STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

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F 000	INITIAL COMMENTS An onsite complaint investigation was conducted from 12/18/24 through 12/20/24 The survey team returned to the facility on 12/27/24 to obtain additional information and on 1/9/25 to validate the credible allegations of immediate jeopardy removal and exited on 1/9/25. Therefore, the exit date was changed to 1/9/25. The following intakes were investigated NC00223958, NC00224115, NC00224847, NC00224848, NC00225017, NC225419 and NC00225418. 1 of the 18 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity J CFR 483.12 at tag F600 at a scope and severity J CFR 483.25 at tag F684 at a scope and severity J CFR 483.30 at tag F714 at a scope and severity J The tags F600 and F684 constituted Substandard Quality of Care. Immediate Jeopardy began on 11/17/24 and was removed on 1/9/25. A partial extended survey was conducted.	F 000		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, 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	F 580		1/9/25

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

Electronically Signed | 01/17/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §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

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F 580	Continued From page 2 room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the resident's Responsible Party (RP), Medical Director and staff, the facility failed to notify the physician at the onset of pain and when the x-ray could not be completed stat (immediately) after Resident #1 had an unwitnessed fall on 11/17/24 (Sunday). The x-ray was not performed 11/18/24 and the results indicated an acute nondisplaced (the bone does not break completely and there will be a crack on the bone) transverse (horizontal and perpendicular to the bone) left femur (thigh bone) fracture. The physician was not made aware of the fracture until 11/22/24 and was not notified the orthopedic consult ordered on 11/19/24 was scheduled for 11/26/24. The facility also failed to notify the physician when the resident's pain was not manageable on night shift (11/20/24 and 11/21/24). Failure to notify the physician delayed orthopedic medical management, care and treatment and put the resident at high risk for complications such as deep vein thrombosis, pneumonia, bed sores, and increased risk for mortality. Resident #1 was seen by the orthopedist on 11/22/24 and was sent directly to the hospital and a left femur intramuscular nail surgery was performed on 11/23/24. Resident #1 had an aspiration event (foods, stomach contents, or fluids are breathed into the lungs) while hospitalized which resulted in acute hypoxic respiratory failure (low levels of oxygen in your blood) and IV antibiotics were initiated on 11/24/24. The resident was prescribed additional oral antibiotics for three days after discharge back to the facility on 11/26/24. This deficient practice affected 1 of 5 residents	F 580	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F580-Notify of Changes # 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; An incident report was completed on 11/17/2024 at 11:05 am by the charge nurse, based on information obtained from certified nursing aide. Resident #1 was observed on the floor next to her bed sitting on her bottom. The resident was assessed by the charge nurse and no injuries were discovered during the initial assessment. The resident was assisted back to bed by the charge nurse and the certified nursing aide without incident. The nurse called the resident□s Responsible Party (RP) and the Nurse Practitioner (NP) and no new orders were given. On 11/17/24 at 11:21 AM another progress note was entered in the electronic record which stated that the resident reported pain in her left hip and	

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reviewed for notification of change (Resident #1).

Immediate jeopardy began on 11/17/24 when the facility failed to notify the Medical Director that the STAT x-ray of Resident #1's left hip could not be completed as ordered on 11/17/24. The immediate jeopardy was removed on 1/5/25 when the facility implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a scope and severity of "D" (no actual harm with potential for more than minimal harm that is immediate jeopardy) to ensure education is completed and monitoring systems put into place and are effective.

Findings included:

Resident #1 was admitted to the facility on 10/20/22 with diagnoses that included vascular dementia, muscle weakness, difficulty in walking, bradycardia (a condition where the heart beats too slowly) (initiated 11/12/24), traumatic brain injury (TBI) in 1999, history of a stroke, chronic obstructive pulmonary disease/asthma, and dysarthria (slurred speech).

An Unwitnessed Fall Report dated 11/17/24 at 11:05 AM and completed by Nurse #1 revealed she was notified by Nurse Aide (NA) #1 that Resident #1 was on the floor next to her bed sitting on her bottom. The on-call provider and responsible party (RP) were notified. She was assessed, and no injuries were noted. Vital signs were within normal limits. Resident #1 reported no pain or discomfort. She was then assisted back to her bed.

Nurse #1 was interviewed on 12/19/24 at 11:14

elbow when the RP arrived at the facility. The facility failed to immediately notify the medical provider of the new onset of pain. The on-call medical provider was not called until 2:14 PM and at that time the medical provider gave new orders for a stat x-ray and Tylenol 500mg every 6 hours as needed for pain. The medical provider was not notified the stat x-ray could not be obtained on 11/17/2024.
On 11/18/2024 the x-ray of the left hip was obtained at 9:23 am. The x-ray resulted on 11/18/2024 12:54 pm and the impressions were an acute transverse, nondisplaced intertrochanteric femur fracture. The residents□ responsible party and NP were informed of the results on 11/18/2024 at 2:59 pm.
On 11/19/2024 the NP assessed the resident after reviewing the x-ray and new orders were given for the resident to be seen by an orthopedic doctor. The NP elected not to send the resident out immediately after conferring with the daughter who stated it was acceptable at the time. An orthopedic appointment was obtained for 11/26/2024. The NP ordered Tramadol 25 milligrams twice a day and to be given every 12 hours as needed for breakthrough pain.
The facility failed to notify the Medical Director (MD) that the orthopedic consult could not be scheduled ASAP.
The facility failed to notify the MD when the resident□s pain was not manageable on night shift for the following dates, 11/20/2024 and 11/21/2024, when Resident #1 grabbed the aide and said stop.

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F 580	Continued From page 4 AM. She revealed that on 11/17/24 around 11:00 AM, NA #1 told her that Resident #1 had fallen in her room. Nurse #1 went to the room and saw Resident #1 on her bottom next to her bed. Although Resident #1 was nonverbal, she could shake/nod her head to yes and no questions. Nurse #1 asked if she was ok, and she said "yes." She then assessed Resident #1, including her extremities (limbs, hands, and feet), and asked if she hit her head. Resident #1 said "no." She was then put back into bed with Nurse #1's assistance. Nurse #1 took vital signs and notified her supervisor at the time (name unknown). Nurse #1 was instructed to complete all documentation related to the fall and then called Resident #1's RP. The RP came later (45 minutes or so) and said Resident #1 complained of pain. Nurse #1 assessed her again, and Resident #1 said she was in pain. She assessed her left leg while she was laying on her right side. When she pressed on it, Resident #1 winced with pain, and there was a bruise. She contacted the On-Call Provider again and told her that the newly onset pain had not been discovered until just then. She was instructed to order an x-ray STAT. Nurse #1 stated she gave Resident #1 some Tylenol and then she left for the night at 7:00 PM. A 72 Hour Post Fall Documentation note dated 11/17/24 at 11:21 AM and completed by Nurse #1 revealed that Resident #1 reported pain in her left hip. The RP was interviewed on 12/18/24 at 1:56 PM. She revealed that when she arrived at the facility on 11/17/24, about 45 minutes after the fall, Resident #1 complained of pain. The RP indicated she reported the pain to Nurse #1.	F 580	The MD was not aware of the fracture until he saw Resident #1 on 11/22/2024 at which time he ordered the resident to be sent to the emergency department if she could not be seen by the orthopedist that day. Resident #1 was seen by the orthopedist on 11/22/2024 and was sent directly to the hospital and a left femur intramuscular nail surgery was performed on 11/23/2024. # - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 12/27/2024 the Director of Nursing and Nurse Managers reviewed residents who have fallen during the last 30 days to confirm that the Medical Director had been notified. Any opportunities identified during this audit will be corrected by the Nurse Managers by 1/3/2025. On 12/27/2024 the Director of Nursing and Nurse Managers reviewed 30 days of diagnostic and laboratory testing to ensure they were obtained as ordered and the Medical Director had been notified. The audit included reading 30 days of progress notes to identify any residents that may have been in pain and were not addressed. Any opportunities identified during this audit will be corrected by the nurse managers by 1/3/2025 # -3 Address what measures will be put	

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F 580	Continued From page 5 An On-Call NP note dated 11/17/24 at 2:32 PM revealed that Resident #1 had a fall at 11:00 AM. No injuries were reported, and Resident #1 denied pain. Now, Resident #1 reported left hip pain with tenderness to palpation. A STAT x-ray of the left hip was ordered, as well as Tylenol 500 milligrams (mg) every 6 hours as needed for pain. Neurological checks should be performed every 4 hours. Physician orders for Resident #1 revealed that a one-time STAT x-ray of the left hip was ordered on 11/17/24 at 3:05 PM. A telephone interview was conducted with Nurse #1 on 12/19/24 at 6:05 PM. She revealed that radiology told her they would get to the facility on 11/17/24 as soon as they could. Nurse #1 indicated she did not notify the On-Call NP that the x-rays were not yet performed when she finished her shift at 7:00 PM on 11/17/24. Nurse #1 could not provide a reason as to why she did not notify the On-Call NP of the STAT x-ray delay. A Medical Progress note dated 11/18/24 at 10:00 AM and completed by the NP revealed that Resident #1 had a fall on 11/17/24. She denied hitting her head, injury, or pain following the fall. Resident #1 appeared at her baseline mental status. A Health Status note dated 11/18/24 at 10:18 AM and completed by Nurse #2 revealed that radiology services were in the facility to perform the STAT x-rays ordered on 11/17/24. Review of the x-ray results dated 11/18/24 revealed an acute nondisplaced transverse left femur fracture. The x-rays were taken at 9:23 AM	F 580	into place or systemic changes made to ensure that the deficient practice will not recur; On 12/20/2024 the Director of Nursing/Staff Development Coordinator began in person education for all nursing staff on the facility policy and procedures for physician notification to include notification of physician for any complaints of unrelieved pain by residents to be reported to the physician immediately. Education also included notification to physician of any delays in physician orders including stat orders and delay in any physician ordered appointments, consultations, and X-rays this is to include the weekends and after hours. Licensed nurses were also educated on utilization of the MD communication book to report diagnostic reports and other non-emergent resident issues. All nurse aides were also educated on the process of notification to licensed nurse of any identified resident issues such as pain or other resident concerns and use the electronic medical record, which is to document the pain and/or concerns of the resident in their electronic medical record. The licensed nurses will review the information and report to the medical provider. The licensed nurses will document in the residents electronic medical record the notification to the medical provider and the plan of care. The Nurse Managers will review the residents electronic medical record daily and the documentation to ensure the medical provider was notified. Education	

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and reported to the facility at 12:54 PM.

Review of a health status dated 11/18/24 at 2:59 PM and completed by Nurse #2 revealed that the results were back from the STAT x-rays. The RP and NP were notified.

During an interview with the Medical Director on 12/20/24 at 12:57 PM, he revealed that the expectation of a STAT x-ray was for it to be performed on the same day it was ordered. If a STAT x-ray was delayed until the next day, he should have been notified.

The Director of Nursing (DON) was interviewed on 12/30/24 at 11:49 AM. She revealed that if a STAT x-ray was not performed within 2-4 hours after it was ordered or before a shift was completed, then Nurse #1 should have contacted the on-call provider for further instructions on whether to wait or receive other orders.

An interview was conducted with the Administrator on 12/31/24 at 12:00 PM. He revealed that if a STAT order was not completed the same day, Nurse #1 should have notified the on-call provider to receive further instruction on how to move forward.

Review of a medical progress note dated 11/19/24 and completed by the NP revealed that Resident #1 had an acute nondisplaced transverse intertrochanteric femur fracture. Resident #1's RP was waiting for the NP to contact her for consultation, which took place the same day. The RP requested an orthopedic evaluation. The NP discussed complications about potential surgery with the RP and told her that orthopedics would consider Resident #1's

will be provided to all new nursing staff and agency staff prior to the beginning of their first shift. Education will be completed by 1/4/2025 by the Director of Nursing/Staff Development Coordinator. This education will become a part of the new hire orientation process for newly hired nursing staff. The Staff Development Coordinator will track the education for all staff who did not receive the education to ensure they receive the education prior to their first assigned shift. The Staff Development Coordinator was notified of her responsibilities on 12/20/2024. Nurse Aides can report directly to the nurse or use the computer system which serves as an alert system within the resident□s electronic record which nurse aides can send alerts to the nurse electronically. Once a computer system alert is triggered the nurse can see it instantly on the clinical dashboard for continued assessment to be done. The Director of Nursing educated Licensed Nurses regarding the requirements for notification of the Physician following a fracture and/or a significant change of condition. The Licensed Nurse will call the Medical Director with any results of fractures and/or a significant change of condition. The Licensed Nurse will place this information in the Medical Directors□ communication book after making verbal notification to the medical providers for additional follow-up by the Medical Director and in-house NP. The Director of Nursing will ensure no staff will work without receiving this education. Any new

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F 580	Continued From page 7 overall health, specifics about the fracture, and new asymptomatic bradycardia. Review of physician orders for Resident #1 revealed that on 11/19/24 an orthopedic surgery consultation for a left hip/leg fracture was ordered. The Transportation Scheduler was interviewed on 1/7/25 at 4:20 PM. She revealed that she had received a consultation order from the NP on 11/19/24 to schedule an orthopedic appointment for Resident #1. The Transportation Scheduler stated she did not receive an order as soon as possible (ASAP) for the appointment from the NP, but she called that day (11/19/24) to schedule. The appointment was originally scheduled for 11/26/24. The Transportation Scheduler indicated she was notified on 11/22/24 to get Resident #1 an immediate orthopedics appointment for that day, but she could not recall who the request came from. Review of Resident #1's medical record revealed that there was no documentation for an orthopedics consultation scheduled for 11/26/24. During a telephone interview with NA #3, who worked with Resident #1 during the overnight shift from 7:00 PM on 11/20/24 until 7:00 AM on 11/21/24, she stated that Resident #1 had fallen 3 days prior, and this was the first time she had worked with Resident #1. NA #3 recalled when she arrived for her shift, she was notified by the off coming NA #5 that Resident #1's left hip was hurt and to be cautious during care. NA #3 remembered that Resident #1 said "ow" during an incontinence care episode when she touched her left hip. NA #3 did not notify anyone of the pain	F 580	hires, including agency staff, will receive education prior to the start of their shift via telephone or in person. The Director of Nursing or designee will complete in person review with any staff that receive education by telephone to assure their understanding of the education received. The Staff Development Coordinator will be responsible for tracking which employees have received their education. The Staff Development Coordinator was made aware of this responsibility on 12/20/24. Review of daily clinical documentation will be integrated into the daily clinical meeting process. #4-Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing will be responsible for audit review of all clinical nursing documentation to ensure that all notifications of changes have been made to the resident, resident□s physician and consistent with his or her authority the resident representative whenever there is; " A accident involving the resident which results in injury and has the potential for requiring physician intervention. " A significant change in the resident□s physical, mental, or psychosocial status in either life-threatening conditions or clinical complications.	

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F 580	Continued From page 8 because she was notified about the left hip at the beginning of her shift. NA #3 further stated she made sure not to change or move Resident #1 during the shift unless necessary. A telephone interview was conducted with NA #2 on 12/19/24 at 10:53 AM. NA #2 confirmed she worked with Resident #1 during the overnight shift from 7:00 PM on 11/21/24 until 7:00 AM on 11/22/24. NA #2 revealed that it appeared Resident #1 was in a lot of pain during her shift because she would refuse care, was not willing to get out of bed, and was not willing to roll side to side. Resident #1 was nonverbal, but when NA #2 tried to turn her in the bed, Resident #1 would grab her arm as if she was telling NA #2 to stop. The DON was interviewed on 12/30/24 at 11:49 AM. She revealed that if Resident #1 was in any discomfort after the fall on 11/17/24, NA #2 and NA #3 should have notified the nurse on duty or the provider. The NAs could have performed a "Stop N Watch," which meant they were not allowed to assess Resident #1's pain, but they could have completed charting in her medical record that would alert the DON, unit managers, and the providers. The Administrator was interviewed on 12/31/24 at 12:00 PM. He revealed that NA #2 and NA #3 should have completed a "Stop N Watch" task as well as notified the charge nurse that they thought Resident #1 had some discomfort during their shifts. A telephone interview was conducted with the Medical Director on 12/19/24 at 10:19 AM. He revealed that he did not review Resident #1's x-ray results reported on 11/18/24 until 11/22/24,	F 580	" 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 " A decision to transfer or discharge the resident from the facility. The Director of Nursing will complete audit of this documentation daily x 4 weeks, biweekly x 4 weeks and then weekly until substantial compliance is achieved. The Director of Nursing will report the finding from the audits to the Quality Assurance Performance Improvement committee for recommendations and/or modifications until a pattern of compliance is achieved. The Administration is responsible for the entire plan of correction. Date of completion: 1/9/25	

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and he did not receive an update from the NP that entire week. He was unaware that an orthopedic appointment had been scheduled for the following week and not sooner. When he saw Resident #1 on 11/22/24, Resident #1 was in pain, and the Medical Director told staff that she needed to be sent out immediately. The Medical Director indicated he was told that Resident #1 had an orthopedic appointment the following week, but he told them she needed to go that day (11/22/24). The Medical Director stated that Resident #1 should have gone to the hospital as soon as the x-ray results came in on 11/18/24, and the surgeon would have made the decision if she was a surgical candidate or not.

During a follow-up telephone interview with the Medical Director on 12/20/24 at 11:13 AM, he revealed that the nurses always put the printout of the x-ray results in his mailbox or the provider communication book to review. The Medical Director stated that he relied on the paperwork in his mailbox or provider communication book for further evaluation or orders. He further stated that he did not see Resident #1's x-ray results in the provider's communication book until 11/22/24.

Review of an Orthopedic Visit note dated 11/22/24 revealed that Resident #1 was in no acute distress, and the left leg was warm and perfused. Resident #1 pointed to the left groin area as a source of pain. Due to the results of the x-rays taken during the visit (intertrochanteric fracture of the left femur), Resident #1 was sent to the hospital from the appointment.

Review of a Hospital Discharge Summary dated 11/26/24 revealed that Resident #1 had a closed intertrochanteric fracture of the left femur. She

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was seen in the orthopedic office on 11/22/24 for further evaluation, and an x-ray was obtained which showed an intertrochanteric fracture of the left femur. She was sent to the emergency department (ED) for further evaluation, and a left femur intramuscular nail surgery was performed on 11/23/24. The discharge summary indicated Resident #1 had an aspiration event while hospitalized which resulted in acute hypoxic respiratory failure and IV antibiotics were initiated on 11/24/24. The resident was prescribed additional oral antibiotics for three days after discharge back to the facility.

The Administrator was notified of immediate jeopardy on 1/3/25 at 8:48 AM.

The facility provided the following Acceptable Allegation of Immediate Jeopardy removal.

An incident report was completed on 11/17/2024 at 11:05 am by the charge nurse, based on information obtained from certified nursing aide. Resident #1 was observed on the floor next to her bed sitting on her bottom. The resident was assessed by the charge nurse and no injuries were discovered during the initial assessment. The resident was assisted back to bed by the charge nurse and the certified nursing aide without incident. The nurse called the resident's Responsible Party (RP) and the Nurse Practitioner (NP) and no new orders were given. On 11/17/24 at 11:21 AM another progress note was entered in the electronic record which stated that the resident reported pain in her left hip and elbow when the RP arrived at the facility. The facility failed to immediately notify the medical provider of the new onset of pain. The on-call medical provider was not called until 2:14 PM and

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at that time the medical provider gave new orders for a stat x-ray and Tylenol 500mg every 6 hours as needed for pain. The medical provider was not notified the stat x-ray could not be obtained on 11/17/2024.

On 11/18/2024 the x-ray of the left hip was obtained at 9:23 am. The x-ray resulted on 11/18/2024 12:54 pm and the impressions were an acute transverse, nondisplaced intertrochanteric femur fracture. The residents' responsible party and NP were informed of the results on 11/18/2024 at 2:59 pm.

On 11/19/2024 the NP assessed the resident after reviewing the x-ray and new orders were given for the resident to be seen by an orthopedic doctor. The NP elected not to send the resident out immediately after conferring with the daughter who stated it was acceptable at the time. An orthopedic appointment was obtained for 11/26/2024. The NP ordered Tramadol 25 milligrams twice a day and to be given every 12 hours as needed for breakthrough pain.

The facility failed to notify the Medical Director (MD) that the orthopedic consult could not be scheduled ASAP.

The facility failed to notify the MD when the resident's pain was not manageable on night shift for the following dates, 11/20/2024 and 11/21/2024, when Resident #1 grabbed the aide and said "stop".
The MD was not aware of the fracture until he saw Resident #1 on 11/22/2024 at which time he ordered the resident to be sent to the emergency department if she could not be seen by the orthopedist that day.

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Resident #1 was seen by the orthopedist on 11/22/2024 and was sent directly to the hospital and a left femur intramuscular nail surgery was performed on 11/23/2024.

On 12/27/2024 the Director of Nursing and Nurse Managers reviewed residents who have fallen during the last 30 days to confirm that the Medical Director had been notified. Any opportunities identified during this audit will be corrected by the Nurse Managers by 1/3/2025.

On 12/27/2024 the Director of Nursing and Nurse Managers reviewed 30 days of diagnostic and laboratory testing to ensure they were obtained as ordered and the Medical Director had been notified. The audit included reading 30 days of progress notes to identify any residents that may have been in pain and were not addressed. Any opportunities identified during this audit will be corrected by the nurse managers by 1/3/2025.

On 12/20/2024 the Director of Nursing/Staff Development Coordinator began in person education for all nursing staff on the facility policy and procedures for physician notification to include notification of physician for any complaints of unrelieved pain by residents to be reported to the physician immediately. Education also included notification to the physician of any delays in physician orders including stat orders and delay in any physician ordered appointments, consultations, and X-rays this is to include the weekends and after hours. Licensed nurses were also educated on utilization of the MD communication book to report diagnostic reports and other non-emergent resident issues. All nurse aides were also educated on the process of

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notification to licensed nurse of any identified resident issues such as pain or other resident concerns and use the electronic medical record, which is to document the pain and/or concerns of the resident in their electronic medical record. The licensed nurses will review the information and report to the medical provider. The licensed nurses will document in the residents' electronic medical record the notification to the medical provider and the plan of care. The Nurse Managers will review the residents electronic medical record daily and the documentation to ensure the medical provider was notified. Education will be provided for all new nursing staff and agency staff prior to the beginning of their first shift. Education will be completed by 1/4/2025 by the Director of Nursing/Staff Development Coordinator. This education will become a part of the new hire orientation process for newly hired nursing staff. The Staff Development Coordinator will track the education for all staff who did not receive the education to ensure they receive the education prior to their first assigned shift. The Staff Development Coordinator was notified of her responsibilities on 12/20/2024. Nurse Aides can report directly to the nurse or use the computer system which serves as an alert system within the resident's electronic record which nurse aides can send alerts to the nurse electronically. Once a computer system alert is triggered the nurse can see it instantly on the clinical dashboard for continued assessment to be done.

The Director of Nursing educated Licensed Nurses regarding the requirements for notification of the Physician following a fracture and/or a significant change of condition. The Licensed Nurse will call the Medical Director with any

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results of fractures and/or a significant change of condition. The Licensed Nurse will place this information in the Medical Directors' communication book after making verbal notification to the medical providers for additional follow-up by the Medical Director and in-house NP. The Director of Nursing will ensure no staff will work without receiving this education. Any new hires, including agency staff, will receive education prior to the start of their shift via telephone or in person. The Director of Nursing or designee will complete in person review with any staff that receive education by telephone to assure their understanding of the education received. The Staff Development Coordinator will be responsible for tracking which employees have received their education. The Staff Development Coordinator was made aware of this responsibility on 12/20/24.

On 1/3/2024 the Director of Nursing and Administrator completed an Ad-Hoc QAPI to ensure that all components of the credible allegation were completed and followed. The QAPI included the Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Regional Director of Clinical Services, Admissions Director, Unit Managers, Maintenance Director and Discharge Planner. Effective 1/3/2025 the Administrator will be responsible to ensure implementation of this immediate jeopardy removal for this alleged non-compliance.

Alleged date of IJ removal: 1/5/2025

An onsite validation was conducted on 01/09/25. A review of in-service records revealed that all nursing staff were educated on the facility's policy

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F 580	Continued From page 15 and procedures for physician notification to include any complaints of unrelieved pain by residents to be reported to the physician immediately. Education also included notification to the physician of any delays in physician orders including STAT orders and delay in any physician ordered appointments, consultations, and X-rays, this is to include the weekends and after hours. Licensed nurses were also educated on utilization of the physician communication book to report diagnostic reports and other non-emergent resident issues. All nurse aides were also educated on the process of notification to the licensed nurse of any resident experiencing issues such as pain or other resident concerns and use of the electronic medical record, which is to document the pain and/or concerns of the resident in their electronic medical record. Interviews conducted with nurses and nurse aides during the onsite validation were completed and the staff were able to verbalize knowledge of the policy and procedures for notification. The physician communication book was reviewed for verification of physician notification. The immediate jeopardy removal date of 01/05/25 was validated.	F 580		
F 600 SS=J	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.	F 600		1/9/25

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F 600	Continued From page 16 §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 record review, and facility staff, Nurse Practitioner (NP), Medical Director, and Responsible Party (RP), and Orthopedic Surgeon interviews, the facility failed to protect a resident's right to be free of neglect as evidenced by the following: they failed to notify the physician at the onset of pain and when an x-ray could not be completed STAT (immediately) after Resident #1 had an unwitnessed fall on 11/17/24 and reported pain in her left hip. The x-ray was completed on 11/18/24 and revealed an acute nondisplaced (the bone does not break completely and there will be a crack on the bone) transverse (horizontal and perpendicular to the bone) left femur (thigh bone) fracture. The NP failed to communicate and collaborate with the Medical Director when the x-ray results were received on 11/18/24 and the facility failed to recognize the seriousness of the injury and identify the need for urgent orthopedic evaluation and surgical intervention. On 11/19/24 the NP ordered scheduled opioid medication for increased pain and ordered an orthopedic consultation at the request of Resident #1's RP. The resident remained in the facility awaiting an orthopedic consultation scheduled for 11/26/24. The facility failed to notify the physician when the resident's pain was not manageable on night shift (11/20/24 and 11/21/24). The Medical Director (MD) was not aware of the fracture or the orthopedic consult scheduled for 11/26/24 until he saw Resident #1 on 11/22/24 at which time he	F 600	F 600-Free from Abuse and Neglect # 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; An incident report was completed on 11/17/2024 at 11:05 am by the charge nurse, based on information obtained from certified nursing aide. Resident #1 was observed on the floor next to her bed sitting on her bottom. The resident was assessed by the charge nurse and no injuries were discovered during the initial assessment. The resident was assisted back to bed by the charge nurse and the certified nursing aide without incident. The charge nurse called the resident□s Responsible Party (RP) and the Nurse Practitioner (NP) and no new orders were given. On 11/17/24 at 11:21 AM another progress note was entered in the electronic record which stated that the resident reported pain in her left hip and elbow when the RP arrived at the facility. The facility failed to immediately notify the medical provider of the new onset of pain. The medical provider was not called until 2:14 PM and at that time the medical provider gave new orders for a stat x-ray	

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F 600	Continued From page 17 ordered the resident to be sent to the emergency department if she could not be seen by the orthopedist that day. The resident was seen by the orthopedist on 11/22/24 and was sent directly to the hospital and a left femur intramuscular nail surgery was performed on 11/23/24. While hospitalized, Resident #1 had an aspiration event (foods, stomach contents, or fluids are breathed into the lungs) which resulted in acute hypoxic respiratory failure (low levels of oxygen in your blood) and Intravenous (IV) antibiotics were initiated on 11/24/24. The resident was prescribed additional oral antibiotics for three days after discharge back to the facility on 11/26/24. The Orthopedic Surgeon indicated an injury like Resident #1's required an immediate transfer to the hospital for evaluation by an orthopedic specialist and that the risks of complications increased with the delay of care such as deep vein thrombosis (blood clots in veins deep in the body), pneumonia, and bed sores. This deficient practice affected 1 of 1 sampled residents reviewed for neglect (Resident #1). Immediate jeopardy began on 11/18/24 when the facility neglected to provide the necessary care and services for Resident #1 when x-ray results verified the resident sustained a transverse left femur fracture. The immediate jeopardy was removed on 1/5/25 when the facility implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a scope and severity of "D" (no actual harm with potential for more than minimal harm that is immediate jeopardy) to ensure education is completed and monitoring systems put into place and are effective. The findings included:	F 600	and Tylenol 500mg every 6 hours as needed for pain. The Tylenol order was not entered until 3:05pm on 11/17/2024. The stat x-ray was not obtained on 11/17/2024. The nursing staff failed to notify the medical provider that the stat x-ray could not be obtained on 11/17/2024. On 11/18/2024 the x-ray of the left hip was obtained at 9:23 am. The x-ray resulted on 11/18/2024 12:54 pm and the impressions were an acute transverse, nondisplaced intertrochanteric femur fracture. The resident□s RP and NP were informed of the results on 11/18/2024 at 2:59 pm. On 11/19/2024 the NP assessed the resident after reviewing the x-ray and new orders were given for the resident to be seen by an orthopedic doctor. The NP elected not to send the resident out immediately after conferring with the daughter who stated it was acceptable at the time. An orthopedic appointment was obtained for 11/26/2024. The NP ordered Tramadol 25 milligrams twice a day and to be given every 12 hours as needed for breakthrough pain. The Medical Director (MD) was not aware of the fracture until he saw Resident #1 on 11/22/24 at which time he ordered the resident to be sent to the emergency department if she could not be seen by the orthopedist that day. Resident #1 was seen by the orthopedist on 11/22/2024 and was sent directly to the	

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F 600	Continued From page 18 This tag is cross referenced to: F580: Based on record review and interviews with the Medical Director and staff, the facility failed to notify the physician at the onset of pain and when the x-ray could not be completed stat (immediately) after Resident #1 had an unwitnessed fall on 11/17/24 (Sunday). The x-ray was not performed 11/18/24 and the results indicated an acute nondisplaced (the bone does not break completely and there will be a crack on the bone) transverse (horizontal and perpendicular to the bone) left femur (thigh bone) fracture. The physician was not made aware of the fracture until 11/22/24 and was not notified the orthopedic consult ordered on 11/19/24 was scheduled for 11/26/24. The facility also failed to notify the physician when the resident's pain was not manageable on night shift (11/20/24 and 11/21/24). Failure to notify the physician delayed orthopedic medical management, care and treatment and put the resident at high risk for complications such as deep vein thrombosis, pneumonia, bed sores, and increased risk for mortality. Resident #1 had an aspiration event (foods, stomach contents, or fluids are breathed into the lungs) while hospitalized which resulted in acute hypoxic respiratory failure (low levels of oxygen in your blood) and IV antibiotics were initiated on 11/24/24. The resident was prescribed additional oral antibiotics for three days after discharge back to the facility on 11/26/24. This deficient practice affected 1 of 5 residents reviewed for notification of change (Resident #1). F684: Based on record review and interviews from the Medical Director, the Nurse Practitioner (NP), Orthopedic Surgeon, Responsible Party	F 600	hospital and a left femur intramuscular nail surgery was performed on 11/23/2024. # - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; To assist in identifying other residents who may have been affected by this deficient practice on 12/20/24 the Nurse Practitioner and Medical Director reviewed the previous 45 days of labs and radiology reports to ensure that all abnormalities have been addressed. On 12/27/2024 the Nurse Managers reviewed residents who have fallen during the last 30 days to assess residents to include active and passive range of motion and pain assessment. This review also included examination of all recent incident reports to identify any patterns or recurring issues related to falls or delayed medical interventions. The Director of Nursing and Regional Director of Clinical Services completed a review of all pain scales on 1/4/25 to	

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F 600	Continued From page 19 (RP) and staff the facility failed to recognize the seriousness of the injury Resident #1 sustained from a fall and identify the need for urgent orthopedic evaluation. Resident #1 reported pain in her left hip on 11/17/24 following a fall. A STAT (with no delay) x-ray was ordered on Sunday 11/17/24, was not completed until 11/18/24, and revealed a nondisplaced (the bone does not break completely and there will be a crack on the bone) transverse (horizontal and perpendicular to the bone) left femur (thigh bone) fracture. On 11/19/24 the NP ordered scheduled opioid medication for increased pain and ordered an orthopedic consultation at the request of Resident #1's RP. The resident remained in the facility awaiting an orthopedics consultation scheduled for 11/26/24. The Medical Director was not aware of the fracture until he saw Resident #1 on 11/22/24 at which time he ordered the resident to be sent to the emergency department if she could not be seen by the orthopedist that day. Resident #1 was seen by the orthopedist on 11/22/24 and was sent directly to the hospital and a left femur intramuscular nail surgery was performed on 11/23/24. While hospitalized, Resident #1 had an aspiration event (foods, stomach contents, or fluids are breathed into the lungs) which resulted in acute hypoxic respiratory failure (low levels of oxygen in your blood) and Intravenous (IV) antibiotics were initiated on 11/24/24. The resident was prescribed additional oral antibiotics for three days after discharge back to the facility on 11/26/24. The Orthopedic Surgeon indicated an injury like Resident #1's required an immediate transfer to the hospital for evaluation by an orthopedic specialist and that the risks of complications increased with the delay of care such as deep vein thrombosis (blood clots in veins deep in the body), pneumonia, and bed	F 600	assist in identifying any resident with unrelieved pain. Any opportunities identified during this audit will be corrected by the Nurse Managers by 1/4/25. On 12/27/2024 the Nurse Managers reviewed residents who have fallen during the last 30 days to validate the Medical Director had been notified. Any opportunities identified during this audit will be corrected by the Nurse Managers by 1/4/2025. # -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 12/20/24 the Director of Nursing/Staff Development Coordinator began in-person education for all facility staff in all departments including agency and contract staff. Education included review of policy regarding abuse/neglect. " Recognizing signs of abuse and neglect " Examples of neglect, including not providing necessary care and services. " Reporting of abuse and neglect " Facility policy and procedures for physician notification to include notification of physician to any complaints of unrelieved pain by residents to be reported to the physician immediately. " Notification to physician of any delays in physician orders including stat orders and delay in any physician ordered appointments and x-rays.	

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F 600	Continued From page 20 sores. This deficient practice affected 1 of 5 residents reviewed for falls (Resident #1). F714: Based on record review, and staff, Medical Director (MD) and Nurse Practitioner (NP) interviews, the NP failed to communicate and collaborate with the MD when Resident #1 was diagnosed on 11/18/24 with an acute nondisplaced (the bone does not break completely and there will be a crack on the bone) transverse (horizontal and perpendicular to the bone) left femur (thigh bone) fracture following an unwitnessed fall on 11/17/24. The NP did not consult with the MD before making the decision the resident was probably not a surgical candidate and attempting to treat the resident in-house. Due to the lack of communication and coordination the Medical Director (MD) was not aware of the fracture until he saw Resident #1 on 11/22/24 at which time he ordered the resident to be sent to the emergency department if she could not be seen by the orthopedist that day. Resident #1 was seen by the orthopedist on 11/22/24 and was sent directly to the hospital and a left femur intramuscular nail surgery was performed on 11/23/24. The lack of communication and collaboration between the NP and MD delayed orthopedic medical management, care and treatment and put the resident at high risk for complications such as deep vein thrombosis, pneumonia, and bed sores. Resident #1 had an aspiration event (foods, stomach contents, or fluids are breathed into the lungs) while hospitalized which resulted in acute hypoxic respiratory failure (low levels of oxygen in your blood) and IV antibiotics were initiated on 11/24/24. The resident was prescribed additional oral antibiotics for three days after discharge back to the facility on 11/26/24. This failure affected 1	F 600	" Education to certified nurse aides on reporting identified pain and other abnormal events identified during delivery of care. Any nursing staff member that did not receive education on 12/20/2024 will receive education by the beginning of the next shift by the DON or designee. The Staff Development Coordinator will be responsible for tracking staff that still require education. Any staff that has not received education will not be allowed to work until education is received. All newly hired licensed staff will be educated by the Staff Development Coordinator on this policy. This education will be added to the orientation process. Staff Development was notified of this responsibility on 12/20/2024. In person education was completed on 12/27/2024 by the Director of Nursing to current medical providers including on-call providers, Nurse Practitioners and Medical Director. Education consisted of communication between all providers should be clear, concise and collaborative. Communication should include a discussion of treatment plans and seeking advice when necessary. Providers should participate in decision making in a timely manner. On 1/3/2025 the Medical Director and the Physician Extenders agreed to meet with the Director of Nursing weekly to discuss abnormal labs, radiology or test results as a team.	

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F 600	Continued From page 21 of 3 reviewed for accidents (Resident #1). The Administrator was notified of immediate jeopardy on 1/3/25 at 8:48 AM. The facility provided the following Acceptable Credible Allegation of Immediate Jeopardy removal. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: An incident report was completed on 11/17/2024 at 11:05 am by the charge nurse, based on information obtained from certified nursing aide. Resident #1 was observed on the floor next to her bed sitting on her bottom. The resident was assessed by the charge nurse and no injuries were discovered during the initial assessment. The resident was assisted back to bed by the charge nurse and the certified nursing aide without incident. The charge nurse called the resident's Responsible Party (RP) and the Nurse Practitioner (NP) and no new orders were given. On 11/17/24 at 11:21 AM another progress note was entered in the electronic record which stated that the resident reported pain in her left hip and elbow when the RP arrived to the facility. The facility failed to immediately notify the medical provider of the new onset of pain. The medical provider was not called until 2:14 PM and at that time the medical provider gave new orders for a stat x-ray and Tylenol 500mg every 6 hours as needed for pain. The Tylenol order was not entered until 3:05pm on 11/17/2024. The stat x-ray was not obtained on 11/17/2024. The nursing staff failed to notify the medical provider that the stat x-ray could not be obtained on	F 600	On 1/3/2025 the Regional Director of Clinical Services informed the Staff Development Coordinator and/or the Director of Nursing to complete monthly training on abuse and neglect for 3 months and then quarterly ongoing. Education will ensure abuse and neglect is explained to all staff per federal guidelines, Neglect as defined at 483.12, the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Effective 1/4/2025 the Administrator will be responsible to ensure implementation of this immediate jeopardy removal for this alleged non-compliance. #4-Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The DON or designee will verify the understanding of education through oral discussion and feedback with all staff and notate this on a tracking tool. The SDC will also do this in orientation. The Director of Nursing or designee will monitor to include reviewing of all newly hired staff to assure that they have received training for abuse and neglect, weekly x 4 weeks, bi-weekly x 1 month then monthly x 1 month.	

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F 600	Continued From page 22 11/17/2024. On 11/18/2024 the x-ray of the left hip was obtained at 9:23 am. The x-ray resulted on 11/18/2024 12:54 pm and the impressions were an acute transverse, nondisplaced intertrochanteric femur fracture. The resident's RP and NP were informed of the results on 11/18/2024 at 2:59 pm. On 11/19/2024 the NP assessed the resident after reviewing the x-ray and new orders were given for the resident to be seen by an orthopedic doctor. The NP elected not to send the resident out immediately after conferring with the daughter who stated it was acceptable at the time. An orthopedic appointment was obtained for 11/26/2024. The NP ordered Tramadol 25 milligrams twice a day and to be given every 12 hours as needed for breakthrough pain. The Medical Director (MD) was not aware of the fracture until he saw Resident #1 on 11/22/24 at which time he ordered the resident to be sent to the emergency department if she could not be seen by the orthopedist that day. Resident #1 was seen by the orthopedist on 11/22/2024 and was sent directly to the hospital and a left femur intramuscular nail surgery was performed on 11/23/2024. The facility failed to notify the physician of an acute change in condition requiring emergent orthopedic medical treatment (x-ray results positive for fracture). The facility failed to notify the physician that an x-x-ray ordered stat was not going to be done stat. The facility failed to notify the physician that the orthopedic consult could	F 600	The Director of Nursing will report the finding from the audits to the Quality Assurance Performance Improvement committee for recommendations and/or modifications until a pattern of compliance is achieved. The Administrator is responsible for this plan of correction. Date of completion: 1/9/25	

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F 600	Continued From page 23	F 600		

not be scheduled ASAP. The facility failed to notify the physician when the resident's pain was not manageable on night shift on 11/20/2024 and 11/21/2024 when resident grabbed the aide and said "stop."

The facility failed to identify the seriousness of Resident #1's left intertrochanteric femur fracture after a fall on 11/17/2024 and identify the urgent need for orthopedic evaluation and surgical intervention. A STAT x-ray was ordered but not completed until 11/18/2024 and confirmed the fracture. The Nurse Practitioner ordered scheduled and as needed opioid pain medication and an orthopedic consultation on 11/19/2204 but failed to collaborate with the MD he was attempting to treat the fracture in- house.

The facilities neglect led to delayed treatment of Resident #1's left intertrochanteric femur fracture on 11/18/2024 causing Resident #1 to be sent to the hospital 11/22/2024. Resident #1 had surgery on 11/23/2024 to repair the left femur fracture.

To assist in identifying other residents who may have been affected by this deficient practice on 12/20/24 the Nurse Practitioner and Medical Director reviewed the previous 45 days of labs and radiology reports to ensure that all abnormalities have been addressed.

On 12/27/2024 the Nurse Managers reviewed residents who have fallen during the last 30 days to assess residents to include active and passive range of motion and pain assessment. This review also included examination of all recent incident reports to identify any patterns or recurring issues related to falls or delayed medical interventions.

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The Director of Nursing and Regional Director of Clinical Services completed a review of all pain scales on 1/4/25 to assist in identifying any resident with unrelieved pain. Any opportunities identified during this audit will be corrected by the Nurse Managers by 1/4/25.

On 12/27/2024 the Nurse Managers reviewed residents who have fallen during the last 30 days to validate the Medical Director had been notified. Any opportunities identified during this audit will be corrected by the Nurse Managers by 1/4/2025.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

On 12/20/24 the Director of Nursing/Staff Development Coordinator began in-person education for all facility staff in all departments including agency and contract staff. Education included review of policy regarding abuse/neglect.
- Recognizing signs of abuse and neglect
- Examples of neglect, including not providing necessary care and services.
- Reporting of abuse and neglect
- Facility policy and procedures for physician notification to include notification of physician to any complaints of unrelieved pain by residents to be reported to the physician immediately.
- Notification to physician of any delays in physician orders including stat orders and delay in any physician ordered appointments and x-rays.
- Education to certified nurse aides on reporting identified pain and other abnormal events identified during delivery of care.

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F 600	Continued From page 25	F 600		

Any nursing staff member that did not receive education on 12/20/2024 will receive education by the beginning of the next shift by the DON or designee. The Staff Development Coordinator will be responsible for tracking staff that still require education. Any staff that has not received education will not be allowed to work until education is received. All newly hired licensed staff will be educated by the Staff Development Coordinator on this policy. This education will be added to the orientation process. Staff Development was notified of this responsibility on 12/20/2024.

The DON or designee will verify the understanding of education through oral discussion and feedback with all staff and notate this on a tracking tool. The SDC will also do this in orientation.

In person education was completed on 12/27/2024 by the Director of Nursing to current medical providers including on-call providers, Nurse Practitioners and Medical Director. Education consisted of communication between all providers should be clear, concise and collaborative. Communication should include a discussion of treatment plans and seeking advice when necessary. Providers should participate in decision making in a timely manner.

On 1/3/2025 the Medical Director and the Physician Extenders agreed to meet with the Director of Nursing weekly to discuss abnormal labs, radiology or test results as a team.

On 1/3/2025 the Regional Director of Clinical Services informed the Staff Development

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F 600	Continued From page 26	F 600		

Coordinator and/or the Director of Nursing to complete monthly training on abuse and neglect for 3 months and then quarterly ongoing. Education will ensure abuse and neglect is explained to all staff per federal guidelines, "Neglect" as defined at 483.12, "the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress."

Effective 1/4/2025 the Administrator will be responsible to ensure implementation of this immediate jeopardy removal for this alleged non-compliance.

Alleged Date of Immediate Jeopardy removal: 1/5/2025

An onsite validation was conducted on 01/09/25. A review of in-service records revealed that all facility staff were educated on the facility's policy and procedures for abuse and neglect. This in-service training included: Recognizing signs of abuse and neglect, examples of neglect, including not providing necessary care and services, reporting of abuse and neglect, facility policy and procedures for physician notification to include notification of physician to any complaints of unrelieved pain by residents to be reported to the physician immediately, notification to physician of any delays in physician orders including STAT orders and delay in any physician ordered appointments and x-rays and education to nurse aides on reporting identified pain and other abnormal events identified during delivery of care. Interviews conducted with staff verified they had received training on abuse and neglect. The immediate jeopardy removal date of 01/05/25

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F 600	Continued From page 27 was validated.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and Administrator interview, the facility failed to report an allegation of neglect to the state agency for 1 of 1 residents reviewed for neglect (Resident #1).	F 609	F609-Reporting of Alleged Violations # 1 - Address how corrective action will be accomplished for those residents found to	1/9/25

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F 609	Continued From page 28 Findings included: The Administrator was notified on 1/3/25 at 8:48 AM of an allegation of neglect after Resident #1 sustained a fall on 11/17/24 and did not receive necessary care and services for a fracture. According to the Complaint Intake Unit (CIU), there was no evidence that an initial allegation report was submitted to the state agency until 1/6/25 at 2:15 PM. The Administrator was interviewed on 1/6/25 at 10:08 AM. He revealed that the initial allegation report was not sent to the state agency on 1/3/25 because all parties involved, including the state agency, were aware of the allegation, so he assumed it was not necessary.	F 609	have been affected by the deficient practice. On 1/6/25 an Initial Allegation Report and 5 day working report were filed for resident #1 with the NC Department of Health and Human Services to report the findings related to resident#1. # - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 1/6/25 the facility Administrator and the Director of Nursing reviewed all reportable events reported to the state agency from 12/1/24 to present for accuracy of reporting within the allowed time frames per regulation F-609. # -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Regional Director of Clinical Services educated the Executive Director and Director of Nursing regarding reporting to the state agencies all events meeting criteria in regulation F-609 within the specified time frames on 1/6/25 The Administrator and/or the Director of Nursing educated all staff members regarding the importance of immediately reporting to the Executive Director and/or the Director of Nursing any events	

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F 609	Continued From page 29	F 609	involving abuse, neglect, exploitation or misappropriation of resident property by 1/6/25 #4-Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. A monitoring tool implemented to track the reporting to the state agencies of any events involving abuse, neglect, exploitation or misappropriation of resident property. This monitor will be reviewed daily 4 weeks, then bi-weekly for 4 weeks, then monthly for 2 months. Reportable events were also added to the department manager stand up meeting going forward for heightened awareness to events and reporting of events. The results of the monitor will be reported to the Quality Assurance Performance Improvement Committee. The Administrator is responsible for the entire plan of correction. Date of completion: 1/9/25	
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		1/9/25

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F 684	Continued From page 30 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Medical Director, the Nurse Practitioner (NP), Orthopedic Surgeon, Responsible Party (RP) and staff, the facility failed to recognize the seriousness of the injury Resident #1 sustained from a fall and identify the need for urgent orthopedic evaluation. Resident #1 reported pain in her left hip on 11/17/24 following a fall. A STAT (immediately) x-ray was ordered on Sunday 11/17/24, was not completed until 11/18/24, and revealed a nondisplaced (the bone does not break completely and there will be a crack on the bone) transverse (horizontal and perpendicular to the bone) left femur (thigh bone) fracture. On 11/19/24 the NP ordered scheduled opioid medication for increased pain and ordered an orthopedic consultation at the request of Resident #1's RP. The resident remained in the facility awaiting an orthopedics consultation scheduled for 11/26/24. The Medical Director was not aware of the fracture until he saw Resident #1 on 11/22/24 at which time he ordered the resident to be sent to the emergency department if she could not be seen by the orthopedist that day. Resident #1 was seen by the orthopedist on 11/22/24 and was sent directly to the hospital and a left femur intramuscular nail surgery was performed on 11/23/24. While hospitalized, Resident #1 had an aspiration event (foods, stomach contents, or fluids are breathed into the lungs) which resulted in acute hypoxic respiratory failure (low levels of oxygen in your blood) and Intravenous (IV) antibiotics were initiated on 11/24/24. The resident was prescribed additional oral antibiotics for three days after discharge back to the facility	F 684	F 684- Quality of Care # 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; An incident report was completed on 11/17/2024 at 11:05 am by the charge nurse, based on information obtained from certified nursing aide. Resident #1 was observed on the floor next to her bed sitting on her bottom. The resident was assessed by the charge nurse and no injuries were discovered during the initial assessment. The resident was assisted back to bed by the charge nurse and the certified nursing aide without incident. The charge nurse called the resident□s Responsible Party (RP) and the Nurse Practitioner (NP) and no new orders were given. On 11/17/24 at 11:21 AM another progress note was entered in the electronic record which stated that the resident reported pain in her left hip and elbow when the RP arrived to the facility. The facility failed to immediately notify the medical provider of the new onset of pain. The medical provider was not called until 2:14 PM and at that time the medical provider gave new orders for a stat x-ray and Tylenol 500mg every 6 hours as needed for pain. The Tylenol order was not entered until 3:05pm on 11/17/2024.	

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F 684	Continued From page 31 on 11/26/24. The Orthopedic Surgeon indicated an injury like Resident #1's required an immediate transfer to the hospital for evaluation by an orthopedic specialist and that the risks of complications increased with the delay of care such as deep vein thrombosis (blood clots in veins deep in the body), pneumonia, and bed sores. This deficient practice affected 1 of 5 residents reviewed for falls (Resident #1). Immediate jeopardy began on 11/18/24 when the facility failed to recognize the seriousness of the injury and identify the need for urgent orthopedic evaluation when x-ray results verified the resident sustained a transverse left femur fracture. The immediate jeopardy was removed on 1/9/25 when the facility implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a scope and severity of "D" (no actual harm with potential for more than minimal harm that is immediate jeopardy) to ensure education is completed and monitoring systems put into place and are effective. Findings included: Resident #1 was admitted to the facility on 10/20/22 with diagnoses that included vascular dementia, muscle weakness, difficulty in walking, bradycardia (initiated 11/12/24), traumatic brain injury (TBI) in 1999, history of a stroke, chronic obstructive pulmonary disease/asthma, and dysarthria (slurred speech). Review of the annual Minimum Data Set (MDS) assessment dated 8/30/24 revealed that Resident #1 had adequate vision/hearing, usually understood/understands, and was severely	F 684	On 11/18/2024 the x-ray of the left hip was obtained at 9:23 am. The x-ray resulted on 11/18/2024 12:54 pm and the impressions were an acute transverse, nondisplaced intertrochanteric femur fracture. The residents RP and NP were informed of the results on 11/18/2024 at 2:59 pm. On 11/19/2024 the NP assessed the resident after reviewing the x-ray and new orders were given for the resident to be seen by an orthopedic doctor. The NP elected not to send the resident out immediately after conferring with the RP who stated it was acceptable at the time. An orthopedic appointment was obtained for 11/26/2024. The NP ordered Tramadol 25 milligrams twice a day and to be given every 12 hours as needed for breakthrough pain. The NP made a determination to treat the injury in-house because he considered the resident to not be a good surgical candidate. The Medical Director (MD) was not aware of the fracture until he saw Resident #1 on 11/22/24 at which time he ordered the resident to be sent to the emergency department if she could not be seen by the orthopedist that day. Resident #1 was seen by the orthopedist on 11/22/24 and was sent directly to the hospital and a left femur intramuscular nail surgery was performed on 11/23/24. # - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice;	

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F 684	Continued From page 32 cognitively impaired. She did not have any falls since the previous assessment, and there was no pain presence or pain medication regimen in place at the time of the review period. Resident #1 was 62 inches tall and weighed 89 pounds. Review of physician orders for Resident #1 revealed that a pain assessment using 0-10 (0 = no pain, 10 = excruciating pain) scale or non-verbal scoring tool every shift was ordered on 11/9/24. Review of an unwitnessed fall report dated 11/17/24 at 11:05 AM and completed by Nurse #1 revealed she was notified by Nurse Aide (NA)#1 that Resident #1 was on the floor next to her bed sitting on her bottom. Resident #1 denied hitting her head. The On-Call Provider and RP were notified. She was assessed, and no injuries were noted. Vital signs were within normal limits. Resident #1 reported no pain or discomfort. She was then assisted back to her bed. Review of a 72-hour post fall documentation note dated 11/17/24 at 11:21 AM and completed by Nurse #1 revealed that Resident #1 reported pain in her left hip when the RP arrived at the facility. An On-Call NP note dated 11/17/24 at 2:32 PM revealed that Resident #1 had a fall at 11:00 AM. No injuries were reported, and Resident #1 denied pain. Now, Resident #1 reported left hip pain with tenderness to palpation (a method of feeling with the fingers or hands during a physical examination). Nurse #1 reports right facial swelling and concern for facial droop. A neurological check was performed by the NP via video and there were no acute deficits noted. A STAT x-ray of the left hip was ordered, as well as	F 684	On 12/27/24 the Director of Nursing, Unit Managers and Regional Director of Clinical Services, reviewed the last 30 days of diagnostic results and progress notes for all residents to identify any instances of delay in carrying out orders, changes in condition, abnormal results, refusals or other clinical conditions that had not been properly identified and acted upon. If there were instances identified, the Unit Manager completed proper assessment and follow-up with resident, medical providers and responsible party as needed. # -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Staff Development Coordinator, Regional Director of Clinical Services, and Unit Managers conducted in-person education for Licensed Nurses, including agency nurses, on recognizing when to seek medical treatment for residents with fracture and changes in condition and notification to the Physician/Medical Director following an incident or change of condition and when receiving ordered diagnostic test results. Requirements for notification included reporting of abnormal labs and x-ray results, if an order is not to be carried out as ordered by the physician or nurse practitioner, refusal of treatment plan by the resident or responsible party. Education also included knowing the risk	

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F 684	Continued From page 33 Tylenol 500 milligrams (mg) every 6 hours as needed (PRN) for pain. Neurological checks should be performed every 4 hours. Review of physician orders for Resident #1 revealed that a one-time STAT x-ray of the left hip was ordered on 11/17/24 at 3:04 PM. On the same day, Tylenol 500mg tablet given every 6 hours as needed for pain was also ordered. Nurse #1 was interviewed on 12/19/24 at 11:14 AM. She revealed that on 11/17/24 around 11:00 AM, NA #1 told her that Resident #1 had fallen in her room. Nurse #1 went to the room and saw Resident #1 on her bottom next to her bed. Although Resident #1 was nonverbal, she could shake/nod her head to yes and no questions. Nurse #1 asked if she was ok, and she said "yes." She then assessed Resident #1, including her extremities (limbs, hands, and feet), and asked if she hit her head. Resident #1 said "no." She was then put back into bed with Nurse #1's assistance. Nurse #1 took vital signs and notified her supervisor at the time (name unknown). Nurse #1 was instructed to complete all documentation related to the fall and then called Resident #1's RP. The RP came later (45 minutes or so) and said Resident #1 complained of pain. Nurse #1 assessed her again, and Resident #1 said she was in pain. She assessed her left leg while she was laying on her right side. When she pressed on it, Resident #1 winced with pain, and there was a bruise. She contacted the On-Call NP again and told her that there was new onset pain. The On-Call NP ordered an x-ray STAT. Nurse #1 stated she gave Resident #1 some Tylenol and then she left for the night at 7:00 PM.	F 684	and benefits of not sending a resident out for treatment when needed and how to effectively communicate this information to the RP or resident if they are responsible for making their own healthcare decisions. Risks include worsening condition, delayed treatment plan, increased pain or discomfort and complications associated with the disease process. The Director of Nursing will ensure that no staff member works without receiving this education. The Staff Development Coordinator is responsible for tracking that all staff received the required education. Any new hires, including agency staff, will receive education prior to the start of their shift. Education will be completed by 1/8/2025 by the Staff Development Coordinator. The Staff Development Coordinator, Regional Director of Clinical Services, and Unit Managers initiated in-person training for all Licensed Nurses, including agency nurses, to ensure they understand the requirements for orders received for diagnostic tests. The requirements included: If the diagnostic test is ordered stat and the mobile diagnostic company is unable to perform the study stat or in an acceptable time at the direction of the medical provider the resident is to be sent to the hospital. The Director of Nursing will ensure no staff will work without receiving this education. Any new hires, including agency staff, will receive education prior to the start of their shift. Education will be completed by 1/4/2025. The Staff Development Coordinator will	

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F 684	Continued From page 34 A follow-up telephone interview was conducted with Nurse #1 on 12/19/24 at 6:05 PM. She revealed that radiology told her they would get to the facility on 11/17/24 as soon as they could. Nurse #1 did not notify the On-Call Provider that the x-rays were not yet performed when she finished her shift at 7:00 PM on 11/17/24. Nurse #1 could not provide a reason as to why she did not notify the On-Call Provider of the STAT x-ray delay. During a telephone interview with the Medical Director on 12/20/24 at 12:57 PM, he revealed that the expectation of a STAT x-ray was for it to be performed on the same day it was ordered. The Director of Nursing (DON) was interviewed on 12/30/24 at 11:49 AM. She revealed that if a STAT x-ray was not performed within 2-4 hours after it was ordered or before a shift was completed, then Nurse #1 should have contacted the On-Call Provider for further instructions on whether to wait or receive other orders. The RP was interviewed via telephone on 12/18/24 at 1:56 PM. She revealed that Nurse #1 called her on 11/17/24 when Resident #1 fell and said she was fine. She visited 45 minutes later, and when asked if anything hurt, Resident #1 would say her left hip. The RP was told by Nurse #1 that an x-ray was ordered. She waited until 8:00 PM, but no one came. During a telephone interview with Nurse #3 on 12/19/24 at 11:41 AM, he revealed that when he arrived for the night shift on 11/17/24, he was instructed by the day shift nurses to pay more attention to Resident #1 due to her trying to get up without assistance. Resident #1 needed	F 684	be responsible for tracking all staff to make sure they have received the required education. The Staff Development Coordinator was informed of her responsibility on 12/27/24. This education will also become a part of the new hire orientation process for all newly hired licensed nurses. On 12/27/24, the Staff Development Coordinator, Regional Director of Clinical Services, and Unit Managers conducted in-person education for all Licensed Nurses, including agency nurses, on the procedure for handling abnormal x-ray results. The training emphasized that abnormal results must be reported to the Medical Director for further orders. Education will be completed by 1/4/2025. Any staff who did not receive the in-person training will be educated before their next scheduled shift. The Staff Development Coordinator is responsible for tracking that all staff receive the required education. This training will also be included in the new hire orientation for all newly hired licensed staff. On 12/27/24 the Director of Nursing and Staff Development Coordinator began in-person training for all certified nurse aides, including agency nurse aides on reporting and recognizing changes in a resident□s condition such as reports of pain, impaired skin integrity, abnormal vital sign, changes in mobility, mood or appetite. The Staff Development Coordinator will be responsible for tracking that all staff have received the required education. This education will be	

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F 684	Continued From page 35 assistance with transfers and was very unsteady on her feet. Review of a medical progress note dated 11/18/24 at 10:00 AM and completed by the NP revealed that Resident #1 had a fall on 11/17/24. She denied hitting her head, injury, or pain following the fall. Resident #1 appeared at her baseline mental status and had tenderness to the left hip with palpation. Review of a health status note dated 11/18/24 at 10:18 AM and completed by Nurse #2 revealed that radiology services were in the facility for Resident #1 to perform the STAT x-rays ordered on 11/17/24. Review of a health status note dated 11/18/24 at 11:40 AM and completed by Nurse #2 revealed that Resident #1 continued to have pain/discomfort in her left hip. Review of the x-ray results dated 11/18/24 revealed an acute transverse left femur fracture. The x-rays were taken at 9:23 AM and reported at 12:54 PM. Review of a 72-hour post fall documentation note dated 11/18/24 at 2:18 PM and completed by Nurse #2 revealed that Resident #1 had a nondisplaced fracture to the left femur and reported a pain level of 4 in the left hip. Review of the November 2024 medication administration record (MAR) revealed that Nurse #2 administered 500mg of as needed Tylenol to Resident #1 on 11/18/24 at 2:54 PM due to a pain level of 7.	F 684	completed by 1/4/25. Any staff who did not receive the in-person training will be educated before their next scheduled shift. The Staff Development Coordinator will be responsible for tracking that all staff receive the required education. This training will also be included in the new hire orientation for all newly hired nurse aides. The Regional Director of Clinical Services educated the Nurse Management team and the Administrator regarding the clinical morning meeting process to include a review of residents with falls and change of condition, to validate the notification of the Medical Director and the new orders received. This education was completed on 1/3/2025. #4-Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing or designee will review all clinical documentation daily to identify instances related to resident changes in condition, abnormal x-ray and laboratory results and pain assessments to ensure that collaboration has with the medical director or physician extenders has occurred and that the resident has been assessed properly for an effective treatment plan to be developed. The reviews will occur daily for 12 weeks until substantial compliance is achieved. The Director of Nursing will report the	

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F 684	Continued From page 36 Nurse #2 was interviewed on 12/19/24 at 12:09 PM. Nurse #2 revealed that she had worked with Resident #1 from 7:00 AM - 7:00 PM on 11/18/24. Resident #1 was not alert and oriented and was nonverbal but able to shake her head yes or no when asked a question. She stated Resident #1 had bruising on her left hip, and an x-ray was ordered. On 11/18/24, it was found that Resident #1 had a left hip/leg fracture. Nurse #2 would ask Resident #1 how she was feeling during medication pass on 11/18/24 and if she was hurting, and she would nod yes if in pain. When working with her and turning her in bed, Nurse #2 noticed that Resident #1 would grimace some. It seemed she had pain from between a 4 to 7 out of 10 on the pain scale on 11/18/24. During a telephone interview with Nurse #3 on 12/19/24 at 11:41 AM, he stated he did not recall if he received any special instructions or was notified of the fracture when he arrived for the night shift on 11/18/24. Resident #1 was nonverbal but would shake her head yes or no for responses. During the week of 11/18/24, he indicated that he could not recall if Resident #1 had any significant signs or symptoms of pain/discomfort. Review of a medical progress note dated 11/19/24 and completed by the NP revealed that Resident #1 had an acute nondisplaced transverse intertrochanteric femur fracture. Resident #1's RP was waiting for the NP to contact her for consultation, which took place the same day. The RP requested an orthopedic evaluation. The NP discussed complications about potential surgery with the RP and told her that orthopedics would consider Resident #1's overall health, specifics about the fracture, and	F 684	finding from the audits to the Quality Assurance Performance Improvement committee for recommendations and/or modifications until a pattern of compliance is achieved. The Administrator is responsible for this plan of correction. Date of completion:1/9/25	

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new asymptomatic bradycardia.

An interview was conducted with the Unit Manager on 12/19/24 at 12:22 PM. She revealed that she spoke to the RP on 11/19/24, and she wanted Resident #1 to be sent out to the hospital. The Unit Manager instructed her to speak to the NP, who then told her that Resident #1 was not a surgical candidate due to her low body mass. The Unit Manager indicated there was a non-verbal scoring tool with pain assessments on the MAR, and all nurses should have performed pain assessments during each shift.

Review of physician orders for Resident #1 revealed that on 11/19/24, an orthopedic surgery consultation for a left hip/leg fracture was ordered.

An order note dated 11/19/24 at 10:16 AM by Nurse #2 revealed that new orders were received for an orthopedic consultation of Resident #1's left femur fracture after a fall.

Review of a health status note dated 11/19/24 at 11:43 AM by Nurse #2 revealed that Resident #1 continued to have pain/discomfort in her left hip. A consultation for orthopedics was ordered.

Review of a 72-hour post fall documentation note dated 11/19/24 at 2:29 PM and completed by Nurse #2 revealed that the note read in part: "Current status of the resident's injuries or reports of pain from the fall: Acute transverse, nondisplaced intertrochanteric fracture femur is noted. No other acute fracture or dislocation. Interventions are currently in place to prevent additional falls: keep wheelchair beside bed, call bell within reach, bed in lowest/locked position,

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and Nurse Aides rounding every 2 hours. Resident's response to new interventions remains in the bed, Tylenol given for pain."

Nurse #2 was interviewed on 12/19/24 at 12:09 PM. Nurse #2 revealed that she had worked with Resident #1 from 7:00 AM - 7:00 PM on 11/19/24. The nurse stated she asked Resident #1 how she was feeling during medication pass on 11/19/24 and if she was hurting, and she would nod yes if in pain. On 11/19/24, an order for Tramadol was added.

Review of a health status note dated 11/19/24 at 2:40 PM and completed by the Unit Manager revealed that Resident #1's RP was at her bedside with some concerns of increased pain due to the left hip/leg fracture. The RP stated that her family told her that Resident #1 needed to go to the hospital for 24-hour care. It was explained to the RP that Resident #1's pain could be managed at the facility; however, if she felt the pain was getting worse, the family could make the decision to send her out to the hospital. The Unit Manager spoke with the NP, who ordered scheduled Tramadol (treats moderate to moderately severe pain). The RP was made aware.

On 11/19/24, a physicians order for Tramadol (opioid) 25mg twice daily due to the resident having increased pain.

During an interview via telephone on 12/18/24 at 1:56 PM the RP indicated they visited on 11/18/24 and found out about the left hip/leg fracture x-ray results. She requested to speak to the NP, but she was not contacted until 11/19/24. He (the NP) told her that Resident #1 had a broken hip and

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would not send her out because she was not a surgical candidate due to her small body frame and the fracture could possibly heal on its own. On 11/19/24, the RP stated she told the Unit Manager that Resident #1 was still in pain, and the RP wanted her to be sent out to the hospital. The RP stated she could not rate Resident #1's pain level due to her dementia but when she (the resident) reached for something she would say her left hip was hurting. When the RP asked if they could send Resident #1 to the hospital, the Unit Manager told her that the hospital would send her right back. The Unit Manager then ordered stronger pain medication. The RP stated her main concern was that Resident #1 was not sent to the hospital immediately after the fall.

During a telephone interview with the RP on 12/18/24 at 10:28 AM, she revealed on 11/19/24 when she spoke to the NP over the phone, he told her that he would not send Resident #1 to the hospital due to her small body frame, and it would be difficult for the surgeons to work on her. The RP recalled the facility scheduled an orthopedic appointment originally for 11/26/24.

During a follow-up telephone interview with the RP on 12/20/24 at 9:56 AM, she revealed that when she spoke to the NP over the phone on 11/19/24, he never spoke to her about the risks of not sending Resident #1 out to the hospital.

Review of a medical progress note dated 11/20/24 and completed by the Medical Director revealed that Resident #1 denied pain and neurological checks remain normal. The note indicated staff were to provide closer supervision and that fall protocols were in place. Laboratory results and radiology were reviewed.

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The Night Nurse Supervisor was interviewed via telephone on 12/21/24 at 7:48 AM. She revealed that she did not assess Resident #1 for pain at all on 11/18/24, 11/19/24, or 11/20/24.. She stated that she took the information in the 72-hour post fall documentation notes from the previous shift and copied the details into the notes she wrote just so that some kind of documentation was completed during her shift. The Night Nurse Supervisor indicated that as a supervisor, she would review the documentation that needed to be completed by the nurses during her shift. If documentation was not completed, then she would have done it herself. Resident #1 was nonverbal, so she could not verbally provide a pain scale rating.

During a telephone interview with NA #3, who worked with Resident #1 during the night shift from 7:00 PM on 11/20/24 until 7:00 AM on 11/21/24, she revealed that Resident #1 had fallen 3 days prior, and this was the first time she had worked with Resident #1. When she arrived for her shift, she was notified by the off coming NA that Resident #1's left hip was hurt and to be cautious during care. NA #3 remembered that Resident #1 said "ow" during an incontinence care episode when she touched her left hip. She did not notify anyone of the pain because she was notified about the left hip at the beginning of her shift. She made sure not to change or move Resident #1 during the shift unless necessary.

Review of a medical progress note dated 11/21/24 and completed by the Medical Director revealed that Resident #1 denied all pain and appeared comfortable. There was no injury since her last fall and fall protocols were already in

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place. Laboratory results and radiology reviewed.

A telephone interview was conducted with NA #2 on 12/19/24 at 10:53 AM. She worked with Resident #1 during the overnight shift from 7:00 PM on 11/21/24 until 7:00 AM on 11/22/24. NA #2 revealed that it appeared Resident #1 was in a lot of pain during her shift because she would refuse care, was not willing to get out of bed, and was not willing to roll side to side. Resident #1 was nonverbal, but when NA #2 tried to turn her in the bed, Resident #1 would grab her arm as if she was telling NA #2 to stop.

Review of the MAR for November 2024 revealed that pain assessments were completed with a "check mark" from 11/19/24 - 11/22/24 without a numerical value or location for pain or a non-verbal pain scoring tool result in the medical record.

Review of a medical progress note date 11/22/24 and completed by the Medical Director revealed that at the time of Resident #1's last fall on 11/17/24, she denied injury and denied pain. Since her last clinical examination on 11/21/24, Resident #1 complained of pain to the nurses. A recent x-ray of the left hip indicated a left intertrochanteric femur fracture. The Medical Director documented an immediate referral to orthopedics was made for today (11/22/24).

A telephone interview was conducted with the Medical Director on 12/19/24 at 10:19 AM. He revealed that he did not review Resident #1's x-ray results from 11/18/24 until 11/22/24, and he did not receive an update from the NP that entire week. When he saw Resident #1 on 11/22/24, Resident #1 was in pain, and the Medical Director

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told staff that she needed to be sent out immediately. The Medical Director indicated he was told that Resident #1 had an orthopedic appointment the following week, but he told them she needed to go that day (11/22/24). The Medical Director stated that Resident #1 should have gone to the hospital as soon as the x-ray results came in on 11/18/24, and the surgeon would have made the decision if she was a surgical candidate or not.

An interview was conducted with the Unit Manager on 12/19/24 at 12:22 PM. She revealed that she thought Resident #1 was not in pain the week after the fall because there was one day (date unknown) that she got out of bed into her wheelchair. However, for most of that week after the 11/17/24 fall, Resident #1 remained in bed, even though she was usually up daily. Every time she (the Unit Manager) asked if Resident #1 was in pain, she shook her head no. The RP told nursing staff that Resident #1 was in pain, but when staff asked her themselves, she would shake her head no. On 11/22/24, after the Medical Director saw the x-ray results and evaluated Resident #1, he wanted her to be sent out to an orthopedic appointment that same day.

The RP was interviewed via telephone on 12/18/24 at 10:28 AM and 1:56 PM. She indicated Resident #1 remained in bed the entire week until 11/22/24, the day she went to the hospital. The Scheduler called the RP on 11/22/24 and told her that the orthopedics appointment was rescheduled for that same day. No reason was provided. The orthopedics office saw the fracture, and Resident #1 was then sent to the emergency department (ED).

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The NP was interviewed on 12/18/24 at 1:00 PM. The NP stated radiology took an x-ray of Resident #1's left hip on 11/18/24 and the results indicated a left femur fracture. He revealed that he was concerned whether Resident #1 would be suitable for surgery due to asymptomatic bradycardia. The NP indicated on 11/19/24 he requested Resident #1 be sent to the first available appointment at an orthopedics office to determine if she was a surgical candidate. The RP told the NP that she wanted Resident #1 to go to surgery, which was why an orthopedic consultation was scheduled for the following week (11/26/24). The NP indicated that he did not send Resident #1 to the emergency department (ED) because he was unsure if she was a surgical candidate or whether she would be better conservatively managed so that the fracture could heal on its own. Resident #1 was having a little bit of pain, which was managed with pain medication. The pain became unmanageable on 11/22/24, and she was seen by the orthopedics office on 11/22/24, who then sent her to the emergency department (ED) for surgery.

Review of an Orthopedic Visit note dated 11/22/24 revealed that Resident #1 was in no acute distress, and the left leg was warm and perfused (adequate blood flow). Resident #1 pointed to the left groin area as a source of pain. Due to the results of the x-rays taken during the visit (intertrochanteric fracture of the left femur), Resident #1 was sent to the hospital from the appointment.

Review of a Hospital Discharge Summary dated 11/26/24 revealed that Resident #1 had a closed intertrochanteric fracture of the left femur. She was seen in the orthopedic office on 11/22/24 for

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further evaluation, and an x-ray was obtained which showed an intertrochanteric fracture of the left femur. She was sent to the ED for further evaluation, and a left femur intramuscular nail surgery was performed on 11/23/24. The discharge summary indicated Resident #1 had an aspiration event while hospitalized which resulted in acute hypoxic respiratory failure and IV antibiotics were initiated on 11/24/24. The resident was prescribed additional oral antibiotics for three days after discharge back to the facility.

The Orthopedic Surgeon, who performed the left hip surgery for Resident #1 on 11/23/24 in the hospital, was interviewed on 1/2/25 at 5:22 PM. He revealed that the healing and the treatment of Resident #1's left hip/leg fracture would not change with the delay of surgery. However, the risk of complications would go up if there was a delay. Such complications could be deep vein thrombosis (blood clots in veins deep in the body), pneumonia, and bed sores. The Orthopedic Surgeon stated that if Resident #1 was lying completely still, then the left hip pain could be well tolerated. However, if she was transferred to a chair or back to bed or rolling in bed, that could be significantly painful for her. In general, the standard of care was that if someone broke a long bone (such as the femur), they would need to be evaluated by an orthopedic specialist, who would then make the final decision for surgery within 24-48 hours after the injury. An injury like this would need an immediate transfer to the hospital. If she came to the clinic to be seen, she would have been sent directly to the ED, and they would not let her go home and wait for surgery. If this type of fracture was not treated within 24-48 hours, there are good outcome studies that were done showing a 30%

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perioperative mortality rate. That mortality rate would decrease if the injury was treated with surgery within 48 hours.

The DON was interviewed on 12/30/24 at 11:58 AM. She revealed that nurses should have used a non-verbal pain tool or a pain scale when assessing Resident #1 for pain. She believed that the nurses chose "N/A" in the MAR when performing the pain assessments because Resident #1 denied pain. If a STAT x-ray was not done within 2-4 hours or before a shift was completed, then the nurse should have contacted the on-call provider for further instructions whether to wait or complete other orders. Resident #1 was noted during that week without pain or discomfort. The providers made their decision, and if any pain or discomfort was observed, the providers and managers would have agreed on further steps. The DON stated Resident #1 was not neglected, and the NP made his judgement call to keep her at the facility.

During an interview with the Administrator on 12/30/24 at 12:31 PM, he revealed that he could not speak on this issue due to not having a clinical background.

The Administrator was notified of immediate jeopardy on 1/3/25 at 8:48 AM.

The facility provided the following Acceptable Credible Allegation of Immediate Jeopardy removal:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

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An incident report was completed on 11/17/2024 at 11:05 am by the charge nurse, based on information obtained from certified nursing aide. Resident #1 was observed on the floor next to her bed sitting on her bottom. The resident was assessed by the charge nurse and no injuries were discovered during the initial assessment. The resident was assisted back to bed by the charge nurse and the certified nursing aide without incident. The charge nurse called the resident's Responsible Party (RP) and the Nurse Practitioner (NP) and no new orders were given. On 11/17/24 at 11:21 AM another progress note was entered in the electronic record which stated that the resident reported pain in her left hip and elbow when the RP arrived to the facility. The facility failed to immediately notify the medical provider of the new onset of pain. The medical provider was not called until 2:14 PM and at that time the medical provider gave new orders for a stat x-ray and Tylenol 500mg every 6 hours as needed for pain. The Tylenol order was not entered until 3:05pm on 11/17/2024.

On 11/18/2024 the x-ray of the left hip was obtained at 9:23 am. The x-ray resulted on 11/18/2024 12:54 pm and the impressions were an acute transverse, nondisplaced intertrochanteric femur fracture. The residents' RP and NP were informed of the results on 11/18/2024 at 2:59 pm.

On 11/19/2024 the NP assessed the resident after reviewing the x-ray and new orders were given for the resident to be seen by an orthopedic doctor. The NP elected not to send the resident out immediately after conferring with the RP who stated it was acceptable at the time. An orthopedic appointment was obtained for

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11/26/2024. The NP ordered Tramadol 25 milligrams twice a day and to be given every 12 hours as needed for breakthrough pain.

The NP made a determination to treat the injury in-house because he considered the resident to not be a good surgical candidate.

The Medical Director was not aware of the fracture until he saw Resident #1 on 11/22/24 at which time he ordered the resident to be sent to the emergency department if she could not be seen by the orthopedist that day.

Resident #1 was seen by the orthopedist on 11/22/24 and was sent directly to the hospital and a left femur intramuscular nail surgery was performed on 11/23/24.

The facility failed to identify the seriousness of Resident #1's left intertrochanteric femur fracture after the fall on 11/17/24, identify the urgent need for orthopedic evaluation and surgical intervention, obtain the x-ray stat as ordered by the medical provider. In addition, the facility also failed to explain to the RP the risk of not sending the resident out for treatment versus managing the fracture in-house without a physician and/or orthopedic consultation. The delay in orthopedic medical management care and treatment put the resident at risk for complications such as DVT, PNA and bed sores.

On 12/27/24 the Director of Nursing, Unit Managers and Regional Director of Clinical Services, reviewed the last 30 days of diagnostic results and progress notes for all residents to identify any instances of delay in carrying out orders, changes in condition, abnormal results,

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refusals or other clinical conditions that had not been properly identified and acted upon. If there were instances identified, the Unit Manager completed proper assessment and follow-up with resident, medical providers and responsible party as needed.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

The Staff Development Coordinator, Regional Director of Clinical Services, and Unit Managers conducted in-person education for Licensed Nurses, including agency nurses, on recognizing when to seek medical treatment for residents with fracture and changes in condition and notification to the Physician/Medical Director following an incident or change of condition and when receiving ordered diagnostic test results. Requirements for notification included reporting of abnormal labs and x-ray results, if an order is not to be carried out as ordered by the physician or nurse practitioner, refusal of treatment plan by the resident or responsible party. Education also included knowing the risk and benefits of not sending a resident out for treatment when needed and how to effectively communicate this information to the RP or resident if they are responsible for making their own healthcare decisions. Risks include worsening condition, delayed treatment plan, increased pain or discomfort and complications associated with the disease process. The Director of Nursing will ensure that no staff member works without receiving this education. The Staff Development Coordinator is responsible for tracking that all staff received the required education. Any new

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hires, including agency staff, will receive education prior to the start of their shift. Education will be completed by 1/8/2025 by the Staff Development Coordinator.

The Staff Development Coordinator, Regional Director of Clinical Services, and Unit Managers initiated in-person training for all Licensed Nurses, including agency nurses, to ensure they understand the requirements for orders received for diagnostic tests. The requirements included: If the diagnostic test is ordered stat and the mobile diagnostic company is unable to perform the study stat or in an acceptable time at the direction of the medical provider the resident is to be sent to the hospital. The Director of Nursing will ensure no staff will work without receiving this education. Any new hires, including agency staff, will receive education prior to the start of their shift. Education will be completed by 1/4/2025. The Staff Development Coordinator will be responsible for tracking all staff to make sure they have received the required education. The Staff Development Coordinator was informed of her responsibility on 12/27/24. This education will also become a part of the new hire orientation process for all newly hired licensed nurses.

On 12/27/24, the Staff Development Coordinator, Regional Director of Clinical Services, and Unit Managers conducted in-person education for all Licensed Nurses, including agency nurses, on the procedure for handling abnormal x-ray results. The training emphasized that abnormal results must be reported to the Medical Director for further orders. Education will be completed by 1/4/2025. Any staff who did not receive the in-person training will be educated before their next scheduled shift. The Staff Development

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Coordinator is responsible for tracking that all staff receive the required education. This training will also be included in the new hire orientation for all newly hired licensed staff.

On 12/27/24 the Director of Nursing and Staff Development Coordinator began in-person training for all certified nurse aides, including agency nurse aides on reporting and recognizing changes in a resident's condition such as reports of pain, impaired skin integrity, abnormal vital sign, changes in mobility, mood or appetite. The Staff Development Coordinator will be responsible for tracking that all staff have received the required education. This education will be completed by 1/4/25. Any staff who did not receive the in-person training will be educated before their next scheduled shift. The Staff Development Coordinator will be responsible for tracking that all staff receive the required education. This training will also be included in the new hire orientation for all newly hired nurse aides.

The Regional Director of Clinical Services educated the Nurse Management team and the Administrator regarding the clinical morning meeting process to include a review of residents with falls and change of condition, to validate the notification of the Medical Director and the new orders received. This education was completed on 1/3/2025.

Effective 1/4/2025 the Administrator will be responsible to ensure implementation of this immediate jeopardy removal for this alleged non-compliance.

Alleged Date of Immediate Jeopardy Removal:

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F 684	Continued From page 51 1/9/2025 An onsite validation was conducted on 01/09/25. A review of the in-service records revealed that education was provided to all Licensed Nurses, including agency nurses, on recognizing when to seek medical treatment for residents with fracture(s), changes in condition and notification to the Physician/Medical Director following an incident or change of condition and/or when receiving ordered diagnostic test results. Requirements for notification included reporting of abnormal labs and x-ray results, if an order is not carried out as ordered by the physician or nurse practitioner, refusal of treatment plan by the resident or responsible party. Education also included knowing the risk and benefits of not sending a resident out for treatment when needed and how to effectively communicate this information to the RP and/or resident if they are responsible for making their own healthcare decisions. Risks include worsening condition, delayed treatment plan, increased pain or discomfort and complications associated with the disease process. Interviews conducted with licensed nurses verified their knowledge of this training. The immediate jeopardy removal date of 01/09/25 was validated.	F 684		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced	F 697		1/9/25

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F 697	Continued From page 52 by: Based on record review, and Medical Director, Nurse Practitioner, Responsible Party and staff interviews, the facility failed to effectively intervene for complaints of pain, failed to provide thorough and ongoing pain assessments, and failed to effectively manage a resident's pain. This was for 1 of 1 resident reviewed for pain (Resident #1). Findings included: Resident #1 was admitted to the facility on 10/20/22 with diagnoses that included vascular dementia, muscle weakness, difficulty in walking, bradycardia (a condition where the heart beats too slowly) (initiated 11/12/24), traumatic brain injury (TBI) in 1999, history of a stroke, chronic obstructive pulmonary disease/asthma, and dysarthria (slurred speech). Review of the annual Minimum Data Set (MDS) assessment dated 8/30/24 revealed that Resident #1 was severely cognitively impaired. She did not have any falls since the previous assessment, and there was no pain presence or pain medication regimen in place at the time of the review period. Review of physician orders for Resident #1 revealed that a pain assessment using 0-10 (0 = no pain, 10 = excruciating pain) scale or non-verbal scoring tool every shift was ordered on 11/9/24. Review of an unwitnessed fall report dated 11/17/24 at 11:05 AM and completed by Nurse #1 revealed she was notified by Nurse Aide (NA)#1 that Resident #1 was on the floor next to her bed	F 697	F697-Pain Management # 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; An incident report was completed on 11/17/2024 at 11:05 am by the charge nurse, based on information obtained from certified nursing aide. Resident #1 was observed on the floor next to her bed sitting on her bottom. The resident was assessed by the charge nurse and no injuries were discovered during the initial assessment. The resident was assisted back to bed by the charge nurse and the certified nursing aide without incident. The charge nurse called the resident□s Responsible Party (RP) and the Nurse Practitioner (NP) and no new orders were given. On 11/17/24 at 11:21 AM another progress note was entered in the electronic record which stated that the resident reported pain in her left hip and elbow when the RP arrived to the facility. The facility failed to immediately notify the medical provider of the new onset of pain. The medical provider was not called until 2:14 PM and at that time the medical provider gave new orders for a stat x-ray and Tylenol 500mg every 6 hours as needed for pain. The Tylenol order was not entered until 3:05pm on 11/17/2024. On 11/18/2024 the x-ray of the left hip was obtained at 9:23 am. The x-ray resulted on 11/18/2024 12:54 pm and the	

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F 697	Continued From page 53 sitting on her bottom. Resident #1 denied hitting her head. The on-call provider and responsible party (RP) were notified. Resident #1 was noted to have regular white socks on both of her feet. She was assessed, and no injuries were noted. Vital signs (VS) were within normal limits (WNL). Resident #1 reported no pain or discomfort. She was then assisted back to her bed. Review of a 72-hour post fall documentation note dated 11/17/24 at 11:21 AM and completed by Nurse #1 revealed that Resident #1 reported pain in her left hip when the RP arrived at the facility. Review of an On-Call Provider note dated 11/17/24 at 4:15 PM and completed by the On-Call Provider revealed that Resident #1 had a fall at 11:00 AM. No injuries were reported, and Resident #1 denied pain. The RP visited the facility and now Resident #1 reported left hip pain with tenderness to palpation. A neurological check was performed via video and there were no acute deficits noted. A STAT (with no delay) x-ray of the left hip was ordered, as well as Tylenol 500 milligrams (mg) every 6 hours as needed for pain. Neurological checks should be performed every 4 hours. Review of physician orders for Resident #1 revealed that a one-time STAT x-ray of the left hip was ordered on 11/17/24 at 3:04 PM. On the same day, Tylenol 500mg tablet given every 6 hours as needed for pain was also ordered at 3:15 PM. Review of Resident #1's vital signs from 11/17/24 - 11/22/24 revealed that she had a pain value of 0 on 11/17/24 at 11:08 AM and 4:14 PM. On 11/18/24, Resident #1 had pain values of 7 at	F 697	impressions were an acute transverse, nondisplaced intertrochanteric femur fracture. The residents RP and NP were informed of the results on 11/18/2024 at 2:59 pm. On 11/19/2024 the NP assessed the resident after reviewing the x-ray and new orders were given for the resident to be seen by an orthopedic doctor. The NP elected not to send the resident out immediately after conferring with the RP who stated it was acceptable at the time. An orthopedic appointment was obtained for 11/26/2024. The NP ordered Tramadol 25 milligrams twice a day and to be given every 12 hours as needed for breakthrough pain. The NP made a determination to treat the injury in-house because he considered the resident to not be a good surgical candidate. The Medical Director (MD) was not aware of the fracture until he saw Resident #1 on 11/22/24 at which time he ordered the resident to be sent to the emergency department if she could not be seen by the orthopedist that day. Resident #1 was seen by the orthopedist on 11/22/24 and was sent directly to the hospital and a left femur intramuscular nail surgery was performed on 11/23/24. # - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 12/27/24 the Director of Nursing/Assistant Director of Nursing/Unit	

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F 697	Continued From page 54 2:54 PM and 4 at 3:26 PM. Only numerical values were entered. Where the pain was located was not included. Nurse #1 was interviewed on 12/19/24 at 11:14 AM. She revealed that she completed all documentation related to Resident #1's fall and called the responsible party (RP). She was nonverbal. She checked on her multiple times after the fall, and she did not voice any pain/concerns. The RP came later that day and said Resident #1 complained of pain. She assessed her again, and Resident #1 said she was in pain. She assessed her left leg while she was laying on her right side. When she pressed on it, she winced with pain and there was a bruise. She contacted the doctor again and told her that the pain had not been discovered until just then. She was instructed to order an x-ray ASAP. She told the RP that Resident #1 could go to the emergency room (ER) because the x-ray time was uncertain. The RP said no to the ER, and she would be ok waiting (not too long). She gave her some Tylenol and then she left for the night at 7:00 PM but the Tylenol was not documented as given. Review of the November 2024 medication administration record (MAR) revealed that Nurse #2 administered 500mg of as needed Tylenol to Resident #1 on 11/18/24 at 2:54 PM due to a pain level of 7. Review of a health note dated 11/19/24 at 2:40 PM and completed by the Unit Manager revealed that Resident #1's RP was at her bedside with some concerns of increased pain due to the left hip/leg fracture. The RP stated that her family told her that Resident #1 needed to go to the hospital	F 697	Manager conducted a quality review audit of current resident□s plan of care for pain management; including but not limited to current pain assessment, pain medication administered per physician□s order and documented on medication administration record for the previous 30 days to ensure residents experiencing pain have pain medications ordered and do not present with unrelieved pain and newly admitted residents with a history of pain have appropriate pain medications ordered. # -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 1/4/25 the Director of Nursing and Staff Development Coordinator provided re-education to all licensed nurses including agency nurses on assessing residents for pain and administering pain medication per physician, proper documentation and notification. This education will become a part of the new hire orientation process for all newly hired licensed nurses. The Director of Nursing, Assistant Director of Nursing and Unit Managers will complete a daily review of physician orders, facility twenty-four-hour shift reports and new admission orders to ensure physician notification for residents experiencing pain without pain medications ordered and/or patients with unrelieved pain.	

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F 697	Continued From page 55 for 24-hour care. It was explained to the RP that Resident #1's pain could be managed at the facility; however, if she felt the pain was getting worse, the family could make the decision to send her out to the hospital. The Unit Manager spoke with the Nurse Practitioner (NP), who ordered scheduled Tramadol (treats moderate to moderately severe pain). The RP was made aware. The NP was interviewed on 12/18/24 at 1:00 PM, and he revealed that Resident #1 was having a little bit of pain on 11/19/24 but was managed with pain medication. Review of physician orders for Resident #1 revealed that on 11/19/24, 25mg of Tramadol was ordered twice daily and as needed every 12 hours. Review of the MAR for November 2024 revealed that pain assessments were completed with a "check mark" from 11/19/24 through 11/22/24 without a numerical value or location for pain or a non-verbal pain scoring tool result in the medical record. Review of a 72-hour post fall documentation note dated 11/19/24 at 2:29 PM and completed by Nurse #2 revealed that Resident #1 remained in bed and Tylenol was given for pain. However, this pain medication administration was not documented. An interview was not conducted with Nurse #2 related to this documentation. Review of a 72-hour post fall documentation note dated 11/19/24 at 10:29 PM and completed by the Night Nurse Supervisor revealed that it read the same information from Nurse #2's 72-hour post	F 697	#4-Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Director of Nursing, ADON or UM to complete Quality Improvement Monitoring on 10 residents medication record daily 2x/weeks, weekly x4weeks, and then monthly to ensure the resident is receiving appropriate pain management and treatment plan. The Director of Nursing will report the findings from the audits to the Quality Assurance Performance Improvement committee for recommendations and/or modifications until a pattern of compliance is achieved. The Administrator is responsible for this plan of correction. Date of completion: 1/9/25	

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fall documentation note at 2:29 PM.

Review of a 72-hour post fall documentation note dated 11/20/24 at 10:45 PM and completed by the Night Nurse Supervisor revealed that Resident #1 had a nondisplaced fracture to the left femur and reported a pain level of 4 in the left hip.

The Night Nurse Supervisor was interviewed on 12/21/24 at 7:48 AM. She revealed that Resident #1 was not assessed for pain by the Night Nurse Supervisor on 11/18/24, 11/19/24, or 11/20/24. She stated that she took the information in the 72-hour Post Fall Documentation notes from the previous shift and copied the details into the notes she wrote just so that some kind of documentation was completed during her shift. The Night Nurse Supervisor indicated that as a supervisor, she would review the documentation that needed to be completed by the nurses during her shift. If documentation was not completed, then she would have done it herself. Resident #1 was nonverbal, so she could not quantify her pain a 4. She stated that Resident #1 was not in pain on 11/18/24 - 11/20/24 during the overnight shifts because a NA (name unknown) got her up out of bed and into the wheelchair without knowing she had a broken hip/leg. However, Resident #1 did not display any nonverbal expressions of pain.

Nurse #3, who worked with Resident #1 during the overnight shifts from 11/17/24 through 11/21/24, was interviewed on 12/19/24 at 11:57 AM. He revealed that during the week of 11/18/24, he could not recall a change in Resident #1's status or if she had displayed any signs/symptoms of pain or discomfort.

During an interview with NA #3, who worked with

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Resident #1 during the overnight shift from 7:00 PM on 11/20/24 until 7:00 AM on 11/21/24, she revealed that Resident #1 had fallen 3 days prior, and this was the first time she had worked with Resident #1. When she arrived for her shift, she was notified by the off going NA that Resident #1's left hip was hurt and to be cautious during care. NA #3 remembered that Resident #1 said "ow" during an incontinence care episode when she touched her left hip. She did not notify anyone of the pain because she was notified about the left hip at the beginning of her shift. She made sure not to change or move Resident #1 during the shift unless necessary.

An interview was conducted with NA #2 on 12/19/24 at 10:53 AM. She worked with Resident #1 during the overnight shift from 7:00 PM on 11/21/24 until 7:00 AM on 11/22/24. NA #2 revealed that it appeared Resident #1 was in a lot of pain during her shift because she would refuse care, was not willing to get out of bed, and was not willing to roll side to side. Resident #1 was nonverbal, but when NA #2 tried to turn her in the bed, Resident #1 would grab her arm as if she was telling NA #2 to stop.

Review of a 72-hour post fall documentation note dated 11/22/24 at 2:24 AM and completed by Nurse #3 revealed that Resident #1 had a nondisplaced fracture to the left femur and reported a pain level of 4.

Nurse #3 was interviewed on 12/23/24 at 9:58 AM. He stated that he could not recall the 72-hour post fall documentation note dated 11/22/24, and no NA notified him that Resident #1 was in pain from 11/18/24 - 11/22/24.

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The RP was interviewed on 12/18/24 at 10:28 AM. She revealed that Resident #1 continued to have pain after the fall on 11/17/24. An x-ray was performed on 11/18/24, which resulted in a left leg/hip fracture.

During a follow-up interview with the RP on 12/18/24 at 1:56 PM, she revealed that on 11/19/24, Resident #1 was still in pain. She asked the Unit Supervisor to order stronger pain medication. Resident #1 remained in bed the entire week until 11/22/24 when she went to the hospital. The RP stated she could not rate Resident #1's pain level due to her dementia, but when she reached for something, she would say her hip was hurting.

An interview was conducted with the Unit Manager on 12/19/24 at 12:22 PM. She revealed that she thought Resident #1 was not in pain the week after the fall because there was one day (date unknown) that she got out of bed into her wheelchair. However, for most of that week after the 11/17/24 fall, Resident #1 remained in bed, even though she was usually up daily. Every time she (the Unit Manager) asked if Resident #1 was in pain, she shook her head no. The RP told nursing staff that Resident #1 was in pain, but when staff asked her themselves, she would shake her head no. On 11/22/24, after the Medical Director saw the x-ray results and evaluated Resident #1, he wanted her to be sent out to an orthopedic appointment that same day.

Review of a medical progress note date 11/22/24 and completed by the Medical Director revealed that at the time of Resident #1's last fall on 11/17/24, she denied injury and denied pain. Since her last clinical examination on 11/21/24,

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Resident #1 complained of pain to the nurses. A recent x-ray of the left hip indicated a left intertrochanteric femur fracture. The MD documented an immediate referral to orthopedics was made for today.

During an interview with the Medical Director on 12/20/24 at 8:27 AM, he revealed that he saw Resident #1 on 11/20/24 and she denied pain. When the MD saw Resident #1 on 11/22/24, and she said she was in pain, he went to look at the provider communication book and found out about the fracture on that day.

Review of an Orthopedic Visit note dated 11/22/24 revealed that Resident #1 was in no acute distress, and the left leg was warm and perfused. Resident #1 pointed to the left groin area as a source of pain. Due to the results of the x-rays taken during the visit (intertrochanteric fracture of the left femur), Resident #1 was sent to the hospital from the appointment.

Review of the emergency department note dated 11/22/24 revealed that Resident #1 was seen for left hip pain after a fall 5 days prior. She was treated for pain with Tylenol and Tramadol at the facility. Resident #1 has had left hip pain "for a while now" but not if resting.

The DON was interviewed on 12/20/24 at 12:25 PM. She stated that she was unable to retrieve the results of the twice daily pain assessments from 11/19/24 - 11/22/24 based on the MAR details. If the nonverbal pain assessment tool was entered and the pain was 0, it would show up in vital signs of Resident #1's medical record. The DON stated she was unsure why the pain assessment results were not included in vital

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F 697	Continued From page 60 signs from 11/19/24 through 11/22/24. If the pain assessment was checked off in the MAR but not displayed in vital signs, then the pain assessment results were not necessarily a 0. During a follow-up interview with the DON on 12/20/24 at 12:47 PM, she revealed that the nurses who completed the pain assessments from 11/19/24 through 11/22/24 must have chosen "not applicable" as a response because the results did not show up in the medical record. During a follow-up interview with the DON on 12/30/24 at 12:00 PM, she revealed that all nurses should have continued with the complete pain assessments after 11/18/24. During an interview with the Administrator on 12/30/24 at 12:32 PM, he revealed that he could not speak on the issue of missing pain assessment from 11/19/24 through 11/22/24 and delayed pain medication due to not having a clinical background.	F 697		
F 714 SS=J	Physician Delegation of Tasks to NPP CFR(s): 483.30(e)(1)(4)(f) §483.30(e) Physician delegation of tasks in SNFs. §483.30(e)(1) Except as specified in paragraph (e)(4) of this section, a physician may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who- (i) Meets the applicable definition in §491.2 of this chapter or, in the case of a clinical nurse specialist, is licensed as such by the State; (ii) Is acting within the scope of practice as defined by State law; and (iii) Is under the supervision of the physician.	F 714		1/9/25

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F 714	Continued From page 61 §483.30(e)(4) A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies. §483.30(f) Performance of physician tasks in NFs. At the option of State, any required physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, Medical Director and Nurse Practitioner (NP) interviews, the NP failed to communicate and collaborate with the Medical Director when Resident #1 was diagnosed on 11/18/24 with an acute nondisplaced (the bone does not break completely and there will be a crack on the bone) transverse (horizontal and perpendicular to the bone) left femur (leg) fracture following an unwitnessed fall on 11/17/24. The NP did not consult with the Medical Director before making the decision the resident was probably not a surgical candidate and attempting to treat the resident in-house. Due to the lack of communication and coordination the Medical Director was not aware of the fracture until he saw Resident #1 on 11/22/24 at which time he ordered the resident to be sent to the emergency department if she could not be seen by the orthopedist that day. Resident #1 was seen by the orthopedist on 11/22/24 and was sent directly	F 714	F714-Physician Delegation of Tasks # 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; An incident report was completed on 11/17/2024 at 11:05 am by the charge nurse, based on information obtained from certified nursing aide. Resident #1 was observed on the floor next to her bed sitting on her bottom. The resident was assessed by the charge nurse and no injuries were discovered during the initial assessment. On 11/17/24 at 11:21 AM another progress note was entered in the electronic record which stated that the resident reported pain in her left hip and elbow when the responsible party (RP) arrived at the facility. The on-call medical	

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F 714	Continued From page 62 to the hospital and a left femur intramuscular nail surgery was performed on 11/23/24. The lack of communication and collaboration between the NP and Medical Director delayed orthopedic medical management, care and treatment and put the resident at high risk for complications such as deep vein thrombosis, pneumonia, and bed sores. Resident #1 had an aspiration event (foods, stomach contents, or fluids are breathed into the lungs) while hospitalized which resulted in acute hypoxic respiratory failure (low levels of oxygen in your blood) and IV antibiotics were initiated on 11/24/24. The resident was prescribed additional oral antibiotics for three days after discharge back to the facility on 11/26/24. This failure affected 1 of 3 reviewed for accidents (Resident #1). Immediate jeopardy began on 11/18/24 when the NP failed to collaborate and communicate with the Medical Director regarding medical management when x-ray results confirmed Resident #1 had an acute nondisplaced intertrochanteric femur fracture. Immediate jeopardy was removed on 1/5/25 when the facility implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a scope and severity of "D" (no actual harm with potential for more than minimal harm that is immediate jeopardy) to ensure education is completed and monitoring systems put into place and are effective. The findings included: Resident #1 was admitted to the facility on 10/20/22 with diagnoses that included vascular dementia, muscle weakness, difficulty in walking, bradycardia (a condition where the heart beats	F 714	provider was called at 2:14 PM and at that time the medical provider gave orders for a stat x-ray. On 11/18/2024 the x-ray of the left hip was obtained at 9:23 am. The x-ray resulted on 11/18/2024 at 12:54 pm and the impressions were an acute transverse, nondisplaced intertrochanteric femur fracture. The resident□s responsible party (RP) and Nurse Practitioner (NP) were informed of the results on 11/18/2024 at 2:59 pm. The NP made a determination to treat the injury in-house but did not consult with the Medical Director regarding this treatment plan before making the decision to treat in house because he considered the resident to not be a good surgical candidate. The Medical Director (MD) saw the resident on 11/20/24 and 11/21/24 but was unaware of the fracture because of the lack of communication and coordination from the facility and the NP. # - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 12/20/2024, the MD reviewed the NP□s notes for the previous 30 days, including the on-call providers, to ensure the plan of care was appropriate for the residents. Any opportunities identified during this audit were corrected by the MD on 12/20/2024. On 12/20/2024, the Regional Director of	

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F 714	Continued From page 63 too slowly) (initiated 11/12/24), traumatic brain injury (TBI) in 1999, history of a stroke, chronic obstructive pulmonary disease/asthma, and dysarthria (slurred speech). Review of the annual Minimum Data Set (MDS) assessment dated 8/30/24 revealed that Resident #1 was severely cognitively impaired, had adequate hearing/vision, could speak clearly, and usually understood/understands. Review of an Unwitnessed Fall Report dated 11/17/24 at 11:05 AM and completed by Nurse #1 revealed she was notified by Nurse Aide (NA) #1 that Resident #1 was on the floor next to her bed sitting on her bottom. She was assessed, and no injuries were noted. Vital signs (VS) were within normal limits (WNL). Resident #1 reported no pain or discomfort and was then assisted back to her bed. Review of a 72 Hour Post Fall Documentation note dated 11/17/24 at 11:21 AM and completed by Nurse #1 revealed that Resident #1 reported pain in her left hip when the responsible party (RP) arrived at the facility. Review of On-Call Provider progress note dated 11/17/24 at 4:15 PM and completed by the on-call provider revealed that Resident #1 had a fall at 11:00 AM on 11/17/24. No injuries were reported, and Resident #1 denied pain. The RP visited the facility and now Resident #1 reported left hip pain with tenderness to palpation. A neurological check was performed via video and there were no acute deficits noted. A STAT (immediately) x-ray of the left hip was ordered, as well as Tylenol 500 milligrams (mg) every 6 hours as needed for pain. Neurological checks should be performed every 4	F 714	Clinical Services, Nurse Practitioner, Medical Director, and the Director of Nursing reviewed Resident #1□s plan of care and collaborated on what the best course of treatment should have been for the resident. # -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 1/4/25 the Regional Vice President educated the Medical Director, NPs, and covering providers on collaborating/consulting following a fracture and/or a significant change of condition. The Medical Director, Nurse Practitioners and covering providers will collaborate 3 times a week via phone, in-person, or virtual to discuss the plan of care for the residents that have obtained a fracture or a significant change in condition. The Regional Vice President educated The Director of Nursing and the Administrator to participate in the meeting. On 1/4/2025, the Medical Director reviewed the guidelines for how the Nurse Practitioners and other covering providers to communicate with the Medical Director. The Medical Director and Regional Vice President discussed this agreement with the NPs and other providers on 1/4/25. The Regional Director of Clinical Services educated the Nurse Management Team and the Director of Nursing regarding the nurse practitioners□ notes, including on call to ensure communication and	

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F 714	Continued From page 64 hours. Review of physician orders for Resident #1 revealed that a one-time STAT x-ray of the left hip was ordered on 11/17/24 at 3:04 PM. Review of a medical progress note dated 11/18/24 at 10:00 AM and completed by the NP revealed that Resident #1 had a fall on 11/17/24. She denied hitting her head, injury, or pain following the fall. Resident #1 appeared at her baseline mental status and had tenderness to the left hip with palpation. Review of a health status note dated 11/18/24 at 10:18 AM and completed by Nurse #2 revealed that radiology services were in the facility to perform the STAT x-ray ordered for Resident #1 on 11/17/24. Review of a health status note dated 11/18/24 at 11:40 AM and completed by Nurse #2 revealed that Resident #1 continued to have pain/discomfort in her left hip. Review of a health status note dated 11/18/24 at 3:00 PM and completed by Nurse #2 revealed Resident #1's x-ray results of the left hip were an acute nondisplaced intertrochanteric (where the hip and thigh meet) femur fracture. Review of Resident #1's radiology results report in the electronic medical record revealed an entry on the x-ray results that noted the Medical Director reviewed the report on 11/18/24 at 6:29 PM. During a telephone interview with the Medical Director on 12/20/24 at 11:13 AM, he revealed	F 714	collaboration is completed. The Director of Nursing, unit managers, staff development nurse and Assistant Director of Nursing will review and print the nurse practitioner notes, including the on-call providers daily and place them in the Medical Director□s communication book. When the Medical Director is not in the facility, he will receive an electronic HIPAA compliant copy of the medical progress notes generated each day. Any new hires, including agency staff, will receive education prior to the start of their shift via telephone or in person. This education was completed on 1/4/2025 by the Regional Director of Clinical Services. #4-Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility Administrator will complete an audit daily x4 weeks, biweekly x 4 weeks then weekly x4 weeks to ensure that the medical progress notes have been placed in the medical director□s communication book and reviewed by the medical director. The finding of these quality assurance audits will be reported to the Quality Assurance Performance Improvement (QAPI) for recommendations and/or modifications until a pattern of compliance is achieved. The Administrator is responsible for this plan of correction.	

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F 714	Continued From page 65 that the nurses always put the printout of x-ray results in his mailbox or provider book to review. The Medical Director stated on 11/18/24 he had cleared all the lab and x-ray results from the computer without looking at the x-ray report for Resident #1. He did not review the x-ray results of any resident if he did not place the original order. He stated that he relied on the paperwork in his mailbox or provider book for further evaluation/orders. Review of a medical progress note dated 11/19/24 and completed by the NP revealed that Resident #1 had an acute nondisplaced transverse intertrochanteric femur fracture. Resident #1's RP was waiting for the NP to contact her for consultation, which took place the same day. The RP requested an orthopedic evaluation. The NP discussed complications about potential surgery with the RP and told her that orthopedics would consider Resident #1's overall health, specifics about the fracture, and new asymptomatic bradycardia. Review of a health note dated 11/19/24 at 2:40 PM and completed by the Unit Manager revealed that Resident #1's RP was at her bedside with some concerns of increased pain due to the left hip/leg fracture. The RP stated that her family told her that Resident #1 needed to go to the hospital for 24-hour care. It was explained to the RP that Resident #1's pain could be managed at the facility; however, if she felt the pain was getting worse, the family could make the decision to send her out to the hospital. The Unit Manager spoke with the NP, who ordered scheduled Tramadol. The RP was made aware. Review of physician orders for Resident #1	F 714	Date of completion: 1/9/25	

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revealed that on 11/19/24, an orthopedic surgery consultation for a left hip/leg fracture was ordered.

Review of a medical progress note dated 11/20/24 and completed by the Medical Director revealed that Resident #1 denied pain and neurological checks remain normal. Staff to provide closer supervision and fall protocols were in place. Laboratory results and radiology reviewed.

Review of a medical progress note dated 11/21/24 and completed by the Medical Director revealed that Resident #1 denied all pain and appeared comfortable. There was no injury since her last fall and fall protocols were already in place. Laboratory results and radiology reviewed.

Review of a medical progress note date 11/22/24 and completed by the Medical Director revealed that at the time of Resident #1's last fall on 11/17/24, she denied injury and denied pain. Since her last clinical examination on 11/21/24, Resident #1 complained of pain to the nurses. A recent x-ray of the left hip indicated a left intertrochanteric femur fracture. The Medical Director documented an immediate referral to orthopedics that had been made for today.

A telephone interview was conducted with the Medical Director on 12/19/24 at 10:19 AM. He revealed that he did not review Resident #1's x-ray results from 11/18/24 until 11/22/24, and he did not receive an update from the NP that entire week. When he saw Resident #1 on 11/22/24, Resident #1 was in pain, and the Medical Director told staff that she needed to be sent out immediately. The Medical Director indicated he

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was told that Resident #1 had an orthopedic appointment the following week, but he told them she needed to go that day (11/22/24). The Medical Director stated that Resident #1 should have gone to the hospital as soon as the x-ray results came in on 11/18/24, and the surgeon would have made the decision if she was a surgical candidate or not.

A telephone interview was conducted with the Unit Manager on 1/3/25 at 8:33 AM, and she revealed that the NP did consult with her and the Director of Nursing (DON) on 11/18/24 about the decision to keep Resident #1 in the facility and order an orthopedic consultation.

The NP was interviewed on 12/18/24 at 1:00 PM. The NP stated radiology took an x-ray of Resident #1's left hip on 11/18/24 and the results indicated a left femur fracture. He revealed that he was concerned whether Resident #1 would be suitable for surgery due to asymptomatic bradycardia (asymptomatic). The NP indicated on 11/19/24 he requested Resident #1 be sent to the first available appointment at an orthopedics office to determine if she was a surgical candidate. The RP told the NP that she wanted Resident #1 to go to surgery, which was why an orthopedic consultation was scheduled for the following week (11/26/24). The NP indicated that he did not send Resident #1 to the ER because he was unsure if she was a surgical candidate or whether she would be better conservatively managed so that the fracture could heal on its own. Resident #1 was having a little bit of pain, which was managed with pain medication. The pain became unmanageable on 11/22/24, and she was seen by the orthopedics office on 11/22/24, who then sent her to the ER for surgery.

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During a follow-up telephone interview with the NP on 12/20/24 at 8:09 AM, he revealed that he did not recall why the MD was not consulted prior to 11/22/24. The NP stated he made the decision to keep Resident #1 in the facility from consultations with the unit supervisor and the DON.

During a follow-up telephone interview with the NP on 1/2/25 at 3:34 PM, he revealed that he was not trained to communicate with the Medical Director on specific topics. The NP and the Medical Director communicate on things that require additional assessments or moderate to severe issues (for example: a suspected arterial blockage in the lower extremities). The NP stated the only time he would communicate to the Medical Director about x-rays, or a fracture, was if he had a question about the treatment.

During a follow-up telephone interview with the Medical Director on 12/20/24 at 8:27 AM, he revealed the NP consulted with him quite often, but he should have consulted with the Medical Director about the fracture when he found out on 11/18/24. The Medical Director stated that the NP had lots of experience and was qualified to look at x-rays and make decisions. However, in this case, the NP made the wrong decision. He should have sent Resident #1 out when the x-ray results were received. The Medical Director indicated that he had seen Resident #1 on 11/20/24, and she denied pain. He was unaware of the fracture on that date, and he was unaware that an x-ray was ordered by the On-Call Provider. He became aware of the fracture on 11/22/24 from the provider communication book. When he saw Resident #1 on 11/22/24, and she

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said she was in pain, he went to look at the communication report and found out about the fracture on that day. The fracture report was not in the communication book the days prior.

During an additional telephone interview with the Medical Director on 1/2/25 at 3:09 PM, he revealed that the NP could have made the decision on his own to wait for surgery for Resident #1 because he had a lot of experience and was an independent practitioner. The NP made those types of decisions daily and well. The Medical Director stated that if the NP was comfortable managing those type of situations (fractures), then he did not need to consult with the Medical Director. The Medical Director indicated that he expected the NP to communicate with him when he was unsure/unclear about something or had a question, which the NP did regularly. The Medical Director indicated he and the NP spoke daily.

Review of an Orthopedic Visit note dated 11/22/24 revealed that Resident #1 was in no acute distress, and the left leg was warm and perfused. Resident #1 pointed to the left groin area as a source of pain. Due to the results of the x-rays taken during the visit (intertrochanteric fracture of the left femur), Resident #1 was sent to the hospital from the appointment.

Review of a Hospital Discharge Summary dated 11/26/24 revealed that Resident #1 had a closed intertrochanteric fracture of the left femur. She was seen in the orthopedic office on 11/22/24 for further evaluation, and an x-ray was obtained which showed an intertrochanteric fracture of the left femur. She was sent to the ER for further evaluation, and a left femur intramuscular nail

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surgery was performed on 11/23/24. The discharge summary indicated Resident #1 had an aspiration event while hospitalized which resulted in acute hypoxic respiratory failure and IV antibiotics were initiated on 11/24/24. The resident was prescribed additional oral antibiotics for three days after discharge back to the facility.

During an interview with the DON on 12/30/24 at 12:03 PM, she revealed that she was unaware of the medical providers' communication protocol.

During a follow-up telephone interview with the DON on 1/6/25 at 8:54 AM, the DON recalled the NP giving the order for the orthopedic consultation and an explanation why Resident #1 may not have been a surgical candidate but did not ask for her opinion.

An interview was conducted with the Administrator on 12/30/24 at 12:34 PM, and he revealed that he could not speak on the medical provider collaboration issue due to not having a clinical background.

The Administrator was notified of immediate jeopardy on 1/3/25 at 8:48 AM.

The facility provided the following Acceptable Allegation of Immediate Jeopardy removal.

An incident report was completed on 11/17/2024 at 11:05 am by the charge nurse, based on information obtained from certified nursing aide. Resident #1 was observed on the floor next to her bed sitting on her bottom. The resident was assessed by the charge nurse and no injuries were discovered during the initial assessment. On 11/17/24 at 11:21 AM another progress note was

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entered in the electronic record which stated that the resident reported pain in her left hip and elbow when the responsible party (RP) arrived to the facility. The on-call medical provider was called at 2:14 PM and at that time the medical provider gave orders for a stat x-ray.

On 11/18/2024 the x-ray of the left hip was obtained at 9:23 am. The x-ray resulted on 11/18/2024 at 12:54 pm and the impressions were an acute transverse, nondisplaced intertrochanteric femur fracture. The resident's responsible party (RP) and Nurse Practitioner (NP) were informed of the results on 11/18/2024 at 2:59 pm. The NP made a determination to treat the injury in-house, but did not consult with the Medical Director regarding this treatment plan before making the decision to treat in house because he considered the resident to not be a good surgical candidate.
The Medical Director (MD) saw the resident on 11/20/24 and 11/21/24 but was unaware of the fracture because of the lack of communication and coordination from the facility and the NP.

On 12/20/2024, the MD reviewed the NP's notes for the previous 30 days, including the on-call providers, to ensure the plan of care was appropriate for the residents. Any opportunities identified during this audit were corrected by the MD on 12/20/2024.

On 12/20/2024, the Regional Director of Clinical Services, Nurse Practitioner, Medical Director, and the Director of Nursing reviewed Resident #1's plan of care and collaborated on what the best course of treatment should have been for the resident.

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On 1/4/25 the Regional Vice President educated the Medical Director, NPs, and covering providers on collaborating/consulting following a fracture and/or a significant change of condition. The Medical Director, Nurse Practitioners and covering providers will collaborate 3 times a week via phone, in-person, or virtual to discuss the plan of care for the residents that have obtained a fracture or a significant change in condition. The Regional Vice President educated The Director of Nursing and the Administrator to participate in the meeting.

On 1/4/2025, the Medical Director reviewed the guidelines for how the Nurse Practitioners and other covering providers to communicate with the Medical Director. The Medical Director and Regional Vice President discussed this agreement with the NPs and other providers on 1/4/25.

The Regional Director of Clinical Services educated the Nurse Management Team and the Director of Nursing regarding the nurse practitioners' notes, including on call to ensure communication and collaboration is completed. The Director of Nursing, unit managers, staff development nurse and Assistant Director of Nursing will review and print the nurse practitioner notes, including the on-call providers daily and place them in the Medical Director's communication book. When the Medical Director is not in the facility, he will receive an electronic HIPAA compliant copy of the medical progress notes generated each day. Any new hires, including agency staff, will receive education prior to the start of their shift via telephone or in person. This education was completed on 1/4/2025 by the Regional Director of Clinical

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F 714	Continued From page 73 Services. Effective 1/4/2025 the Administrator will be responsible to ensure implementation of this immediate jeopardy removal for this alleged non-compliance. Alleged Date of Immediate Jeopardy Removal: 1/5/2025 An onsite validation was conducted on 01/09/25. The in-service conducted by Regional Vice President with the Medical Director, Nurse Practitioners, and covering providers on collaborating/consulting following a fracture and/or a significant change of condition was reviewed. The Medical Director, Nurse Practitioners and covering providers will collaborate 3 times a week via phone, in-person, or virtual to discuss the plan of care for the residents that have obtained a fracture or a significant change in condition. Interviews completed with the Medical Director and Nurse Practitioner verified knowledge of the new process for collaborating and consulting following a significant change in condition. The immediate jeopardy removal date of 01/05/25 was validated.	F 714		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted	F 842		1/9/25

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to do so.

§483.70(h) Medical records.
§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(4) Medical records must be retained for-
(i) The period of time required by State law; or

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F 842	Continued From page 75 (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure a medical record was accurate regarding post fall documentation. This was for 1 of 5 sampled residents whose medical record was reviewed for documentation (Resident #1). The findings included: Resident #1 was admitted to the facility on 10/20/22. Review of a 72-hour post fall documentation note dated 11/17/24 at 11:21 AM and completed by Nurse #1 revealed that Resident #1 reported pain in her left hip when the responsible party (RP) arrived at the facility. Review of a 72-hour post fall documentation note dated 11/18/24 at 2:18 PM and completed by	F 842	F842-Resident Records-Identifiable Information # 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #1 chart was reviewed for the incorrect documentation on the 72-hour post fall evaluations. The 72-Hour post fall evaluations for 11/18/24 at 11:43PM, 11/19/24 at 10:29PM and 11/20/24 at 10:45pm were correctly labeled as incorrect documentation in the resident□s chart. # - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice;	

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	345006	A. BUILDING _____ B. WING _____	C 01/09/2025

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F 842	Continued From page 76 Nurse #2 revealed that Resident #1 had a nondisplaced fracture to the left femur and reported a pain level of 4 in the left hip. Review of a 72-hour post fall documentation note dated 11/18/24 at 11:43 PM and completed by the Night Nurse Supervisor revealed that it read the same information from Nurse #1's 72-hour post fall documentation note dated 11/17/24 at 11:21 AM for Resident #1. Review of a 72-hour post fall documentation note dated 11/19/24 at 2:29 PM and completed by Nurse #2 revealed that the note read in part: "Current status of the resident's injuries or reports of pain from the fall: Acute transverse, nondisplaced intertrochanteric fracture femur is noted. No other acute fracture or dislocation. Interventions currently in place to prevent additional falls: keep wheelchair beside bed, call bell within reach, bed in lowest/locked position, and Nurse Aides rounding every 2 hours. Resident's response to new interventions remains in the bed, Tylenol given for pain." Review of a 72-hour post fall documentation note dated 11/19/24 at 10:29 PM and completed by the Night Nurse Supervisor revealed that it read the same information from Nurse #2's 72-hour post fall documentation note dated 11/19/24 at 2:29 PM for Resident #1. Review of a 72-hour post fall documentation note dated 11/20/24 at 10:45 PM and completed by the Night Nurse Supervisor revealed that it read the same information from Nurse #2's 72-hour post fall documentation note dated 11/18/24 at 2:18 PM.	F 842	On January 2, 2025, the Regional Director of Clinical Services completed a review of all 72 Hour post fall documentation for the previous 30 days to ensure that there was no occurrences of documentation that had been copied and pasted into any resident□s medical records. # -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Effective 1/6/2024 the Director of Nursing and the Staff Development Coordinator began education for all licensed nurses, including agency staff. This education included: " How to accurately complete a 72-hour post fall evaluation " Importance of accurate and truthful documentation in medical records " Consequences of inaccurate documentation such as errors, miscommunication and potential harm to the patient. " Proper assessment and documentation of findings in the medical record " Components of Quality Nursing Documentation. Any staff member that did not receive the education on 1/6/2025 will receive education by the beginning of their next scheduled shift. All newly hired licensed staff will be education by the Staff Development Coordinator. The Staff Development Coordinator will be	

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F 842	Continued From page 77 The Night Nurse Supervisor was interviewed via telephone on 12/21/24 at 7:48 AM. She revealed that Resident #1 was not assessed for pain on 11/18/24, 11/19/24, or 11/20/24. She stated that she took the information in the 72-hour Post Fall Documentation notes from the previous shift and copied the details into the notes she wrote just so that some kind of documentation was completed during her shift. The Night Nurse Supervisor indicated that as a supervisor, she would review the documentation that needed to be completed by the nurses during her shift. If documentation was not completed, then she would have done it herself. Resident #1 was nonverbal, so she could not quantify her pain a 4. Review of a 72-hour post fall documentation note dated 11/22/24 at 2:24 AM and completed by Nurse #3 revealed that it read the same information from Nurse #2's 72-hour post fall documentation note dated 11/18/24 at 2:18 PM. Nurse #3 was interviewed on 12/23/24 at 9:58 AM. He stated that he could not recall the 72-hour post fall documentation note dated 11/22/24, and no Nurse Aide (NA) notified him that Resident #1 was in pain on 11/22/24. The Director of Nursing (DON) was interviewed on 1/6/25 at 8:54 AM. She revealed that the Night Nurse Supervisor and Nurse #3 should only enter documentation that was factual and accurate. The DON stated that each nurse was supposed to assess the pain of Resident #1 during each shift and record their observations. The Night Nurse Supervisor and Nurse #3 should have assessed Resident #1 for each note entered.	F 842	responsible for assuring that all staff have received the education. #4-Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing will conduct daily audits of all 72-Hour assessments for accuracy and originality. These audits will be performed daily x4 weeks, bi-weekly x4 weeks and then weekly x4 weeks. The Director of Nursing will be responsible for the findings and audits and will report to the Quality Assurance Performance Improvement committee for recommendations and/or modifications until a pattern of compliance is achieved. The Administrator is responsible for the entire plan of correction. Date of completion: 1/9/25	