport for any concerns identified.

The Administrator will present the findings of the Resident Questionnaires Van Transport and Medical Transport Audits to the Quality Assurance Committee on 3/7/23 and monthly x 1 month. The Quality Assurance Committee will review the Resident Questionnaires Van Transport and Medical Transport Audits monthly x 1 months to determine trends and/or issues that may require further interventions put into place and to determine the need for further and/or frequency of monitoring.

The Administrator and DON were responsible for the implementation of corrective actions to include all 100% audits, in-services and monitoring related to the plan of correction.

Date of corrective action completion: 3/8/23.

The facility's credible allegation of Immediate Jeopardy removal was validated on 7/5/23 and the corrective action plan was verified as completed on 3/8/23. The validation was evidenced by staff interviews, record reviews, and review of competency training logs. The

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F 689	Continued From page 51 interventions included verified training for the previous transportation driver with a certificate of completion for safe transport, continuous audit of the transportation driver's performance with weekly performance checklists, initial and continuous questionnaires for alert and oriented residents related to their transportation experience, and audits of incident reports within 30 days of the incident on 3/2/23.	F 689		