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F 000	INITIAL COMMENTS A complaint investigation survey was conducted on 4/29/25 through 4/30/25. Event ID# TT7711. The following intake was investigated: NC00229573. 1 of 3 complaint allegations resulted in deficiency.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, and Nurse Practitioner (NP), Medical Director, and staff interviews, the facility failed to provide care in a safe manner when Resident #1 rolled out of her bed that was raised to just below the hip onto the floor during incontinence care. Resident #1 was sent to the Emergency Room (ER) for pain in her right shoulder and right hip with some deformity and external rotation. Resident #1 was diagnosed with an "unusual" right hip impaction fracture (occurs when a bone is broken and the broken ends are forced into each other) of the femoral head (the rounded end of thigh bone that fits into the socket of the hip joint). Resident #1 was admitted to the hospital and underwent hip replacement. This was for 1 of 3 residents (Resident #1) reviewed for accidents. Findings included:	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 05/09/2025

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Resident #1 was admitted to the facility on 2/3/25 with diagnoses that included osteomyelitis (infection of the bone) of vertebra in the lumbar region, type 2 diabetes mellitus and infection of her heart valve.

The Nursing Assistant (NA) Care Guide dated 2/3/25 indicated Resident #1 was marked as needing set-up for eating, 2 person-assist for bed mobility, 2 person-assist for transfers and was dependent on staff for incontinent care.

A physician order for Resident #1 dated 2/3/25 indicated an apixaban (anticoagulant) 5 milligrams (mg) twice a day to be given orally.

The care plan for Resident #1 dated 2/4/25 revealed a problem area identified was an Activities of Daily Living (ADL) self-performance deficit related to cognitive impairment. Another problem area identified was the resident being at risk for falls/injury from falls related to impaired mobility, impaired cognition, and incontinence. The approaches included assisting with transfer, mobility, and toileting.

The Minimum Data Set (MDS) assessment dated 2/10/25 revealed Resident #1 was moderately cognitively impaired. She was coded as totally dependent for rolling left and right side. She was coded for upper (shoulder, elbow, wrist, hand) and lower (hip, knee, ankle, foot) extremities impairment. She was also coded for use of anticoagulants and her recorded weight was 248 pounds.

The occupational therapy assessment notes dated 2/19/25 revealed Resident #1 required

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maximal assistance for bed mobility. The physical therapy evaluation notes dated 2/19/25 revealed Resident #1 was dependent for bed mobility (roll left and right, sit to lying, lying to sitting on side of the bed).

The Event Report completed by Nurse #1 for Resident #1 dated 4/9/25 at 2:36 pm indicated Resident #1 had a witnessed fall during care in the resident's room. The report detailed Resident #1 was in pain with a pain level marked as 6 (0-10 scale with 10 being the worst pain possible). A body observation indicated no injury was noted and range of motion (ROM) was painful in lower extremity. The positioning assessment revealed that there was no rotation/deformity/shortening noted. It was documented that Resident #1 was alert and oriented to name and place. There were no contributing factors marked for this event and the intervention recorded was that Resident #1 was transferred to the ER.

A progress note on 4/9/25 at 1:50 pm revealed Resident #1 was ordered by the NP to be transferred to ER via Emergency Medical Services (EMS).

The hospital records from the ER dated 4/9/25 revealed Resident #1 was complaining of pain in her shoulders and her right leg after the fall. The admission notes assessments indicated an abrasion overlying the anterior (front) portion of the left shoulder. There was some mild underlying tenderness, mild pain on the palpation (a method of feeling with the fingers or hands during a physical examination) of the right shoulder. There was some external rotation of the right leg and tenderness in the hip, knee and ankle.

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The radiology reports from the hospital dated 4/9/25 for the right hip revealed an unusual fracture of the right hip, superior subluxation (partial/incomplete dislocation) of the proximal (closer to the center of the body) femur with impaction fracture of the femoral head which may be impacted on the acetabulum (hip socket). The clinical data report revealed that Resident #1 complained of pain in her right and left shoulder, right knee, chest, and right ankle.

The Computed Tomography (CT) scan result from the hospital on 4/9/25 revealed a superolateral subluxation (partial separation of joints) of the right femoral head with respect to the acetabulum (concave surface of the pelvis) with impacted appearance of the femoral head on the superior acetabulum. A fracture involving the anterosuperior acetabulum (a prominent landmark that lies in the superior hip that can be palpated called lighthouse of the hip) with displaced fracture fragments.

The Orthopedic consultation from the hospital on 4/9/25 revealed Resident #1 had severe pain from the right hip. It was noted that any movement or mobilization of the bed was excruciatingly painful.

Review of the hospital records revealed Resident #1 required medical treatment for other health issues before she could have surgery. Resident #1 went through orthopedic surgery for hip replacement on 4/14/25.

The hospital records indicated that Resident #1 was discharged from the hospital on 4/17/25 and did not return to the facility.

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NA #2 was interviewed on 4/29/25 at 3:01 pm and revealed that she took care of Resident #1 before the day of the fall. NA #2 stated the resident was always marked in the NA Care Guide for 2 person-assist for bed mobility. NA #2 stated she called for help anytime she took care of the resident. NA #2 further stated that they kept a binder in the nurses' station where staff could find the Care Guide for each resident.

Interview with NA #1 via telephone on 4/29/25 at 12:54 pm revealed she was assigned to Resident #1 and was providing incontinence care before lunch around 11:30 am on 4/9/25. NA #1 stated she rolled Resident #1 away from her onto the resident's right side to clean her backside. NA #1 stated she lifted and crossed the resident's left leg over towards the top of the right leg. Resident #1 rolled too far over and went straight to the floor. NA #1 stated she didn't see if Resident #1 hit anything as she couldn't see the other side (right side) of the bed (NA #1 was on the left side). When she looked at the resident on the other side of the bed, Resident #1 was on her the right side of her body on the floor. NA #1 stated she called out for the nurses to help while staying with Resident #1. She stated that Resident #1 was talking and complaining of pain in her right hip. NA #1 stated the height of the bed when the resident fell was just below the hip. NA #1 stated she was alone doing the incontinent care and she thought she could do it herself. NA #1 stated she had not always taken care of Resident #1 because the nurse aides rotated their schedule daily and she knew where the Care Guide was at the nurses' station binder.

An interview with Nurse #1 on 4/29/25 at 12:22

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pm revealed she was working the morning shift on 4/9/25 and was called into the room for Resident #1 at around 11:30 am. Nurse #1 stated NA #1 called out for help for Resident #1 who fell out of bed during incontinence care. Nurse #1 stated when she got in the room Resident #1 was lying flat on her back on the floor. She stated Resident #1 was talking and complained of right leg pain. According to her the resident stated she hit her head on the nightstand before reaching the floor. Nurse #1 stated she assessed Resident #1 and vital signs were normal. Nurse #1 stated there was no bruising and nothing out of position on the resident's shoulders and legs. She stated the resident complained of pain around 7-8 on the pain scale. Nurse #1 and the other staff transferred the resident to her bed. Nurse #1 stated the in-house NP was in the building that day and was called to assess Resident #1. The NP came and talked to Resident #1 and ordered EMS to transport the resident to the ER for treatment.

The NP was interviewed via telephone on 4/29/25 at 3:26 pm. The NP stated she was called in the room of Resident #1 for a fall just before noon (12:00 pm) on 4/9/25. The NP stated she went straight to the resident's room and the resident's vital signs were normal. The NP stated Resident #1 was back in bed when she saw the resident and spoke with her. She was told by Resident #1 she hit her head on the nightstand. She knew that it was important to send the resident out for evaluation due to Resident #1 was taking blood thinner (anticoagulant) medication. The NP stated that Resident #1 was complaining of pain all over and refused to be touched for examination. The NP stated that she suspected a hip fracture from the fall due to the resident's right leg being

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externally rotated and it was noticeably shorter. The NP stated Resident #1 was not able move her legs and there were no lacerations noted. The NP stated she ordered the resident to be evaluated at the ER.

The interview with the Medical Director of the facility on 4/29/25 at 4:42 pm revealed Resident #1, as he recalled, needed 2 person-assist because of her immobility status. The Medical Director stated that if a resident was immobile and needed 2 person-assist, the facility staff should move the resident by two nurse aides. The Medical Director declined to rule out the cause of the fracture but deferred to the NP's assessment and what was revealed in the hospital records.

An interview with the Director of Nursing (DON) on 4/29/25 at 1:11 pm revealed that Resident #1 was marked for 2 person-assist and that NA #1 did not follow the facility protocol to have another NA help with bed mobility during incontinent care.

An interview with the Administrator on 4/29/25 at 1:12 pm revealed that the Rehab Department was in communication with the Nursing Department for mobility and transfers of each resident. She stated that NA #1 failed to follow the Care Guide for Resident #1 that was provided in the binder.

The facility provided the following corrective action plan with a corrective date of 4/11/25.

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

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F 689	Continued From page 7 On 4/9/25 Nurse Aide (NA) #1 was providing incontinence care for Resident #1 with no assistance when the care guide called for a 2 person assist with care. NA #1 rolled Resident #1 on her side to clean her back and she rolled off the bed hitting her head on the nightstand and was complaining of right hip pain, NA #1 called out for help and Nurse #1 came to the room to assess the resident. The Nurse Practitioner (NP) was in the building and assessed Resident #1, who complained of right hip pain and noted a possible abnormality of the right leg but was unable to do a thorough assessment due to resident refusal, she then gave an order to send the resident to the ER for evaluation. Resident #1 was diagnosed with severe/aggressive changes of septic arthritis and osteomyelitis involving the right hip. The right hip is subluxed superiorly and laterally and the femoral head and neck are partially destroyed with pathological fracture. On 4/9/25 NA #1 was immediately retrained by the Director of Nursing (DON) to check the care guide for staff assistance for 1 or 2 staff before providing resident care. The DON also provided education to NA #1 on never turning a resident away from you when providing care alone, they should be turned toward you when providing care alone. NA #1 was required to repeat back to the DON what she had been educated on to ensure understanding. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 4/10/25 the Administrator, Director of Nursing, Unit Managers, and the MDS Nurse audited 100% of all current resident care guides to ensure	F 689		

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they were up to date and correct. Changes were made at the time of the audit if needed.

On 4/10/25 the DON and the Regional Clinical Manager completed an audit of all current residents with falls for the past 30 days to ensure no other adverse events took place due to deficient practice. No other issues were found.

On 4/10/25 residents who have a care guide stated maximum assistance of 2 people with activities of daily living (ADL) have been identified as having the potential to be affected by the deficient practice. The DON and the Regional Clinical Manager completed an audit of current residents with a care guide of the maximum assistance of 2 people with Activities of Daily Living (ADL), and 22 residents were identified to have the potential to be affected by the deficient practice by requiring maximum assistance of 2 people with ADLs.

On 4/10/25 an audit was conducted by the DON or designee to verify by observation that residents were provided with the correct assistance with ADL care and bed mobility. No other residents were found to be affected as ADL care was provided by maximum assistance of 2 people for the 22 residents identified. Residents were interviewed while observations were completed, and none had concerns with ADL care or assistance.

What measures will be put in place or systemic changes will be made to ensure deficient practice will not recur.

On 4/10/25 education was completed with current Nurse Aide staff by the DON and the Regional

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Clinical Manager on ADL care and bed mobility for residents that require maximum assistance of 2 people for safety. NAs that did not receive the education will receive education prior to his/her next scheduled shift. The DON will keep a list to ensure all Nurse Aide staff receive education and will add the education to the new hire orientation education. New NA staff will not be allowed to begin work until education has been completed.

On 4/10/25 the Administrator and Director of Nursing made the decision to switch to pocket care guides for staff. All residents care guides transitioned to pocket care guides on 4/10/25. The Unit managers, Staff development Coordinator and aides were notified of this change on 04/10/25.

The facility will establish a "pocket care guide", which is updated daily (Mon-Fri) by the DON or designee. This care guide will be printed for each shift daily and will be distributed by the Unit Managers or designee to the NAs to carry with them during their shift. The pocket guide will consist of the following information: Resident name and room number, any isolation precautions, dining location, dining assistance, assistance needed with transfers, assistance needed with bed mobility, brief size and color, skin - float heels, turn and reposition, bowel and bladder continence, side rails, recent falls, fall interventions, Mechanical lift status, equipment, other.

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

On 4/10/25 an ad hoc QAPI meeting was held to

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discuss the deficient practice and implement a plan of correction with audit tools. Root cause analysis revealed Resident #1 was care planned for maximum assistance of 2 people however NA #1 was providing care alone.

The Director of Nursing or Unit Managers will observe 10 random resident care interactions weekly for the next 90 days for residents who are 2 person-assist for ADL Care. Re-education will be provided immediately to any staff observed not providing care per the care guide.

The Director of Nursing will be responsible for taking the audits to QA monthly for 3 months until substantial compliance is achieved.

The facility's date of compliance is 4/11/25.

On 4/30/2025, the facility's coorective action plan was validated. Resident #1 never came back to the facility after the hospitalization. During the tour of the facility, residents were observed to have 2 person-assist during incontinence care. The in-services by the facility included information on the use of pocket Care Guide and that each nursing staff should always have one with them. Staff interviews confirmed education was received for the use of the Care Guide and provided by the Unit Manager/Supervisor daily. The facility provided evidence of an Ad Hoc meeting was held to discuss the deficient practice and implement a plan of correction with audit tools. The facility provided evidence of Quality Assurance auditing of all residents with fall. Interviews with NAs revealed they have their own copy of the Care Guide with them. The alleged compliance date of 4/11/25 was validated.