STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 04/26/2024

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GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW HILL, NC 28580

(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 A complaint investigation survey was conducted 04/26/24. Event ID# HC0J11. The following intake was investigated NC00215906. 1 of the 1 complaint allegation resulted in deficiency. Past non-compliance was identified at: CFR 483.12 at tag F600 at a scope and severity (G) Non-compliance began on 04/06/24. The facility came back in compliance effective 04/12/24.	F 000		
F 580 SS=D	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, 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).	F 580		

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

Electronically Signed | 05/14/2024

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F 580	Continued From page 1 (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 §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 observations, record review, staff and Physician interviews the facility failed to notify the Physician of a residents change in condition when an injury of unknown source was identified. The resident was observed with unexplained bruising and swelling under the eye and x-rays confirmed a fracture of the bridge of the nasal bones. This occurred for 1 of 1 cognitively impaired resident (Resident #1) reviewed for an injury of unknown source and notification of the Physician.	F 580	Past noncompliance: no plan of correction required.	

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Findings included.

Resident #1 was admitted to the facility on 12/04/20.

The Minimum Data Set (MDS) quarterly assessment dated 03/15/24 revealed Resident #1 had severely impaired cognition.

An Investigation Report dated 04/08/24 revealed that on 04/06/24 Resident #1 presented with swelling and bruising of her nose and under her eyes. A full investigation was conducted on 04/08/24 and it was not determined how the resident sustained the injury. The investigation revealed at approximately 11:00 PM on 04/06/24 Nurse Aide #1 reported swelling on the bridge of Resident #1's nose. Nurse #2 was notified. An x-ray report dated 04/08/24 for Resident #1 revealed a minimally displaced fracture of the nasal bridge.

Review of Resident #1's progress notes from 04/06/24 through 04/08/24 revealed no evidence that the Physician was notified when the injury was identified.

During a phone interview on 04/26/24 at 5:20 PM Nurse #2 stated she came on shift at 11:00 PM on 04/06/24 and was the assigned nurse for Resident #1. She stated Nurse Aide #1 asked her to go down and look at Resident #1. She went down at that time and observed bruising and swelling underneath her left eye. Nurse #2 stated although her eye was bruised and swollen it did not look like a serious injury. She indicated she did not notify the Physician. She stated it was a small bruise with no open areas, and no bleeding

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or other signs of trauma, so she didn't think it was necessary to call the Physician. She stated she decided she would let the day shift nurse notify the Physician. She stated since the incident she had received in-service training on reporting injuries of unknown source immediately to the Director of Nursing and the Physician.

During an interview on 04/26/24 at 12:45 PM Nurse #1 stated she was Resident #1's assigned nurse on Saturday 04/06/24 from 7:00 AM through 11:00 PM. She stated when she left her shift on 04/06/24 at 11:00 PM there was no bruising, swelling, or injury. She stated she returned to work the next morning and Medication Aide #1 reported to her that Nurse Aide #1 reported that Resident #1 had a black and bruised eye. Nurse #1 stated Nurse #2 who was on duty during the night shift did not report anything to her regarding the injury. She indicated there was no record that the Physician was notified. She stated she called and informed the Director of Nursing (DON) about the unexplained injury sometime that day on 04/07/24 but thought it was before 5:00 PM and the DON stated she would take care of it. She indicated she did not notify the Physician of the injury. Nurse #1 stated since the incident she had received training on reporting a change in condition including notification of the Physician.

During an interview on 04/26/24 at 3:50 PM the Director of Nursing (DON) stated she was not made aware until Monday 04/08/24 of the injury of unknown source. She stated the Physician wasn't notified until 04/08/24 and ordered an x-ray which resulted in a nasal fracture. The DON indicated Nurse #2 who initially observed the bruising and swelling should have notified the

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Physician at that time regarding a change in condition due to unexplained bruising and swelling so that treatment decisions could be initiated. She stated Nurse #2 should have followed the facility protocol for injuries of unknown source which included to notify the DON and the Physician for further orders and that was not done.

During a phone interview on 04/26/24 at 4:40 PM the Physician stated he wasn't notified of the injury of unknown source until Monday 04/08/24. He stated he ordered an x-ray that showed a minimally displaced fracture to the nose. He reported he evaluated Resident #1 on Tuesday 04/09/24. He stated he should have been notified at least by the following day since the injury occurred at 11:00 PM at night. He stated there was no delay in treatment by doing the x-ray on Monday. He stated Resident #1 was evaluated by the Ear, Nose, & Throat (ENT) physician on 04/11/24 and from the outcome of that evaluation along with conversations with her Responsible Party it was decided that no treatment would be indicated for the nasal fracture.

During an interview on 04/26/24 at 6:00 PM the Administrator stated she was notified of the injury late in the day on 04/08/24. She indicated Nurse #2 should have reported the injury of unknow source on the night of 04/06/24 to the Director of Nursing and to the Physician. She stated education was provided to all nursing staff regarding monitoring for an acute change in condition including injuries of unknown source and including notification of the Physician. She stated an ad hoc Quality Assurance (QA) meeting was held on 04/09/24 and the decision was made by the Quality Assurance (QA) Committee to

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initiate a Performance Improvement Plan regarding this occurrence. She reported the Plan of Correction was initiated on 04/08/24 which included reporting of an acute change in condition to the DON, and Physician.

The Plan of Correction included:

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

On 04/08/24 Resident #1 was assessed by the Director of Nursing. Resident #1 was noted to have bilateral bruising under her eyes and across the bridge of her nose.

On 04/08/24 the physician was notified, an x-ray was ordered which resulted in a minimally displaced fracture of the nasal bridge.

On 04/08/24 through 04/09/24 progress notes were reviewed for the last 7 days to ensure documented acute change in condition to include new/worsening pain, bruising, or signs of a fracture were assessed and reported timely to the physician, and the DON. There were no concerns identified.

On 04/09/24 through 04/10/24 education was conducted with all nursing staff regarding the facility's abuse and neglect policy and reporting changes in condition to the DON and Physician.

On 04/09/24 Resident #1 was evaluated by the Physician. There was no new treatment implemented.

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

On 04/08/24 the DON and Staff Facilitator performed skin assessments on cognitively impaired residents to ensure that any concerns or change in condition had been assessed, and interventions initiated if indicated, and the physician notified for further recommendations, with documentation in the electronic medical record. There were no negative findings.

On 04/08/24 the DON and Staff Facilitator initiated questionnaires of all alert and oriented residents regarding new/worsening pain, injuries not reported to the nurse, and signs/symptoms of a fracture. The questionnaire was to ensure that any concerns or change in condition had been assessed, and interventions initiated if indicated, and the physician notified for further recommendations, with documentation in the electronic medical record. There were no negative findings.

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

On 04/09/24 the DON and Staff Facilitator initiated education with all nursing staff regarding notification of an acute change including notification of the physician for further recommendations, and to include documentation in the medical record. Education was completed

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by 04/10/24 . After 04/10/24 any staff who had not completed their education would be required to do so prior to the next shift. Newly hired staff would be educated during orientation.

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

The decision to monitor and take to QA was 04/08/24.

The unit managers will review progress notes 5 times per week for 4 weeks utilizing the acute change auditing tool. The unit manager will address any concerns identified.

The Social Worker will complete 5 resident questionaries weekly for 4 weeks to identify any concerns. The unit managers will address any concerns identified.

The Administrator and DON will review the audits weekly for 4 weeks to ensure all areas of concern were addressed appropriately.

The Administrator or DON will present the findings of the audit tools/questionaries to the QAPI committee for 1 month to review and to determine trends or issues, or the need for continued monitoring.

A QAPI (Quality Assurance Performance Improvement) meeting was held again on 04/16/24 with the Interdisciplinary team where the plan of correction was discussed.

The facility alleged compliance with the corrective

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F 580	Continued From page 8 action plan on 04/12/24. Validation of the corrective action was completed on 04/26/24. This included staff interviews regarding the incident, and in-service training that was received to ensure understanding and knowledge of the training provided. The initial audits were verified. There were no concerns identified. The corrective action plan was validated to be completed as of 04/12/24.	F 580		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and Physician interviews, the facility failed to protect the resident's right to be free from injury of unknown source that resulted in bruising under the eyes and a fracture of the bridge of the nasal bones. This occurred for 1 of 1 cognitively impaired resident reviewed for an injury of unknown source. (Resident #1)	F 600	Past noncompliance: no plan of correction required.	

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Findings included.

Resident #1 was admitted to the facility on 12/04/20 with diagnoses including in part cerebral vascular accident (CVA), quadriplegia, and dementia.

The Minimum Data Set (MDS) quarterly assessment dated 03/15/24 revealed Resident #1 had severely impaired cognition. She exhibited no physical or verbal behaviors directed toward others (e.g. hitting, kicking, grabbing, or yelling). She exhibited no other behaviors such as hitting or scratching herself. She required total dependent care by staff for activities of daily living (ADLs). She had no falls and received anticoagulant (prevents clot formation) medications. She had no rejection of care.

An Investigation Report dated 04/08/24 revealed that on 04/06/24 Resident #1 presented with swelling and bruising of her nose and under her eyes. A full investigation was conducted on 04/08/24 and it was not determined how the resident sustained the injury. The investigation revealed at approximately 11:00 PM on 04/06/24 Nurse Aide #1 reported swelling on the bridge of Resident #1's nose. Nurse #2 was notified. Nurse #2 instructed Nurse Aide #1 to apply an ice pack to her face. Nurse #2 indicated she administered Tylenol. Nurse Aide #1 stated Resident #1's nose continued to swell and appeared bruised. An x-ray report dated 04/08/24 for Resident #1 revealed a minimally displaced fracture of the nasal bridge.

Review of Resident #1's progress notes from 04/05/24 the day prior to the appearance of

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bruising and swelling under the eyes and the nasal bridge through 04/0624 at 11:00 PM when the injury was identified revealed no documentation of an injury that occurred. There were no reported falls.

Review of the Medication Administration Record (MAR) dated April 2024 revealed Resident #1 received scheduled Plavix (prevents blood clot formation) 75 milligrams (mg) every morning for anticoagulation therapy. A known side effect of this medication included bruising.

During an observation on 04/26/24 at 11:30 AM of Resident #1 was observed lying in bed. She was oriented to person only. She could not verbalize the cause of her injury. She was noted to have a small yellow discolored area under her left eye suggestive of an old bruise. A full skin assessment was observed with the assigned nurse. There were no further injuries noted.

During an interview on 04/26/24 at 11:45 AM Resident #1's roommate who was alert and oriented reported the bruising suddenly appeared under her eyes, but she didn't know what happened. She indicted she had never witnessed any staff member mistreating Resident #1. She stated Resident #1 had dementia and was resistive to care at times, but she had not witnessed her falling from bed or having any accidents related to her injury.

During a phone interview on 04/26/24 at 5:20 PM Nurse #2 stated she came on shift at 11:00 PM on 04/06/24 and was the assigned nurse for Resident #1. She stated Nurse Aide #1 asked her to go down and look at Resident #1. She went down at that time and observed bruising and

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swelling underneath her left eye. Resident #1 was not able to verbalize what caused the injury. She stated she did not receive any report from the day shift nurse (Nurse #1) who reported to her when she came on duty regarding an injury. She reported that Resident #1 received anticoagulant medication, so she wasn't alarmed because the bruising and swelling was a small area. She asked Resident #1 if her face "bothered" her and she said "yes". She reported she administered Tylenol 650 milligrams once at that time and applied an ice pack. Nurse #2 stated although her eye was bruised and swollen it did not look like a serious injury. She asked Nurse Aide #1 what happened, and she could not provide an answer. She stated when Nurse #1 came in the next day, she mentioned it to her, but Nurse #1 didn't know what could have happened to cause the injury. She stated she gave Nurse #1 report and went home. She stated it was a small bruise with no open areas, and no bleeding or other signs of trauma. She stated she decided she would let the day shift nurse notify the doctor. She stated since the incident she had received in service training on reporting injuries of unknown source, abuse training, and monitoring for an acute change in condition.

During an interview on 04/26/24 at 12:45 PM Nurse #1 stated she was Resident #1's assigned nurse on Saturday 04/06/24 from 7:00 AM through 11:00 PM. She stated when she left her shift on 04/06/24 at 11:00 PM there was no bruising, swelling, or injury. She stated Nurse Aide #1 reported to her earlier that day around 4:00 PM on 04/06/24 that Resident #1 had blood on her gown. She assessed Resident #1 and observed blood coming from her mouth and determined she had bitten her tongue. They

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cleaned her mouth and held pressure and the bleeding stopped. Nurse #1 reported she left the room and finished her medication pass. Before leaving her shift at 11:00 PM she reported Resident #1 did not have anything wrong with her face and her mouth was not bleeding, and there was no bruising or swelling. She stated she returned to work the next morning and Medication Aide #1 reported to her that Nurse Aide #1 reported that Resident #1 had a black and bruised eye. Nurse #1 stated Nurse #2 who was on duty during the night shift, did not report anything to her regarding the injury. Nurse #1 stated she assessed Resident #1 just after 7:00 AM and noted that her left eye was bruised and red. She reported she reviewed her electronic medical record and there was no documentation as to what happened. She stated she called and informed the Director of Nursing (DON) about the unexplained injury sometime that day on 04/07/24 but thought it was before 5:00 PM and the DON stated she would take care of it. She reported Resident #1 never complained of pain on 04/07/24. She indicated that although Resident #1 had dementia she was oriented to person and could voice her needs. She stated Resident #1 had been in the facility for years and did not have a history of falls that she was aware of. She stated Resident #1 would tense up when turning her and providing care. She required total care by staff and used the mechanical lift for transfers but stayed in bed most of the time. She stated Resident #1 would push staff away at times when they attempted to administer medications or provide care. She stated Resident #1 was not able to turn or reposition herself without assistance. She stated since the incident Resident #1 had no changes in her behavior and remained at baseline. Nurse #1 stated since the

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incident she had received training on monitoring for an acute change in condition, abuse training, and reporting a change in condition, reporting skin issues, and signs and symptoms of fractures.

During an interview on 04/26/24 at 1:20 PM Nurse Aide #1 stated she worked a double shift on 04/06/24 from 3:00 PM through 7:00 AM on 04/07/24 and was assigned to Resident #1. She stated when she arrived for work around 3:30 PM she provided incontinence care and saw a speck of blood on her gown near her neckline. She called for Nurse #1 to look at her. There were no skin tears and at that moment she started spitting out a small amount of blood. She thought she may be losing a tooth. The nurse assessed her and thought she bit her tongue and instructed her to get her cleaned up. She stated Resident #1 had no complaints of pain and they checked her teeth to make sure none were loose. Resident #1 seemed okay, and she continued on with her shift. Later that evening around 11:30 PM she noticed Resident #1's face turning red, and she had bruising under her eyes. She reported this to Nurse #2, the oncoming 11:00 PM to 7:00 AM nurse. Nurse #2 went in around 11:15 PM and told her to get an ice pack and put the ice pack on her face for 1 hour. Nurse Aide #1 went back to remove the ice pack an hour later and noticed her eye was getting darker on both sides under her eyes. She reported this to Nurse #2 right away and the nurse told her she was going to leave it for the morning nurse at 7:00 AM since it was late. She indicated she was not given any further instruction that night from Nurse #2. She stated Resident #1 required total care and used the mechanical lift for transfers. She indicated she could not turn or reposition herself without staff

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assistance. She was disoriented most of the time. She stated she was called in to work the next week during the investigation and was told that Resident #1 had a broken nose. She stated she had no idea of how the injury occurred. She stated she received in-service training regarding abuse and reporting injuries.

During an interview on 4/26/24 at 1:50 PM Nurse Aide #2 stated she worked Saturday 04/06/24 from 7:00 AM to 10:00 PM and was assigned to Resident #1 from 7:00 AM until 3:00 PM. She stated after she arrived for her shift, she checked on her residents and reported nothing unusual regarding Resident #1. She reported there was no redness, or bruising. She gave her a bath around 10:30 AM Saturday morning. She moved her bed away from the wall due to her pushing against the wall and resisting when trying to change or reposition her. She stated she acts as though she doesn't like to be repositioned, so she uses her arms to block. She indicated Resident #1 could not turn and reposition without staff assistance. She reported she did not have bed rails on the bed. She gave the bath, repositioned her, and sat her up in the bed to get ready for lunch at that time and there was nothing unusual noticed. She checked on her again at lunch and nothing was unusual. She went in her room again around 2:30 - 2:45 PM to change her and there were no signs of bruising or swelling. She stated around 3:15 PM the nurse aide for 2nd shift reported her mouth was bleeding. Nurse #1 told her she had just checked her, and nothing was wrong with her mouth. She stated she was surprised to hear of her mouth bleeding because she had just left her at 2:45 PM and she was fine. She stated at 3:00 PM she changed assignments

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and only saw her at a glance later that day. When she returned to work Sunday morning, she was assigned to Resident #1 again. When she went in to see her at the beginning of her shift she had two black eyes. She stated she immediately reported it to Nurse #1. Nurse #1 went in to assess her and didn't know what had happened. She stated she thought the injury happened overnight. She stated she received in service training since this incident on abuse turning and repositioning, falls, skin tears, reporting changes in behaviors, and reporting signs of bruising.

During an interview on 4/26/24 at 1:00 PM Nurse Aide #3 stated she worked on Friday 04/05/24 from 7:00 AM until 3:00 PM the day prior to the reported injury and was assigned to Resident #1. She reported there was no bruising or swelling observed during that time. She didn't know how the injury occurred but was later told she had a broken nose. She stated Resident #1 was total care and required the mechanical lift with 2-person assistance for transfers. She was cooperative with care most days, but she did try to pull on your clothes or would push against the wall when you tried to turn and reposition her or provide any care for her. She stated she typically moved her bed slightly from the wall during care, so she didn't push against the wall, but stated she always pushed the bed back against the wall following care. She stated Resident #1 had dementia but could voice her needs. She had no complaints of pain and no history of falls that she was aware of. She reported it was never determined what caused the injury. She stated she received in-service training on abuse, sliding residents in bed, signs, and symptoms of fractures, and reporting injuries.

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During a phone interview on 04/26/24 at 4:40 PM the Physician stated he was notified of the injury of unknown source on Monday 04/08/24. He stated he ordered an x-ray that showed a minimally displaced fracture to the nose. He reported he evaluated Resident #1 on Tuesday 04/07/24 and interviewed staff and her roommate and asked if she had been dropped or fallen. He stated he could not determine how the injury occurred. He reported Resident #1 had been bedridden for many years. He stated there was no delay in treatment by doing the x-ray on Monday. He stated Resident #1 was evaluated by the Ear, Nose, & Throat (ENT) physician on 04/11/24 and from the outcome of that evaluation along with conversations with her Responsible Party it was decided that no treatment would be indicated for the nasal fracture.

During an interview on 04/26/24 at 3:50 PM the Director of Nursing (DON) stated she was not made aware until Monday 04/08/24 of the injury of unknown source. She reported she found out about Resident #1's injury on Monday morning from either a nurse or nurse aide but could not recall exactly. She went to assess Resident #1's nose and she had bilateral bruising under her eyes and across the bridge of her nose. She started an investigation at that time and the Responsible Party was notified. She stated the Physician was notified on 04/08/24 and ordered an x-ray which resulted in a nasal fracture. The Physician evaluated her on 04/09/24. Resident #1 was evaluated by an Ear, Nose, and Throat (ENT) physician on 04/11/24. She stated the Police came on 04/08/24 and talked with Resident #1 and her roommate. The Police determined no foul play and could not determine what caused the injury.

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During an interview on 04/26/24 at 6:00 PM the Administrator stated she was notified of the injury late in the day on 04/08/24. She stated an investigation was initiated at that time related to the injury. She stated the Physician, and the Responsible Party were made aware immediately. She stated an x-ray was ordered and showed the nasal fracture. She stated staff statements were obtained during their investigation. Resident interviews were conducted regarding abuse, or injuries that had not been reported and no concerns were identified. She stated they could not determine how the fracture occurred and thought she could have turned into the wall. She stated since the incident they have placed a pad between her bed and the wall. She stated education was provided to all nursing staff regarding the provision of care including abuse training, and monitoring for an acute change in condition including injuries of unknown source. She stated an ad hoc Quality Assurance (QA) meeting was held on 04/09/24 and the decision was made by the Quality Assurance (QA) Committee to initiate a Performance Improvement Plan regarding this occurrence. She reported the Plan of Correction was initiated on 04/08/24 which included monitoring for an acute change in condition to include new bruising, pain, or injury of unknown source. Reporting of an acute change in condition to the DON, physician, and the Responsible Party, and follow through of interventions and monitoring for a change in condition.

The Plan of Correction included:

Address how corrective action will be accomplished for those residents found to have

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been affected by the deficient practice;

On 04/08/24 Resident #1 was assessed by the Director of Nursing. Resident #1 was noted to have bilateral bruising under her eyes and across the bridge of her nose.

On 04/08/24 the physician was notified, an x-ray was ordered which resulted in a minimally displaced fracture of the nasal bridge. The Responsible Party was notified.

On 04/08/24 Adult Protective Services and law enforcement were notified.

On 04/08/24 through 04/09/24 interviews were conducted with all alert and oriented residents regarding resident abuse and how to report abuse and neglect, and injuries of unknown source. There were no concerns identified.

On 04/08/24 through 04/09/24 skin assessments were completed on all non-alert and oriented residents for signs of abuse and neglect. There were no concerns identified.

On 04/08/24 through 04/09/24 grievance logs were reviewed for the past 30 days to ensure all allegations were reported timely. There were no concerns identified.

On 04/08/24 through 04/09/24progress notes were reviewed for the last 7 days to ensure documented acute change in condition to include new/worsening pain, bruising, or signs of a fracture were assessed and reported timely to the physician, DON, and Responsible Party. There were no concerns identified.

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F 600	Continued From page 19 On 04/08/24 the Administrator, and the Director of Nursing were educated by the Clinical Director regarding reportable events including injuries of unknown source or events that were suspicious of a crime and it must be reported to the State Agency within 2 hours. On 04/09/24 through 04/10/24 education was conducted with all nursing staff regarding the facility's abuse and neglect policy, reporting changes in condition, interventions for an acute change in condition, signs/symptoms of fractures, performing neurological checks, and turning and repositioning residents. On 04/09/24 Resident #1 was evaluated by the Physician. There was no new treatment implemented. On 04/11/24 Resident #1 was evaluated by the Ear, Nose, & Throat (ENT) physician. There was no new treatment implemented. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 04/08/24 the DON and Staff Facilitator performed skin assessments on cognitively impaired residents to ensure that any concerns or change in condition had been assessed, and interventions initiated if indicated, and the physician notified for further recommendations, and the Responsible Party had been notified with documentation in the electronic medical record. There were no negative findings. There were no negative findings.	F 600		

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F 600	Continued From page 20 On 04/08/24 the DON and Staff Facilitator initiated questionnaires of all alert and oriented residents regarding new/worsening pain, injuries not reported to the nurse, and signs/symptoms of a fracture. The questionnaire was to ensure that any concerns or change in condition had been assessed, and interventions initiated if indicated, and the physician notified for further recommendations, and the Responsible Party had been notified with documentation in the electronic medical record. There were no negative findings. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 04/09/24 the DON and Staff Facilitator initiated education with all nursing staff regarding abuse, notification of an acute change with emphasis on assessing a change to include new/worsening pain, signs of a fracture, obtaining vital signs, initiating interventions for an acute change, notification of the physician for further recommendations, and notifying the responsible party to include documentation in the medical record. Education was provided on signs/symptoms of a fracture to include bruising and swelling. Completing neurological checks per the standing order for all known or suspected head injuries or unwitnessed fall. Education was completed by 04/10/24 . After 04/10/24 any staff who had not completed their education would be required to do so prior to the next shift. Newly hired staff would be educated during orientation.	F 600		

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

The decision to monitor and take to QA was made on 04/09/24.

The unit managers will review progress notes 5 times per week for 4 weeks utilizing the acute change auditing tool. The unit manager will address any concerns identified.

The Social Worker will complete 5 resident questionaries weekly for 4 weeks to identify any concerns. The unit managers will address any concerns identified.

The Administrator and DON will review the audits weekly for 4 weeks to ensure all areas of concern were addressed appropriately.

The Administrator or DON will present the findings of the audit tools/questionaries to the QAPI committee for 1 month to review and to determine trends or issues, or the need for continued monitoring.

A QAPI (Quality Assurance Performance Improvement) meeting was held again on 04/16/24 with the Interdisciplinary team where the plan of correction was discussed.

The facility alleged compliance with the corrective action plan on 04/12/24.

Validation of the corrective action was completed on 04/26/24. This included staff interviews regarding the incident, and in-service training that

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F 600	Continued From page 22 was received to ensure understanding and knowledge of the training provided. The initial audits were verified. There were no concerns identified.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by:	F 607		

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F 607	Continued From page 23 Based on record review and staff interviews the facility failed to implement their policy for injuries of unknown source that required facility staff to immediately report the injury to facility management. A staff member failed to report unexplained bruising under the eyes and over the nose to facility management as soon as the injury was observed for 1 of 1 residents (Resident #1) reviewed for injuries of unknown source. Findings included. The facility policy dated 11/28/18 included an action checklist for injuries of unknown source. The checklist included in part to notify the Administrator and/or the Director of Nursing immediately of an incident. Resident #1 was admitted to the facility on 12/04/20 with diagnoses including in part cerebral vascular accident (CVA), quadriplegia, and dementia. The Minimum Data Set (MDS) quarterly assessment dated 03/15/24 revealed Resident #1 had severely impaired cognition. She required total dependent care with activities of daily living. An Investigation Report dated 04/08/24 revealed that on 04/06/24 Resident #1 presented with swelling and bruising of her nose and under her eyes. A full investigation was conducted on 04/08/24 and it was not determined how the resident sustained the injury. The investigation revealed at approximately 11:00 PM on 04/06/24 Nurse Aide #1 reported swelling on the bridge of Resident #1's nose. Nurse #2 was notified. Nurse #2 instructed Nurse Aide #1	F 607	Past noncompliance: no plan of correction required.	

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to apply an ice pack to her face. Nurse #2 indicated she administered Tylenol. Nurse Aide #1 stated Resident #1's nose continued to swell and appeared bruised. An x-ray report dated 04/08/24 for Resident #1 revealed a minimally displaced fracture of the nasal bridge.

During a phone interview on 04/26/24 at 5:20 PM Nurse #2 stated she came on shift at 11:00 PM on 04/06/24 and was the assigned nurse for Resident #1. She stated Nurse Aide #1 asked her to go down and look at Resident #1. She went down at that time and observed bruising and swelling underneath her left eye. She stated Resident #1 was not able to verbalize what caused the injury. She stated she did not receive any report from Nurse #1 regarding an injury. She reported that Resident #1 received anticoagulant medication, so she wasn't alarmed because the bruising and swelling was a small area. She asked Resident #1 if her face "bothered" her and she said "yes". She reported she administered Tylenol 650 milligrams once at that time and applied an ice pack. Nurse #2 stated although her eye was bruised and swollen it did not look like a serious injury. She asked Nurse Aide #1 what happened, and she could not provide an answer. She stated she didn't think about doing anything else that night to address the unexplained injury. She stated when Nurse #1 came in the next day, she mentioned it to her, but Nurse #1 didn't go into any details of what could have happened to cause the injury. She stated she did not notify the Administrator or the Director of Nursing regarding the injury of unknown source. She stated it was a small bruise with no open areas, and no bleeding or other signs of trauma, so she didn't think it was necessary. She stated she decided she would let the day shift

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nurse notify the doctor. She stated since the incident she had received in service training on reporting injuries of unknown source.

During an interview on 04/26/24 at 12:45 PM Nurse #1 stated she was Resident #1's assigned nurse on Saturday 04/06/24 from 7:00 AM through 11:00 PM. She stated when she left her shift on 04/06/24 at 11:00 PM there was no bruising, swelling, or injury. She stated she returned to work the next morning and Medication Aide #1 reported to her that Nurse Aide #1 reported that Resident #1 had a black and bruised eye. Nurse #1 stated Nurse #2 who was on duty during the night shift, did not report anything to her regarding the injury. Nurse #1 stated she assessed Resident #1 just after 7:00 AM and noted that her left eye was bruised and red. She reported she reviewed her electronic medical record and there was no documentation as to what happened. She stated she called and informed the Director of Nursing (DON) about the unexplained injury sometime that day on 04/07/24 but thought it was before 5:00 PM and the DON stated she would take care of it. She stated she was busy that day and that was why the DON was not notified sooner. Nurse #1 stated since the incident she had received training on reporting a change in condition. She stated she should have completed an incident report when she observed the facial bruising and swelling on the morning of 04/07/24 and notified the DON right away since she was uncertain if the night shift nurse had reported it.

During an interview on 04/26/24 at 3:50 PM the Director of Nursing (DON) stated she was not made aware until Monday 04/08/24 of the injury of unknown source. She reported she found out

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about Resident #1's injury on Monday morning from either a nurse or nurse aide but could not recall exactly. She went to assess Resident #1's nose and she had bilateral bruising under her eyes and across the bridge of her nose. She started an investigation at that time. She stated the Physician was notified on 04/08/24 and ordered an x-ray which resulted in a nasal fracture. The DON stated Nurse #2 who initially observed the bruising and swelling should have notified her right away. She stated Nurse #2 should have followed the facility protocol for injuries of unknown source which included to notify the Administrator or the DON immediately and that was not done.

During an interview on 04/26/24 at 6:00 PM the Administrator stated she was notified of the injury late in the day on 04/08/24. She indicated Nurse #2 should have reported the injury of unknow source to her or the Director of Nursing (DON) on the night of 04/06/24. She stated education was provided to all nursing staff regarding notifying facility management of injuries of unknown source. She stated education was provided to nursing staff on reporting injuries of unknown source immediately and the protocol on what to do when an injury was identified. She stated a full investigation was completed and it was never determined how the injury occurred. She stated an ad hoc Quality Assurance (QA) meeting was held on 04/09/24 and the decision was made by the Quality Assurance (QA) Committee to initiate a Performance Improvement Plan regarding this occurrence. She reported the Plan of Correction was initiated on 04/08/24 which included reporting injuries of unknown source.

The Plan of Correction included.

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

On 04/08/24 Resident #1 was assessed by the Director of Nursing. Resident #1 was noted to have bilateral bruising under her eyes and across the bridge of her nose.

On 04/08/24 the physician was notified, an x-ray was ordered which resulted in a minimally displaced fracture of the nasal bridge. The Responsible Party was notified.

On 04/08/24 through 04/09/24 interviews were conducted with all alert and oriented residents regarding resident abuse and how to report abuse and neglect, and injuries of unknown source. There were no concerns identified.

On 04/08/24 through 04/09/24 grievance logs were reviewed for the past 30 days to ensure all allegations were reported timely. There were no concerns identified.

On 04/08/24 through 04/09/24progress notes were reviewed for the last 7 days to ensure documented acute change in condition to include injuries of unknown source were assessed and reported timely to the physician, DON, and Responsible Party. There were no concerns identified.

On 04/08/24 the Administrator, and the Director of Nursing were educated by the Clinical Director regarding reportable events including injuries of unknown source or events that were suspicious of a crime and it must be reported to the State

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F 607	Continued From page 28 Agency within 2 hours. On 04/09/24 through 04/10/24 education was conducted with all nursing staff regarding the facility's abuse and neglect policy, reporting changes in condition including injuries of unknown source. On 04/09/24 Resident #1 was evaluated by the Physician. There was no new treatment implemented. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 04/08/24 the DON and Staff Facilitator performed skin assessments on cognitively impaired residents to ensure that any concerns or change in condition had been assessed, and interventions initiated if indicated, and the physician notified for further recommendations, and the Responsible Party had been notified with documentation in the electronic medical record. There were no negative findings. On 04/08/24 the DON and Staff Facilitator initiated questionnaires of all alert and oriented residents regarding new/worsening pain, injuries not reported to the nurse, and signs/symptoms of a fracture. The questionnaire was to ensure that any concerns or change in condition had been assessed, and interventions initiated if indicated, and the physician notified for further recommendations, and the Responsible Party had been notified with documentation in the electronic medical record. There were no	F 607		

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negative findings.

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

On 04/09/24 the DON and Staff Facilitator initiated education with all nursing staff regarding notification of an acute change with emphasis on assessing a change to include new/worsening pain, signs of a fracture, obtaining vital signs, initiating interventions for an acute change, notification of the physician for further recommendations, and notifying the responsible party to include documentation in the medical record. Education was provided on signs/symptoms of a fracture to include bruising and swelling. Completing neurological checks per the standing order for all known or suspected head injuries or unwitnessed fall. Education was completed by 04/10/24 . After 04/10/24 any staff who had not completed their education would be required to do so prior to the next shift. Newly hired staff would be educated during orientation.

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

The unit managers will review progress notes 5 times per week for 4 weeks utilizing the acute change auditing tool. The unit manager will address any concerns identified.

The Social Worker will complete 5 resident questionaries weekly for 4 weeks to identify any concerns. The unit managers will address any

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F 607	Continued From page 30 concerns identified. The Administrator and DON will review the audits weekly for 4 weeks to ensure all areas of concern were addressed appropriately. The Administrator or DON will present the findings of the audit tools/questionaries to the QAPI committee for 1 month to review and to determine trends or issues, or the need for continued monitoring. A QAPI (Quality Assurance Performance Improvement) meeting was held again on 04/16/24 with the Interdisciplinary team where the plan of correction was discussed. The facility alleged compliance with the corrective action plan on 04/12/24. Validation of the corrective action was completed on 04/26/24. This included staff interviews regarding the incident, and in-service training that was received to ensure understanding and knowledge of the training provided. The initial audits were verified. There were no concerns identified.	F 607		
F 684 SS=D	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	F 684		

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F 684	Continued From page 31 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Physician interviews the facility failed to monitor a resident following the identification of an injury of unknown source that resulted in bruising and a fracture of the nasal bridge. Neurological checks were not conducted following the unwitnessed head injury, vital signs were not obtained, and pain assessments were not conducted. This occurred for 1 of 1 cognitively impaired resident reviewed for an injury of unknown source. (Resident #1) Findings included. Resident #1 was admitted to the facility on 12/04/20 with diagnoses including in part cerebral vascular accident (CVA), quadriplegia, and dementia. The Minimum Data Set (MDS) quarterly assessment dated 03/15/24 revealed Resident #1 had severely impaired cognition. She exhibited no physical or verbal behaviors directed toward others (e.g. hitting, kicking, grabbing, or yelling). She exhibited no other behaviors such as hitting or scratching herself. She required total dependent care by staff for activities of daily living (ADLs). She had no falls and received anticoagulant (blood thinning) medications. She had no rejection of care. An Investigation Report dated 04/08/24 revealed that on 04/06/24 Resident #1 presented with swelling and bruising of her nose and under her eyes. A full investigation was conducted on 04/08/24 and it was not determined how the resident sustained the injury. The investigation	F 684	Past noncompliance: no plan of correction required.	

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revealed at approximately 11:00 PM on 04/06/24 Nurse Aide #1 reported swelling on the bridge of Resident #1's nose. Nurse #2 was notified. Nurse #2 instructed Nurse Aide #1 to apply an ice pack to her face. Nurse #2 indicated she administered Tylenol. Nurse Aide #1 stated Resident #1's nose continued to swell and appeared bruised. An x-ray report dated 04/08/24 for Resident #1 revealed a minimally displaced fracture of the nasal bridge.

Review of Resident #1's progress notes from 04/06/24 through 04/08/24 revealed no documentation of an injury. There was no documentation of the swelling and bruising that was observed on 04/06/24. There was no documentation that neurological checks were conducted for an unwitnessed head injury, or that vital signs were obtained. There was no record of pain assessments or that as needed Tylenol was administered.

Review of the Medication Administration Record (MAR) dated April 2024 revealed Resident #1 received scheduled Plavix (a medication to prevent clot formation) 75 milligrams (mg) every morning for anticoagulation therapy. A known side effect of this medication included bruising.

Review of the Medication Administration Record (MAR) dated April 2024 revealed Resident #1 had an order to administer Tylenol 650 mgs every 4 hours as needed for pain. There was no documentation that Tylenol was administered to Resident #1 from 04/06/24 through 04/11/24.

An observation was conducted on 04/26/24 at 11:30 AM of Resident #1. She was observed lying in bed. She was oriented to person only. She

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could not verbalize the cause of her injury. She was noted to have a small yellow area under her left eye suggestive of an old bruise. A full skin assessment was observed with the assigned nurse. There were no further injuries noted.

During a phone interview on 04/26/24 at 5:20 PM Nurse #2 stated she came on shift at 11:00 PM on 04/06/24 and was the assigned nurse for Resident #1. She stated Nurse Aide #1 asked her to go down and look at Resident #1. She went down at that time and observed bruising and swelling underneath her left eye. She stated Resident #1 was not able to verbalize what caused the injury. She stated she did not receive any report from Nurse #1 regarding an injury. She reported that Resident #1 received anticoagulant medication, so she wasn't alarmed because the bruising and swelling was a small area. She asked Resident #1 if her face "bothered" her and she said "yes". She reported she administered Tylenol 650 mgs. once at that time and applied an ice pack. Nurse #2 stated although her eye was bruised and swollen it did not look like a serious injury. She asked Nurse Aide #1 what happened, and she could not provide an answer. She stated she didn't think about doing anything else that night to address the unexplained injury. She indicated she did not complete neurological checks to determine any concerns such as ongoing headache, dizziness, or difficulty speaking. She asked Nurse Aide #1 to obtain vital signs, but stated she did not know if the vital signs were ever obtained, and she did not follow up with the nurse aide. She stated she did not receive any further reports during the shift that Resident #1 had ongoing pain but indicated she did not provide further monitoring to address her

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pain. She reported she wanted to speak to Nurse #1 who worked on 04/06/24 to find out if she had observed anything. She stated when Nurse #1 came in the next day, she mentioned it to her, but Nurse #1 didn't go into any details of what could have happened to cause the injury. She stated she gave Nurse #1 report and went home. She stated outside of the paperwork she was instructed to fill out on Monday 04/08/24 regarding the injury of unknown source, she didn't do any paperwork or notification on the night the area was first observed. She stated she did not notify the Director of Nursing regarding the injury of unknown source and did not notify the Physician or Resident #1's Responsible Party. She stated it was a small bruise with no open areas, and no bleeding or other signs of trauma, so she didn't think it was necessary to call the physician. She stated she decided she would let the day shift nurse notify the doctor. She stated since the incident she had received in service training on reporting injuries of unknown source, monitoring for an acute change in condition including conducting neurological checks, obtaining vital signs, and conducting pain assessments.

During an interview on 04/26/24 at 12:45 PM Nurse #1 stated she was Resident #1's assigned nurse on Saturday 04/06/24 from 7:00 AM through 11:00 PM. She stated when she left her shift on 04/06/24 at 11:00 PM there was no bruising, swelling, or injury. She stated Nurse Aide #1 reported to her earlier that day around 4:00 PM on 04/06/24 that Resident #1 had blood on her gown. She assessed Resident #1 and observed blood coming from her mouth and determined she had bitten her tongue. They cleaned her mouth and held pressure and the

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bleeding stopped. Nurse #1 reported she left the room and finished her medication pass. Before leaving her shift at 11:00 PM she reported Resident #1 did not have anything wrong with her face and her mouth was not bleeding. There was no bruising or swelling. She stated she returned to work the next morning and Medication Aide #1 reported to her that Nurse Aide #1 reported that Resident #1 had a black and bruised eye. Nurse #1 stated Nurse #2 who was on duty during the night shift, did not report anything to her regarding the injury. Nurse #1 stated she assessed Resident #1 just after 7:00 AM and noted that her left eye was bruised and red. She reported she reviewed her electronic medical record and there was no documentation as to what happened. She stated she called and informed the Director of Nursing (DON) about the unexplained injury sometime that day on 04/07/24 but thought it was before 5:00 PM and the DON stated she would take care of it. She stated she was busy that day and that was why the DON was not notified sooner. She reported Resident #1 never complained of pain on 04/07/24. She indicated that although Resident #1 had dementia she was oriented to person and could voice her needs. She stated Resident #1 had been in the facility for years and did not have a history of falls that she was aware of. She stated Resident #1 would tense up when turning her and providing care. She stated she required total care by staff and required the mechanical lift for transfers but stayed in bed most of the time. She stated Resident #1 would push staff away at times when they attempted to administer medications or provide care. She stated since the incident Resident #1 had no changes in her behavior and remained at baseline. Nurse #1 stated since the incident she had received training on monitoring

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for an acute change in condition, and reporting a change in condition, reporting skin issues, and signs and symptoms of fractures. She stated in hindsight she should have completed an incident report when she observed the facial bruising and swelling on the morning of 04/07/24 and notified the DON right away since she was uncertain if the night shift nurse had reported it.

During an interview on 04/26/24 at 1:20 PM Nurse Aide #1 stated she worked a double shift on 04/06/24 from 3:00 PM through 7:00 AM on 04/07/24 and was assigned to Resident #1. She stated when she arrived for work around 3:30 PM she provided incontinence care and saw a speck of blood on her gown near her neckline. She called for Nurse #1 to look at her. There were no skin tears and at that moment she started spitting out a small amount of blood. She thought she may be losing a tooth. The nurse assessed her and thought she bit her tongue and instructed her to get her cleaned up. She stated Resident #1 had no complaints of pain and they checked her teeth to make sure none were loose. Resident #1 seemed okay, and she continued on with her shift. Later that evening around 11:30 PM she noticed Resident #1's face was turning red and had bruising under her eyes. She reported this to Nurse #2, the oncoming 11:00 PM to 7:00 AM nurse. Nurse #2 went in around 11:15 PM and told her to get an ice pack and put the ice pack on her face for 1 hour. Nurse Aide #1 went back to remove the ice pack an hour later and noticed her eye was getting darker on both sides under her eyes. She reported this to Nurse #2 right away and the nurse told her she was going to leave it for the morning nurse at 7:00 AM since it was late. She indicated she was not given any further instruction that night from Nurse #2. She stated

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she was called in to work the next week during the investigation and was told that Resident #1 had a broken nose. She stated she had no idea of how the injury occurred. She stated she received in-service training regarding reporting injuries such as a change in behavior and reporting bruising and swelling.

During an interview on 04/26/24 at 3:50 PM the Director of Nursing (DON) stated she was not made aware until Monday 04/08/24 of the injury of unknown source. She reported she found out about Resident #1's injury on Monday morning from either a nurse or nurse aide but could not recall exactly. She went to assess Resident #1's nose and she had bilateral bruising under her eyes and across the bridge of her nose. She started an investigation at that time and the Responsible Party was notified. She stated the Physician was notified on 04/08/24 and ordered an x-ray which resulted in a nasal fracture. The physician evaluated her on 04/09/24. Resident #1 was evaluated by an Ear, Nose, and Throat (ENT) physician on 04/11/24. The DON stated Nurse #2 who initially observed the bruising and swelling should have notified her right away. She stated Nurse #2 should have followed the facility protocol for injuries of unknown source which included to notify the DON, and the Physician for further orders and that was not done. She stated there was no record that Nurse #2 provided monitoring on the night shift after the injury was identified. She stated there were no neurological checks, and no record of vital signs. She stated nurses must initiate neurological checks for any resident with a known or suspected head injury when the resident was unable to report hitting their head per the facility standing order. She indicated if there was no order for neurological

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checks the nurse was to notify the physician of the injury to obtain orders for neurological checks to include frequency, duration, and parameters for notifying the physician. She indicated neurological checks were to be documented in the residents progress notes. She indicated that during the investigation it was determined that Nurse #2 did not complete neurological assessments, obtain vitals signs, and there was no documentation that Tylenol was administered to Resident #1. She stated the Police came on 04/08/24 and talked with Resident #1 and her roommate. The Police determined no foul play and could not determine what caused the injury.

During a phone interview on 04/26/24 at 4:40 PM the Physician stated he was notified of the injury of unknown source on Monday 04/08/24. He stated he ordered an x-ray that showed a minimally displaced fracture to the nose. He reported he evaluated Resident #1 on Tuesday 04/07/24 and interviewed staff and her roommate and asked if she had been dropped or fallen. He stated he could not determine how the injury occurred. He reported Resident #1 had been bedridden for many years. He stated he should have been notified at least by the following day since the injury occurred at 11:00 PM at night. He stated there was no delay in treatment by doing the x-ray on Monday. He stated Resident #1 was evaluated by the ENT physician on 04/11/24 and from the outcome of that evaluation along with conversations with her Responsible Party it was decided that no treatment would be indicated for the nasal fracture.

During an interview on 04/26/24 at 6:00 PM the Administrator stated she was notified of the injury late in the day on 04/08/24. She stated Nurse #2

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should have reported the injury of unknow source on the night of 04/06/24. She stated education was provided to all nursing staff regarding monitoring for an acute change in condition including injuries of unknown source. She stated Nurse #2 should have conducted ongoing monitoring for a change in condition during the night and indicated that was not done. She stated education was provided to nursing staff on reporting injuries of unknown source and the protocol on what to do when an injury was identified. She stated a full investigation was completed and it was never determined how the injury occurred. She stated an ad hoc Quality Assurance (QA) meeting was held on 04/09/24 and the decision was made by the Quality Assurance (QA) Committee to initiate a Performance Improvement Plan regarding this occurrence. She reported the Plan of Correction was initiated on 04/08/24 which included monitoring for an acute change in condition to include new bruising, pain, or injury of unknown source. Reporting of an acute change in condition to the DON, physician, and the Responsible Party, and follow through of interventions and monitoring for a change in condition.

The Plan of Correction included:

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

On 04/08/24 Resident #1 was assessed by the Director of Nursing. Resident #1 was noted to have bilateral bruising under her eyes and across the bridge of her nose.

On 04/08/24 the physician was notified, an x-ray

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	345366	A. BUILDING _____ B. WING _____	C 04/26/2024

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was ordered which resulted in a minimally displaced fracture of the nasal bridge. The Responsible Party was notified.

On 04/08/24 Adult Protective Services and law enforcement were notified.

On 04/08/24 through 04/09/24 interviews were conducted with all alert and oriented residents regarding resident abuse and how to report abuse and neglect, and injuries of unknown source. There were no concerns identified.

On 04/08/24 through 04/09/24 skin assessments were completed on all non-alert and oriented residents for signs of abuse and neglect. There were no concerns identified.

On 04/08/24 through 04/09/24 grievance logs were reviewed for the past 30 days to ensure all allegations were reported timely. There were no concerns identified.

On 04/08/24 through 04/09/24progress notes were reviewed for the last 7 days to ensure documented acute change in condition to include new/worsening pain, bruising, or signs of a fracture were assessed and reported timely to the physician, DON, and Responsible Party. There were no concerns identified.

On 04/08/24 the Administrator, and the Director of Nursing were educated by the Clinical Director regarding reportable events including injuries of unknown source or events that were suspicious of a crime and it must be reported to the State Agency within 2 hours.

On 04/09/24 through 04/10/24 education was

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conducted with all nursing staff regarding the facility's abuse and neglect policy, reporting changes in condition, interventions for an acute change in condition, signs/symptoms of fractures, performing neurological checks, and turning and repositioning residents.

On 04/09/24 Resident #1 was evaluated by the Physician. There was no new treatment implemented.

On 04/11/24 Resident #1 was evaluated by the Ear, Nose, & Throat (ENT) physician. There was no new treatment implemented.

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

On 04/08/24 the DON and Staff Facilitator performed skin assessments on cognitively impaired residents to ensure that any concerns or change in condition had been assessed, and interventions initiated if indicated, and the physician notified for further recommendations, and the Responsible Party had been notified with documentation in the electronic medical record. There were no negative findings. There were no negative findings.

On 04/08/24 the DON and Staff Facilitator initiated questionnaires of all alert and oriented residents regarding new/worsening pain, injuries not reported to the nurse, and signs/symptoms of a fracture. The questionnaire was to ensure that any concerns or change in condition had been assessed, and interventions initiated if indicated, and the physician notified for further

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recommendations, and the Responsible Party had been notified with documentation in the electronic medical record. There were no negative findings.

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

On 04/09/24 the DON and Staff Facilitator initiated education with all nursing staff regarding abuse, notification of an acute change with emphasis on assessing a change to include new/worsening pain, signs of a fracture, obtaining vital signs, initiating interventions for an acute change, notification of the physician for further recommendations, and notifying the responsible party to include documentation in the medical record. Education was provided on signs/symptoms of a fracture to include bruising and swelling. Completing neurological checks per the standing order for all known or suspected head injuries or unwitnessed fall. Education was completed by 04/10/24 . After 04/10/24 any staff who had not completed their education would be required to do so prior to the next shift. Newly hired staff would be educated during orientation.

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

The decision to monitor and take to QA was made on 04/09/24.

The unit managers will review progress notes 5

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times per week for 4 weeks utilizing the acute change auditing tool. The unit manager will address any concerns identified.

The Social Worker will complete 5 resident questionaries weekly for 4 weeks to identify any concerns. The unit managers will address any concerns identified.

The Administrator and DON will review the audits weekly for 4 weeks to ensure all areas of concern were addressed appropriately.

The Administrator or DON will present the findings of the audit tools/questionaries to the QAPI committee for 1 month to review and to determine trends or issues, or the need for continued monitoring.

A QAPI (Quality Assurance Performance Improvement) meeting was held again on 04/16/24 with the Interdisciplinary team where the plan of correction was discussed.

The facility alleged compliance with the corrective action plan on 04/12/24.

Validation of the corrective action was completed on 04/26/24. This included staff interviews regarding the incident, and in-service training that was received to ensure understanding and knowledge of the training provided. The initial audits were verified. There were no concerns identified.