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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 2/21/24 through 2/23/24. The following intake was investigated: NC00213594. This intake resulted in immediate jeopardy. 1 of the 1 complaint allegation resulted in deficiency. 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. 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 observations, record review, staff interviews, and Medical Director interview, the facility failed to provide care in a safe manner for 1 of 3 residents reviewed for accidents (Resident #1). On 1/21/24 Resident #1 was positioned on her left side with the bed raised to waist height by	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 03/15/2024

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Nurse Aide (NA) #1 to perform incontinence care and bathing. NA #1 left the resident unattended on her left side to obtain supplies on the other side of the bed, and Resident #1 fell from the bed onto her right side on the floor and sustained a laceration to her head and a skin tear to her right elbow. Resident #1 was transferred to the emergency room for evaluation where she received a computerized tomography (CT) head and cervical spine imaging which was notable for small hemorrhagic contusions (bleeding inside the brain) to bilateral temporal lobes (area of the brain behind the ears). No surgical intervention was recommended, and Resident #1 continued to decline despite fluids, nutrition, and supportive care measures. Resident #1 was placed on hospice care and according to the death certificate expired on 1/31/24 with the cause of death identified as blunt force trauma to the head related to a fall from bed.

The findings included:

Resident #1 was admitted to the facility on 12/19/23 with diagnoses which included stroke, hemiplegia (paralysis of one side of the body), and post-polio syndrome (viral infection on nervous system with decreased muscular function and acute weakness).

A physician order dated 12/20/23 for aspirin 325 milligrams one time a day.

Resident #1's care plan initiated on 12/19/23 revealed she was at risk for fall related injury and falls related to stroke with right sided weakness and altered cognition with interventions which included to keep the environment as safe as possible to and keep the bed in the appropriate

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position.

Review of the Resident Care Guide (A nurse aide's guide for providing care to a resident) (no date) revealed Resident #1 required extensive assistance for bed mobility which included rolling from side to side.

The Minimum Data Set (MDS) significant change assessment dated 1/09/24 revealed Resident #1 had severe cognitive impairment, she required substantial maximum assistance (staff does more than half of the effort, lifts and holds limbs) with turning and repositioning and she was dependent on staff for toileting and bathing. Resident #1 was coded for a feeding tube and antiplatelet medication use during the 7-day lookback period.

During a telephone interview on 2/21/24 at 12:41 pm Nurse Aide (NA) #1 revealed she was assigned to Resident #1 on the morning of the fall. NA #1 stated she prepared Resident #1 for incontinence care and bathing, she had positioned Resident #1 on her left side slightly past center of the bed but not on the edge of the bed, and Resident #1 had both hands on her one-quarter side bed rail (a rail attached to the bed frame and used to assist resident with positioning) on the left side of the bed. NA #1 stated Resident #1 had weakness on one side of her body, but she was unable to remember which side. NA #1 reported she forgot to obtain the personal care wipes from the bedside table on the other side of the bed, so she left Resident #1 on her left side with the bed elevated at about waist height and walked around the foot of the bed to retrieve the personal care wipes. NA #1 stated when she walked back around the foot of the bed towards Resident #1, she witnessed

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Resident #1 start falling forward from the bed. NA #1 stated she tried to grab Resident #1's right hip in an attempt to stop the fall, but she was unable to stop Resident #1's fall from the bed. NA #1 stated she should have lowered Resident #1's bed before she walked around the bed to get the personal care wipes, but she was near the bed and did not think Resident #1 would fall.

The fall incident report initiated on 1/21/24 at 6:08 am and completed by Nurse #1 revealed Resident #1 was observed on the floor with active bleeding from the right side of her head and a skin tear to her right elbow. Resident #1 was unable to report pain, pressure was applied by Nurse #1 to the right side of the head until emergency medical technicians (EMTs) arrived and transported Resident #1 to the emergency department. The physician and Resident #1's Responsible Party (RP) were notified of the fall and emergent transfer for evaluation.

An interview was conducted on 2/21/24 at 1:13 pm with Nurse #1 who was assigned to Resident #1 at the time of the fall on 1/21/24. Nurse #1 stated she was notified by NA #1 that Resident #1 had rolled off the bed when she was in the room to provide care. Nurse #1 stated she entered the room and observed Resident #1 to be on the floor between the bed and the window with her feeding tube line wrapped around her waist. Nurse #1 stated Resident #1 had a large amount of blood from the right side of her head, but she was able to respond to her name. Nurse #1 stated she stayed with her, applied pressure to the wound and tried to keep Resident #1 comfortable until the EMTs arrived.

Review of the hospital record dated 1/21/24

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revealed Resident #1 presented as a trauma consultation status post fall from bed with nausea and vomiting, atrial fibrillation (irregular heart beat), and an abrasion and hematoma (localized bleeding outside the blood vessels) to right occipital lobe (very back of the skull) upon arrival to the emergency department. A computed tomography (CT) scan of the head was completed which revealed Resident #1 had a small hemorrhagic contusion (bleeding inside the brain) to the left and right temporal lobes (area of the brain behind the ears), a small left-sided subdural (pool of blood between the brain and the outermost covering) hemorrhage, and trace right-sided subdural hemorrhage. No surgical intervention was recommended. Resident #1 continued to decline despite fluids, nutrition, and supportive care measures. Resident #1 was placed on hospice services and expired on 1/31/24.

The Certificate of Death revealed Resident #1 expired on 1/31/24 and the immediate cause of death was determined to be blunt force trauma to the head related to a fall from bed that occurred on 1/21/24.

A telephone interview was conducted on 2/22/24 at 8:15 am with the Rehabilitation Director who revealed Resident #1 received therapy services which included physical, occupational, and speech at the facility. The Rehabilitation Director stated Resident #1 had right sided weakness with a score of 0 out of 5 on the manual muscle testing grading system which indicated no visible or palpable contraction (flaccidity) of the right upper extremity. The Rehabilitation Director stated Resident #1 had no significant functional improvement identified throughout her admission

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and remained dependent upon staff for activities of daily living.

A telephone interview was conducted on 2/22/24 at 7:37 pm with the Medical Director who revealed Resident #1 had right sided weakness from her history of stroke and general muscle weakness from history of post-polio syndrome. He stated he was unable to recall if Resident #1 had purposeful function of her right upper extremity to perform tasks. He stated Resident #1 did participate in therapy services at the facility. The Medical Director stated he was notified of Resident #1's fall and transfer to the emergency department.

An interview was conducted on 2/21/24 at 5:11 pm with the Director of Nursing (DON) who revealed NA #1 should have prepared all needed supplies prior to positioning Resident #1 on her side to provide care. The DON stated NA #1 failed to position Resident #1 in a safe position on the bed and place the bed in a low position before she walked to the other side to the bed to obtain the supplies.

An interview was conducted with the Administrator on 2/22/24 at 2:45 pm who revealed NA #1 was responsible to follow the policies and procedures regarding positioning and turning of residents and performing a bed bath properly to ensure Resident safety.

The Administrator was notified of immediate jeopardy on 2/21/24 at 2:27 pm.

The facility provided the following corrective action plan with a completion date of 1/30/24:

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1. How corrective action will be accomplished for resident(s) found to have been affected:

On 1/23/24 the DON completed a root cause analysis and Nurse Aide (NA) #1 did not follow policy and procedure for transfer and bed bath.

One on one education was provided to NA #1 by the DON on 1/23/24 which included turning and repositioning of residents, bed bath policy which included gather and prepare necessary equipment and supplies, turning resident toward staff or obtain coworker to be on other side of resident.

2. How corrective action will be accomplished for resident(s) having potential to be affected by the same issue needing to be addressed:

A review of the facility incident reports for the past thirty (30) day period was conducted by the interdisciplinary team (IDT) on 1/23/24 to identify any similar situations that may have occurred, no findings were identified.

All residents who must be turned and positioned could be affected. Residents were identified by the Unit Managers who utilized the Minimum Data Set (MDS) CMS-802 (a list of resident census and condition), and a review of resident care plans was completed on 1/23/24.

A review of all falls for the past 30-day period was completed on 1/23/24 by the IDT, which consisted of the Social Worker, Unit Managers, MDS Coordinator, Assistant Director of Nursing, and the DON to identify any incident that resulted in a fall could have been caused by a transfer/bed bath provision of care. No findings were noted.

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A review of the grievances was completed by the Assistant Director of Nursing on 1/23/24 with no complaints of improper transfer and bed bath provision of care policy.

3. What measure will be put in place or systemic changes made to ensure that the identified issues does not occur in the future:
All nursing staff were to be re-educated on turning and positioning in bed and bed bath. The education was completed on 1/26/24 by the Assistant Director of Nursing and the Director of Nursing. Policy and Procedures presented: Bed Bath, which included but not limited to, gather, and prepare the necessary equipment and supplies, always turn resident towards you or obtain a coworker to stay on the opposite side of the bed, and return the bed to original position after completing provision of care. Turning and positioning a resident in bed, which included but not limited to, obtain positioning devices as needed, have resident flex arms across their chest if able, flex the resident's knees and roll toward you utilizing a pillow or positioning wedge to maintain the resident in the side lying position, and support with pillows as needed.

The facility does not utilize agency staff.

All new staff will be educated by the Assistant Director of Nursing during orientation and prior to working on the floor for turning and positioning and bed bath education with a skill checkoff list to document the education was completed. The education is tracked by the Assistant Director of Nursing.

4. Indicate how the facility plans to monitor its

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performance to make sure the solutions are achieved and sustained:
The Administrator and Director of Nursing met to complete an Ad Hoc meeting on deficient practice and steps to correct deficient practice on 1/29/24.

Facility care audits will be completed on different shifts and different days of the week. The facility will observe 3 residents daily for 5 days, then 3 residents weekly for 4 weeks, then 3 residents monthly for 2 months. Audits will include bed bath procedure, turning and positioning procedures, including turning the resident towards staff member.

Monthly reporting to the Quality Assurance Performance Improvement committee (QAPI) will occur to gauge the effectiveness of interventions and to determine when substantial compliance has been obtained and maintained. The audit process with stop at the time on the recommendation of the QAPI committee. The QAPI committee members include the Administrator, Director of Nursing, Assistant Director of Nursing, Social Worker, MDS Coordinator, Director of Maintenance, Director of Environmental Services, Food Services Director, Activities Director, and the Medical Director.

The Director of Nursing is responsible for implementation and obtaining compliance for the plan.

Alleged date of compliance: 1/30/24

Onsite validation was completed on 2/21/24 through record review, staff interviews, and observations of resident care including incontinence care and turning and repositioning.

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F 689	Continued From page 9 Staff were interviewed to validate the in-service was completed on turning and positioning residents in bed, proper procedure to perform resident bed bath with emphasis on resident safety and to have all supplies before care was started. A review was completed of the resident care audits, and of the 2/14/24 Quality Assurance and Performance Improvement (QAPI) meeting minutes. The facility's corrective action plan was validated to be completed as of 1/30/24.	F 689		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.	F 867		3/20/24

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

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

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

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

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its

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performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

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F 867	Continued From page 12 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, and Medical Director interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the 12/09/22 recertification and complaint investigation. This was for 1 recited deficiency on the current complaint investigation survey of 2/23/24 in the area of Provide Supervision to Prevent Accidents (F689). The continued failure during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag is cross-referenced to: F689 Based on observations, record review, staff interviews, and Medical Director interview, the facility failed to provide care in a safe manner for 1 of 3 residents reviewed for accidents (Resident #1). On 1/21/24 Resident #1 was positioned on her left side with the bed raised to waist height by Nurse Aide (NA) #1 to perform incontinence care and bathing. NA #1 left the resident unattended on her left side to obtain supplies on the other side of the bed, and Resident #1 fell from the bed onto her right side on the floor and sustained a laceration to her head and a skin tear to her right elbow. Resident #1 was transferred to the	F 867	F867 The facility will continue to ensure that the quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. The facility will ensure that proper transfer/bathing techniques are utilized to ensure resident safety is maintained. Resident #1 was discharged from the facility and did not return. This incident was cited as a Past Non-Compliance and was corrected. All Residents had the potential to be affected by the same deficient practice. The facility's quality assurance committee will be in serviced by the Regional Clinical Coordinator on the procedures for developing and implementing appropriate plans of action to correct identified quality concerns on 3/20/24. Education will include determining the root cause of the	

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F 867	Continued From page 13 emergency room for evaluation where she received a computerized tomography (CT) head and cervical spine imaging which was notable for small hemorrhagic contusions (bleeding inside the brain) to bilateral temporal lobes (area of the brain behind the ears). No surgical intervention was recommended, and Resident #1 continued to decline despite fluids, nutrition, and supportive care measures. Resident #1 was placed on hospice care and according to the death certificate expired on 1/31/24 with the cause of death identified as blunt force trauma to the head related to a fall from bed. During the 12/09/22 recertification and complaint investigation survey the facility failed to secure a resident's wheelchair to the transportation van securement system per manufacturer instructions and failed to apply a lap and shoulder restraint across a resident per manufacturer instructions which resulted in three falls on the transportation van. A telephone interview was conducted on 2/23/24 at 8:30 am with the Administrator who revealed the facility continued to monitor all incident events for root cause analysis for the residents of the facility from the previous recertification survey. The Administrator stated Resident #1's fall was determined to be an isolated incident based on the root cause analysis, auditing, and record review that was completed by the Director of Nursing and the nursing management team.	F 867	identified concerns, and identifying, implementing, and monitoring the corrective action plan and recognizing when an action plan may need to be revised. The facility's QAPI Team will complete education for QAPI related activities as recommended by Alliant Health QIO. First education session was a Zoom call with the North Carolina Health Care Facilities Association on "Back to Basics – Root Cause Analysis – Plan of Corrections – Past Noncompliance" on 3/14/24. Additional education will be scheduled as needed and or per Allian Health QIO recommendations. QA monitoring will at least quarterly at QAPI meetings with results shared with Regional Clinical Services Coordinator to ensure quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies and monitoring of the corrective action plans and revising the corrective action plan as needed. Audit results will be reported to the QAPI Committee 2 quarters beginning on 4/10/24 and concerns will be reported to the Regional Clinical Services Coordinator for review input and changes as indicated. Continued compliance will be monitored	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345389	A. BUILDING _____ B. WING _____	C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 14	F 867	through the facility's Quality Assurance Performance Improvement Committee. Compliance will be monitored by the QA Committee and the Regional Clinical Coordinator for 2 quarters and deficient practice is resolved. Additional education/training/actions will be provided for any issues identified.	