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F 000	INITIAL COMMENTS A complaint investigation was conducted from 7/17/2023 to 7/18/2023. Event ID #BX6V11. The following intakes were investigated NC00204625, NC00202991, and NC00201971. 1 of the 5 complaint allegations resulted in deficiency. Intake NC00204625 resulted in immediate jeopardy. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity (J). The tag F689 constituted Substandard Quality of Care. Non-compliance began on 7/12/2023. The facility came back in compliance effective 7/15/2023. A partial extended survey was conducted.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Medical Director interviews, the facility failed to provide Activities of Daily Living (ADL) care safely to a dependent resident for 1 of 3 residents reviewed	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 09/15/2023

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for supervision to prevent accidents (Resident #1). On 7/12/23 Nursing Assistant (NA) #1 began providing care to Resident #1 who was on an alternating air pressure mattress, she left the resident on his right side with the bed at waist height and exited the room to speak with the nurse and obtain supplies. While unattended, Resident #1 fell off the bed onto his back on the floor hitting his head, resulting in a hematoma (a pool of mostly clotted blood that forms in an organ, body tissue or body space) to the back of his head, shoulder pain, and left scalp pain. Resident #1 was transferred to the emergency room and prior to Computerized Tomography (CT) scan being performed the resident went into cardiac arrest and was unable to be revived.

The findings included:

Resident #1 was most recently admitted to the facility on 5/10/22 with diagnoses that included quadriplegia, acute transverse myelitis (transverse myelitis interrupts the messages that the spinal cord nerves send throughout the body), and osteoporosis.

Resident #1's quarterly Minimum Data Set dated 5/16/23 revealed he was cognitively intact. He was assessed as dependent on 2 or more staff for assistance with bed mobility and upper and lower extremity impairment on both sides. Resident #1 was not coded for any falls since the prior assessment.

Review of the active physician orders for July 2023 revealed Resident #1 had an order for a pressure reduction mattress (alternating air pressure mattress).

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Resident #1's active care plan on 7/12/23 (last revised on 7/14/21) revealed he was at risk for falls related to quadriplegic status and immobility and muscle spasms. Interventions included assist resident with ADL's,

The Occurrence note completed by Nurse #1 dated 7/12/23 revealed the writer was called to the room by the housekeeper yelling "Resident #1 on the floor." When arriving to the room resident was noted flat on the floor beside his bed. A bump was noted on the back of his head, and when moving him he complained of left shoulder pain. He was assisted back to bed with a mechanical lift with 2 staff assist. The note indicated Resident #1 refused to go to hospital, "States I'll be alright."

The Fall Incident Report initiated on 7/12/23 and signed completed by Nurse #1 on 7/12/23 was reviewed. It revealed Resident #1 was found on the floor beside his bed, lying flat on his back. He was assessed for possible injury, noted with a bump/raised area on back of head. The Nurse Practitioner was notified and ordered to transfer out.

NA #1 (agency staff) was interviewed on 7/18/23 at 5:32 PM. She indicated on 7/12/23 Nurse #1 stopped her in the hall and asked her to "clean up" Resident #1. When changing Resident #1 she noticed that his colostomy bag was leaking, she cleaned him up and told Nurse #1 the colostomy bag was leaking. Nurse #1 returned, changed the leaking bag and when NA #1 finished cleaning up the resident, he asked her to change his wound dressing. She indicated the resident was insistent that she change his dressing. NA #1 stated Resident #1 was in the

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middle of the bed when she stepped out of room to tell the nurse he wanted his dressing changed. She reported the next thing she knew the housekeeper was running in the hall yelling that Resident #1 was on the floor. NA #1 revealed that herself, Nurse #1, Nurse #2, and NA #2 all ran to the room and found Resident #1 lying on his back on the floor. She indicated Nurse #1 assessed the resident, and Nurse #2 encouraged him to go to the hospital and he refused. Resident #1 stated he was fine and wanted to get up off the floor. She and NA #2 used a mechanical lift to assist Resident #1 back to bed and once in bed he complained he was dizzy and nauseated. NA #1 stated she checked his vital signs, and informed Nurse #1 that he changed his mind and wanted to go to the hospital. NA #1 stated when she stepped out of the room to speak with the Nurse, Resident #1 was in the center of the bed and she had lowered his bed to her kneecaps. NA #1 stated she had no training on the alternating air pressure mattress and was not aware there was a static mode (a mode that ceased fluctuation of air pressure). NA #1 indicated she should have used pillows to support Resident #1 in bed when she left the room. NA #1 stated her staffing agency would not send her back to work at the facility.

A phone interview was conducted with Nurse #1 on 7/17/23 at 10:39 AM. She revealed on 7/12/23 she had changed Resident #1's colostomy bag and when she left the room, his bed was left waist high, per the resident's choice. Shortly afterwards she heard a housekeeper running in the hall yelling, "Resident #1 has fallen." Nurse #1 indicated she called "Code Green" (for fall) and she, the Unit Manager, NA #1, and NA #2 ran into the room. She stated Resident #1 was lying flat

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on his back on the floor. The bed was still at waist height. She assessed him and found a small bump on the back of his head; he was assisted back to bed using the mechanical lift. Resident #1 then insisted he did not want to go to the hospital. Nurse #1 revealed shortly after that, NA #1 came to tell her the resident complained he was dizzy and wanted to go to the hospital. She revealed when EMS arrived Resident #1's looked pale and the bump on the back of his head increased in size and fit in the palm of her hand.

The Unit Manager was interviewed on 7/17/23 at 11:01 AM. She indicated she was called to the room 7/12/23 by the housekeeper and found Resident #1 was lying flat on his back on the floor. She indicated when she ran into Resident #1's, room, his bed was at waist height. She indicated that the resident did not want to go to the hospital and wanted to stay in the facility. Then staff informed her Resident #1 complained of a headache and wanted to go to the hospital. The Unit Manager indicated that Resident #1 had an oscillating air mattress and when NA #1 left the room to get supplies, he fell off the bed flat onto his back on the floor. She indicated NA #1 should not have left Resident #1 alone. She added that after the incident she took all of the third floor NA's into Resident #1's room and had them demonstrate they knew how to operate an alternating air pressure mattress.

Nurse Aide #2 (NA) was interviewed on 7/18/23 at 11:05 AM, stated that she was called to the room on 7/12/23 to help get Resident #1 off the floor. She revealed after Nurse #1 had assessed the resident they (NA #1 and NA #2) used a mechanical lift to transfer Resident #1 back into bed. NA #2 indicated his bed was at waist level

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when she entered the room to assist.

The Emergency Medical Services (EMS) report dated 7/12/23 revealed Resident #1 had a 3-foot fall from a nursing home bed with primary injury to his head. Other signs and symptoms included hypotension, injury to his shoulder and upper arm and nausea and vomiting.

An Emergency Room report dated 7/12/23 revealed upon arrival at 11:21 AM EMS reported a Glasgow Coma Scale (a scale used to objectively describe the extent of impaired consciousness) score of 13 (indicative of a mild head injury) and an x-ray was conducted in the ER of Resident #1's pelvis and was negative for fracture. While in the trauma bay prior to CT scan, Resident #1 lost pulse and cardiopulmonary resuscitation was started. During resuscitation, he progressed through multiple irregular heartbeats and received defibrillation (delivers a dose of electric current to the heart). After greater than 40 minutes of resuscitation efforts he expired at 12:49 PM.

A telephone interview was conducted with the Medical Director on 7/17/23 at 2:25 PM. He indicated X-rays taken in the Emergency Room were negative for fractures and his Glasgow Coma Scale revealed a mild head injury. He revealed the resident was on the way for a CT scan, went into bradycardia (abnormal heart rhythm), coded, and passed away in the hospital. The Medical Director revealed Resident #1 had no signs or symptoms of deterioration prior to the incident and the decline happened rapidly after the fall. He stated Resident #1 had had a high-level spinal injury prior to admission, Covid-19 within the last year and he could have

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been respiratory compromised.

An interview on 7/17/23 at 3:15 PM with the Administrator revealed he and the DON were not in the facility at the time of the 7/12/23 fall and when staff informed him Resident #1 had passed, he reached out to his Corporate Nurse. He indicated he thought Resident #1's positioning in bed was "not right" and that when NA #1 left the room he rolled off the bed.

The Administrator was notified of Immediate Jeopardy on 7/18/23 at 9:15 AM.

The facility provided the following corrective action plan with a completion date of 7/15/23:

Overview of Event:
On 7/12/2023 at approximately 9:45am, Nurse #1 was in the room of Resident #1 administering medications. While in the room, she noted that his colostomy was leaking. She instructed Certified Nursing Assistant (CNA) #1 to clean the resident and she would return to replace the bag. Nurse #1 stated after care was provided by CNA #1, she returned to the room and changed the colostomy bag. Shortly after, CNA #1 came to Nurse #1 and asked her to change the dressing on Resident #1's buttocks because it was soiled. Nurse #1 was in the process of administering medications to other residents and stated she could not perform the dressing change at that specific time but would change the dressing as soon as possible. CNA #1 returned to Resident #1's room. CNA #1 needed to obtain a protective cover for Resident #1's wound on his buttocks. She exited Resident # 1's room again to speak with Nurse #1 leaving Resident #1 turned on his right side in the bed with bed at waist level height.

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Shortly after, at approximately 9:58am, a Housekeeper saw Resident #1 lying on the floor next to his bed, the housekeeper immediately called for help. At 9:59am, a Code Green (fall response code for the facility) was called by the Unit Manager and staff responded to the room. Nurse #1 entered the room and observed Resident #1 on the floor lying on his back. The resident was on the right side of the bed. Nurse #1 asked Resident #1 what happened, and he stated someone changed his mattress/setting and he fell off the bed. Nurse #1 informed Resident #1 that from her understanding, his mattress nor mattress settings were changed. Nurse #1 performed an assessment and noted a quarter size hematoma to the back of the resident's head. She assessed his shoulders and he complained of left shoulder pain. Nurse #1 instructed the CNA #1 to transfer the resident back to bed with the mechanical lift with two Certified Nursing Assistants. At 10:01am, staff retrieved the mechanical lift and transferred Resident #1 back to bed. Once Resident #1 was in bed, Nurse #1 continued to assess Resident #1 which included neuro checks. His pupils were equal and reactive, and he had no complaints of blurred vision. Nurse #1 performed range of motion and Resident #1 continued to complain of left shoulder pain. Nurse #1 informed Resident #1 that he would need to go to the hospital for further evaluation and he refused, stating he was fine. Approximately 15 minutes later Resident #1 complained of headache, dizziness, and nausea. Resident #1 agreed to go to the hospital. At 11:00am Emergency Medical Services (EMS) arrived and at 11:12am (EMS) transported the resident to the hospital. Nurse #1 notified his emergency contact and made the Provider aware of the incident. An investigation was initiated by

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the Administrator and Director of Nursing (DON) on 7/12/23.
Ad Hoc QAPI Committee Review:

An Ad Hoc (Quality Assurance Performance Improvement) QAPI meeting was conducted on 7/13/2023 by the QAPI Committee (Administrator, DON, Social Service Manager, Infection Prevention Control Officer, Minimum Data Set (MDS) Coordinator(s), Therapy Manager, Unit Manager(s), Business Office Manager, Activities Assistant Director, Maintenance Director, Dietary Assistant Manager and Medical Director) to discuss this event and plan to address the event. As well, the facility Vice President of Operations and Regional Clinical Director attended the meeting. Based upon record review, staff interview(s), Resident #1's environmental observation and CNA return demonstration, the QAPI Committee has identified the following root cause(s) of the event:

1. Root Cause: Resident positioned on his right side without stabilization (pillow, wedge etc.) and bed at waist level position per interview with CNA #1. CNA #1 left the room to speak to Nurse #1 to obtain supplies. Resident #1 was left unsupervised. Upon fluctuation of the air mattress, the resident's body shifted while in the turned position. Subsequently, the resident fell to the floor.

Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice:
- The Nurse assessed Resident #1 immediately when he was found on the floor. He initially refused to go to the hospital, but after further evaluation he agreed and was transported to the

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Hospital by EMS. Nurse #1 updated his emergency contact. At 12:49 pm per hospital records, Resident #1 was on the way for a CT scan. During transport Resident #1 became bradycardic. Subsequently, coding (cardiac arrest) and passing away.

How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice.

- On 7/14/2023, an audit of all residents who are currently on an air mattress was performed by the Maintenance Director to ensure they are functioning properly. No issues were identified.
- On 7/14/2023, all current residents were reviewed by the Therapy Director and Nursing Management to ensure their level of assistance for Activities of Daily Living (ADL) support accurately reflects the number of staff support needed (+1 or +2 assist)
- On 7/14/2023 an audit of all care plans/Kardex was performed by the MDS coordinator/designee to ensure ADL care plans are accurate and up to date. Any issues identified were corrected.
- On 7/14/2023, an audit of all residents who require air mattresses was performed by the DON/or designee. This audit included a review of the order to include checking function of the mattress. The care plan/Kardex was reviewed to ensure use of the air mattress is reflected. Any issues were corrected on 7/14/23.

Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur:

- On 7/13/2023 the DON/or designee began education with all nursing staff including agency nursing staff on bed mobility, with emphasis upon turn/repositioning stabilization while in a turned position (with pillows, wedges, etc.), lowering the

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bed's height to a safe position prior to exiting the room and ensuring all supplies are readily available in the room prior to initiating care. If supplies are needed while in the room, call for assistance in obtaining the needed supplies. Do not leave the resident unsupervised with the bed height in a high position.
- On 7/14/2023 the DON/or designee initiated bed mobility competencies with all nursing staff including agency nursing staff, with emphasis upon turn/repositioning stabilization while in a turned position (with pillows, wedges, etc.) and lowering the bed's height to a safe position prior to exiting the room.
- As a precaution on 7/12/2023, the DON/or designee began education with all nursing staff including agency nursing staff on air mattress functionality (control modes-static and alternating). Specifically for residents on air mattresses, ensure the bed is placed into static mode for repositioning, then returned to alternate pressure (standard mode) once repositioning is completed.
- On 7/13/2023, the DON/designee began education with all licensed nurses including agency on the expectation that when dressings are soiled, they need to be changed in a timely manner by the Licensed Nurse.
- Effective 7/14/2023, nursing staff will not be allowed to work until the education including bed mobility competency is completed.
- New Hire: Newly hired Nursing Staff (including agency) will be provided with this education by the facility Staff Development Coordinator (SDC) or designee during their orientation period.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

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The decision to monitor as part of this corrective action was made on 7/13/2023.
- On 7/13/2023, the Regional Clinical Director and Vice President of Operations provided education to the Administrator and Director of Nursing on the QAPI committee role in maintaining compliance with this plan. Additionally, any further identified quality issues should have interventions established to avoid further non-compliance.
- Retention Questions with (5) staff related to air mattress functionality and checking Kardex for ADL support needs and bed height position to ensure safety of the residents. Questionnaires will be completed weekly for 12 weeks.
- Observation competency for bed mobility will be completed weekly for 12 weeks with (3) staff to ensure emphasis upon turn/repositioning stabilization while in a turned position (with pillows, wedges, etc.), lowering the bed's height to a safe position prior to exiting the room and ensuring all supplies are readily available in the room prior to initiating care. If supplies are needed while in the room, call for assistance in obtaining the needed supplies. Do not leave the resident unsupervised with the bed height in a high position.
- New Admissions will be reviewed 5x weekly in the clinical morning meeting to ensure the ADL support needs are accurate and care plan/Kardex is updated. Team Members include Director of Nursing, Unit Managers, Social Work Manager, Minimum Data Set (MDS) Coordinator, and Infection Control Nurse.

The Director of Nursing will report the results of the plan of correction audits to the QAPI Committee. The QAPI committee will review the audits to make recommendations to ensure compliance is sustained and ongoing; and

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RALEIGH REHABILITATION CENTER	616 WADE AVENUE RALEIGH, NC 27605

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F 689	Continued From page 12 determine the need for further auditing beyond the three (3) months. The title of the person who is responsible for implementing and maintaining compliance with this plan: The Administrator and the Director of Nursing Completion Date: 7/15/2023 Onsite validation was completed on 7/18/23 through staff interviews, observation, and record review. Inservice sign in sheets and staff interviews verified in-services were completed on bed mobility with an emphasis on turning/positioning/stabilization, ensuring all supplies are readily available prior to beginning care, calling for assistance if a need arises during care, air mattress safety and control modes, and bed height safety. Education was confirmed for agency nursing staff and facility nursing staff. Bed mobility competencies were verified. Education was also verified for the Administrator and DON on the QAPI committee's role in maintaining compliance. Observation of staff operating the air mattress control modes revealed no issues. Evidence of audits were reviewed for care plans/kardex, bed mobility, air mattress control modes and proper functioning, and bed height safety. Resident interviews were conducted with no issues identified. The facility's action plan was validated to be completed as of 7/15/23.	F 689		