STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345381	A. BUILDING _____ B. WING _____	C 08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced COVID-19 Focused was conducted on 08/03/2022 through 08/09/2022. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID#5WKZ11	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 08/03/2022 through 08/09/2022. The facility was found in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event ID# 5WKZ11. The following intakes were investigated: NC00191465, NC00189385, NC00190276 One of the five complaint allegations was substantiated resulting in a deficiency. Intake NC001911465 resulted in Immediate Jeopardy. Immediate Jeopardy was identified at: CFR 483.25 at tag F684 at a scope and severity J CFR 483.25 at tag F689 at a scope and severity J The tags F684 and F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 6/01/2022 and was removed on 8/06/2022. A partial extended survey was conducted.	F 000		
F 684	Quality of Care	F 684		8/10/22

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

Electronically Signed | 09/02/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 684 SS=J	Continued From page 1 CFR(s): 483.25	F 684		

§ 483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff interviews, and physician interview the facility failed to have a nurse assess one (Resident #1) of three residents reviewed for assessment after injury. Resident #1 had her right leg pinched between the bed and the sit to stand lift during a transfer to the shower chair. Before reporting the injury to the nurse, Resident #1 was transferred to a shower chair, received a shower, and was transferred back to bed. Resident #1 experienced pain and was transferred to the hospital where she expired from complications with a traumatic right calf hematoma.

Immediate Jeopardy began on 6/1/2022 when Nurse aide (NA #8) was transferring Resident #1 and pinched her leg between the bed and the sit to stand lift causing pain. Prior to notification of the nurse of the injury, Resident #1 was transferred with the sit to stand lift onto the shower chair, given a shower, and then transferred onto the bed without the use of a lift. The immediate jeopardy was removed on 8/6/2022 when the facility implemented an acceptable credible allegation for Immediate Jeopardy removal. The facility remains out of

1. Corrective action for affected Resident

Resident #1 is no longer in the facility

2. How will facility identify other like residents:
A 30-day lookback of incidents to identify any where a lift was involved was completed. There were no incidents involving lifts noted. This was completed on 8/6/2022.

3. Specify the action the facility will take to alter the proces or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

Current nursing staff was reeducated concerning when to notify the nurse prior to moving a resident when there is any change of condition. Changes included: any change of condition whether medical changes (including physical

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	345381	A. BUILDING _____ B. WING _____	C 08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

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F 684	Continued From page 2 compliance at a lower scope and severity level of a "D" (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems and education put into place are effective. Findings included: Resident #1 was admitted to the facility on 1/14/2022 for rehabilitative services. Resident #1 had multiple diagnoses some of which included Type 2 Diabetes Mellitus, atrial fibrillation, thrombocytopenia, and heart failure. Documentation on the quarterly Minimum Data Set assessment dated 5/31/2022 did not assess Resident #1 for her cognition. Resident #1 was coded as having highly impaired hearing and impaired vision but was able to be understood and understood others. Resident #1 was coded on the same assessment as being able to transfer with the extensive assistance of one person and as not being steady with surface to surface transfers. Resident #1 was coded as having range of motion impairment on both sides of her lower extremities. In addition, Resident #1 was coded as receiving an anticoagulant on 7 days of the assessment period. Documentation on the care plan, last revised on 3/14/2022, revealed a focus area for a self-care deficit for Resident #1 relative to weakness, pain, and stiffness in bilateral knees with decreased range of motion. One of the interventions was to transfer Resident #1 with one staff assist. Documentation on the same care plan was a focus area, initiated on 2/3/2022, for Resident #1's use of anticoagulant therapy. Interventions	F 684	changes of condition such as changes in breathing, ability to move as before, vital sign changes, verbal or nonverbal signs of pain), mental changes (including change in level of consciousness, behavioral changes, or increased confusion)or if there has been an incident or accident involving the resident. The staff must get a nurse to assess the resident prior to moving the resident. Specific focus during the reeducation will be that any time a resident expresses pain, whether verbally or non-verbally, during a transfer, the transfer must be stopped, and the resident assessed by a nurse before the any further movement of the resident. At any time there is a need for assessment by a nurse, the staff member must stay with the resident, put the call bell on, and yell out to get assistance. The reeducation was provided by the Director of Nursing, the Assistant Director of Nursing, Unit Managers, and nurses who had been reeducated on the process. This was completed by 8/8/2022. Agency nursing staff and newly hired nursing staff will have this education provided during their orientation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345381	A. BUILDING _____ B. WING _____	C 08/09/2022

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VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

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F 684	Continued From page 3 included administration of medications as ordered, avoidance of activities that may cause injury, and monitoring of signs and symptoms of bleeding. Documentation in a physician's progress note for Resident #1 written by MD #1 dated 4/13/2022 revealed in the assessment and plan portion of the note, "Hematoma - This appears to be a hematoma in the subcutaneous fat layer. The fat it ruptured and bled for 2 days after it was first noted suggested that she might be over anticoagulated. Perhaps there is some venous malformation in this area that makes her prone to do this. She is on Xarelto for stroke prevention. I am hoping that if we put a dressing on it that applies some pressure, stop her Xarelto for 24 hours, and then started at a reduced dose that the leak will clot and then heal. I am afraid that if we stop it for too long, she may become transiently hypercoagulable and that this would put her at risk for stroke or [deep vein thrombosis]." Documentation in the physician orders dated as initiated on 4/14/2022 revealed Resident #1 was receiving 10 milligrams of Xarelto (blood thinner) as one tablet given by mouth one time a day for atrial fibrillation. Documentation in the nursing notes written by Nurse #5 for Resident #1 revealed on 6/1/2022 in a late entry for 9:00 PM stated, "This nurse was notified that this resident had a hematoma on right lower leg. Assessment done. Skin was intact but there was a large blister type of hematoma on lower lateral side of shin. Notified [Doctor] and received orders to apply Betadine to area. Resident was intolerant of any touching of wound.	F 684	4. How will compliance be maintained and monitored Beginning the week of 8/8/2022 the Director of Nursing and/ or designee will monitor 5 residents per week for 12 weeks to ensure that any change of condition had appropriate notification and a timely nursing assessment completed. Any negative findings will be addessed immediately and the MD and RP wil be made aware. 5. QAPI This plan was reviewed in a QAPI meeting on 8/10/2022. The Director of Therapy and the Director of Nursing will report the results of monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. The Director of Nursing, the Director of Therapy, and/or designees are responsible for the Corrective Action Plan Dated: 8/10/2022.	

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	345381	A. BUILDING _____ B. WING _____	C 08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

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F 684	Continued From page 4	F 684		

[As needed] pain [medication] given on request. Hematoma was approximately 4 ½ inch in length, 2 ½ inches in width and 2-3 inches high. Hematoma continued to increase in size and resident continued to complain. Now approximately 45 minutes later hematoma had increased in size to extend from the ankle and up to bottom of knee and expanded across [front] of calf of leg, and approximately 3-4 inches high. Resident request to go to hospital, notified [Doctor], received orders to transfer to hospital, [family] notified, Administrator notified, transported to hospital approximately [10:30 PM]."

NA #8 was interviewed on 8/4/2022 at 11:15 AM. NA #8 revealed on 6/1/2022 she went into the room of Resident #1 at approximately 8:00 PM to give her a shower. NA #8 explained how she set up the sit to stand lift and positioned the resident on the side of the bed with her feet on the lift. NA #8 stated that as she lifted Resident #1 with the sit to stand lift and turned the lift toward the shower chair when the foot of Resident #1 slipped and was pinched between the bed and the lift. NA #8 expressed pain, so she lowered Resident #1 back onto the bed with the sit to stand lift. NA #8 indicated she asked Resident #1 if she was okay to which Resident #1 replied she was fine. NA #8 stated she did not notify the nurse at this point because she thought the resident was not injured. NA #8 again transferred Resident #1 from the bed to the shower chair using the sit to stand lift. NA #8 took Resident #1 to the shower room in the shower chair and gave her a shower. NA #8 noticed while she was in the shower room that there was a bruise on the right leg of Resident #1. NA #8 took Resident #1 back to her room and requested the help of NA #4 and

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	345381	A. BUILDING _____ B. WING _____	C 08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

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F 684	Continued From page 5	F 684		

NA #10. NA #4 and NA #10 put Resident #1 back into the bed and then they went to get a nurse. NA #8 stated she did not think the bruise was that bad, so she went back to work to give another shower.

NA #4 was interviewed on 8/3/2022 at 3:45 PM. NA #4 revealed he was assigned to care for Resident #1 on the 3:00 PM to 11:00 PM shift. NA #4 said he was doing incontinent care rounds with the help of NA #10 on the hallway which Resident #1 resided on 6/1/2022. NA #4 revealed NA #8 did not ask NA #4 for help in transferring Resident #1 to the shower chair. NA #4 indicated he was in a resident room when, NA #8 came to the room asking for help transferring Resident #1 because she had hit her leg. NA #4 stated when he got to the room of Resident #1, he could not believe the size of the bump on her right leg. NA #4 described it as, "really big." NA #4 stated NA #8 had not told the nurse about the injury at that point. NA #4 indicated he did not want to use the sit to stand lift so, NA #4 and NA #10 "strong armed and pivoted" Resident #1 into the bed. NA #4 went to get Nurse #3 after they got her in the bed. Nurse #3 came in and saw the leg and then went to get pain medication for Resident #1 because she was in a lot of pain.

Nurse #3 was interviewed on 8/3/2022 at 4:24 PM. Nurse #3 stated she did not see NA #8 take Resident #1 to the shower. Nurse #3 revealed she was coming back onto the hall and she knew something was wrong as NA #8 and NA #4 approached her. Nurse #3 stated she went to the room of Resident #1 and observed she was in the bed. Nurse #3 revealed she saw a hematoma on the right leg of Resident #8 the size of an orange. Resident #1 did not want anyone to touch the

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	345381	A. BUILDING _____ B. WING _____	C 08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 6	F 684		

hematoma and was in a lot of pain. Nurse #3 went to get pain medication for Resident #1 as NA #4, NA #10, and NA #8 were in the room with Resident #1. Nurse #3 indicated, about 5 minutes later, she gave the pain medication to Resident #1. Nurse #3 stated she thought Resident #1 was overreacting and the large hematoma was as big as it was going to get. Nurse #3 went to get Nurse #5, to help assess the area and contact the nurse practitioner. Nurse #3 stated she did not know how Resident #1 acquired the hematoma, but she assumed it happened prior her getting a shower. Nurse #3 revealed she was not thinking about Resident #1 being on Xarelto at the time of the incident to communicate this to the nurse practitioner.

Nurse #5 was interviewed on 8/4/2022 at 2:59 PM. Nurse #5 stated she was on another hallway when Nurse #3 approached her on 6/1/2022 and asked her to come look at a big bruise on the leg of Resident #1. Nurse #5 explained that it did not seem to her that anybody knew how the injury had occurred. Nurse #5 explained that at the time, all she knew was that Resident #1 was taken for a shower and put back to bed with a bruise on her right leg. Nurse #5 stated she went to the room of Resident #1 and saw she had a blood blister under the skin that was 3 to 4 inches long on the right lower leg, above the ankle and below the calf, with 2 inches rounded on top. Nurse #5 explained how the nurse practitioner was contacted, continued monitoring by nursing staff, and ultimately Resident #1 was sent to the hospital.

An interview was conducted with the facility Administrator on 8/4/2022 at 12:07 PM. The Administrator confirmed NA #8 told her the leg of

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	345381	A. BUILDING _____ B. WING _____	C 08/09/2022

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VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

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F 684	Continued From page 7	F 684		

Resident #1 was pinched between the bed and the sit to stand lift when NA #8 turned the lift to position the resident on the shower chair. The Administrator stated she was not aware Nurse #3 was not notified immediately by NA #8 when the leg of Resident #1 was pinched.

The Director of Nursing (DON) was interviewed on 8/5/2022 at 11:17 AM. The DON revealed she was not in the position of DON on 6/1/2022. The DON stated she would not have expected a nurse aide to notify a nurse of a transfer where a resident expressed generalized pain but it would be her expectation if a resident had an injury and expresed pain, a nurse should be notified for an assessment.

An interview was conducted with the Medical Director and physician (MD #1) for Resident #1 on 8/4/2022 at 3:23 PM. MD #1 stated he was made aware of Resident #1 being sent to the hospital for a pinched lateral leg that developed into a bruise and kept growing. MD #1 felt the occurrence was very unusual and the facility staff could not have had any way of predicting the hematoma would grow larger necessitating her being sent to the hospital any sooner than she was.

Documentation on the discharge summary from the hospital dated 6/15/2022 revealed in the history of present injury stated in part, "Patient presented from skilled facility after receiving a trauma to her right lower extremity causing a development of very large hematoma. After she arrived at the hospital the hematoma erupted with significant blood loss per [emergency department] provider." Documentation in the hospital course revealed Resident #1 had hemorrhagic shock

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	345381	A. BUILDING _____ B. WING _____	C 08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 8	F 684		

secondary to ruptured hematoma of her right lower extremity. Ultimately Resident #1 had respiratory failure, her left lung collapsed, transitioned to Hospice care, and expired on 6/15/2022.

Documentation on the death certificate for Resident #1, dated as signed on 6/16/2022, listed the immediate cause of death as "complications traumatic right calf hematoma." Under the description of how the injury occurred the death certificate stated, "traumatic injury to right calf while using lift to transfer patient."

The Administrator was notified of the immediate jeopardy on 8/5/2022 at 10:15 AM.

The facility provided the following credible allegation:

F 684

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

Resident #1 was not assessed after an injury during a transfer with a sit to stand lift. She was then transferred several times.

NA #8 was transferring Resident #1 with the sit to stand lift to a shower chair. Resident #1's right leg shifted and was pinched between the bed and the lift. Resident #1 expressed pain.

NA #8 transferred Resident #1 back to the bed and did not notify the nurse.

NA #8 transferred Resident #1 to the shower

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345381	A. BUILDING _____ B. WING _____	C 08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

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F 684	Continued From page 9	F 684		

chair and then to the shower room.

After the shower NA #8 noticed a bruise on the right leg of Resident #1 but did not notify the nurse. NA #8 took Resident #1 back to her room and notified NA #4 and NA #10 of an injury to the leg of Resident #1. NA #4 and NA #10 transferred Resident #1 from the shower chair to the bed without the use of a lift.

Nurse #3 was then notified by NA #8 of an injury to the right leg of Resident #1 for assessment.

There has been a 30-day lookback of incidents to identify any where a lift was involved. There were no incidents involving lifts.

o 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.

Current nursing staff will be reeducated concerning when to notify the nurse prior to moving a resident when there is any change of condition. This will specify any change of condition of a resident whether medical changes (including physical changes of condition such as changes in breathing, ability to move as before, vital sign changes, verbal, or nonverbal signs of pain), mental changes (including change in level of consciousness, behavioral changes, or increased confusion) or if there has been an incident or accident involving the resident. The staff must get a nurse to assess the resident prior to moving the resident.

Specific focus during the reeducation will be that any time a resident expresses pain, whether

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VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

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F 684	Continued From page 10	F 684		

verbally or non-verbally, during a transfer, the transfer must be stopped, and the resident assessed by a nurse before the any further movement of the resident.

At any time, there is a need for assessment by a nurse, the staff member must stay with the resident, put the call bell on, and yell out to get assistance.

This reeducation was provided by the Director of Nursing, the Assistant Director of Nursing, or the Unit Manager on 8/5/2022 for nursing staff and nursing agency staff able to come to the facility. For any nursing staff and nursing agency staff members who were not able to come to the facility on 8/5/2022, a nurse that has been reeducated will be assigned to meet each oncoming shift to complete the reeducation before they take the next assignment. The Director of Nursing has begun and will continue to track the reeducation until completion of training of all current nursing staff and nursing agency staff.

8/6/2022 is the alleged date of immediate jeopardy removal.

The credible allegation was validated on 8/9/2022 as evidenced by:
Surveyor was present on 08/09/22 to review the evidence to removal of the IJ for F 684. During this visit, interviews with alert residents indicated no issues. Interviews were conducted with several staff from each hall who revealed knowledge of the training on lift skill and education training. All staff had been trained and education provided by 08/05/22 on notifying a nurse prior to moving a resident when there is a

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VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

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F 684	Continued From page 11 change in condition.	F 684		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and a Physician interview the facility failed to safely transfer from the bed to the shower chair one (Resident #1) of three residents reviewed for supervision during transfers. Resident #1 experienced pain and was transferred to the hospital where she expired from complications with a traumatic right calf hematoma. Immediate Jeopardy began on 6/1/2022 when Nurse aide (NA #8) transferred Resident #1 from the bed to the shower chair pinching her leg between the bed and the sit to stand lift. NA #8 then sat Resident #1 back down on the bed using the sit to stand lift when the resident expressed pain. NA #8 used the sit to stand lift to transfer Resident #1 to the shower chair, gave her a shower, and returned her to her room. NA #4 and NA #10 lifted Resident #1 from the shower chair onto the bed without the use of a lift prior to notifying the nurse of an injury to the leg of Resident #1. The immediate jeopardy was removed on 8/6/2022 when the facility implemented an acceptable credible allegation for	F 689	1. Corrective action for affected resident: Resident #1 is no longer in the facility 2. How will the facility identify other like residents: All residents who require assistance with transfers are at risk for this issue. There was a 30-day lookback of incidents completed on 8/6/2022 to identify any where a lift was involved. There were no incidents involving lifts. The current in-house residents were reviewed and assessments were completed to determine the correct residents' transfer status. The review was done by the Director of Rehabilitation and completed 8/5/2022.	8/10/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345381	A. BUILDING _____ B. WING _____	C 08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 12 Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level of a "D" (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems and education put into place are effective. Findings included: Resident #1 was admitted to the facility on 1/14/2022 for rehabilitative services. Resident #1 had multiple diagnoses some of which included Type 2 Diabetes Mellitus, atrial fibrillation, thrombocytopenia, and heart failure. Documentation on the quarterly Minimum Data Set assessment dated 5/31/2022 did not assess Resident #1 for her cognition. Resident #1 was coded as having highly impaired hearing and impaired vision but was able to be understood and understood others. Resident #1 was coded on the same assessment as being able to transfer with the extensive assistance of one person and as not being steady with surface to surface transfers. Resident #1 was coded as having range of motion impairment on both sides of her lower extremities. In addition, Resident #1 was coded as receiving an anticoagulant on 7 days of the assessment period. Documentation on the care plan, last revised on 3/14/2022, revealed a focus area for a self-care deficit for Resident #1 relative to weakness, pain, and stiffness in bilateral knees with decreased range of motion. One of the interventions was to transfer Resident #1 with one staff assist. Documentation on the same care plan was a focus area for Resident #1's use of anticoagulant	F 689	Care plans were reviewed and all changes identified by the Director of Rehabilitation were updated in the residents' care plan by the nurses who perform Minimum Data Set (MDS) assessments. The residents' transfer information was placed into the care plans in instructive language of the following transfer types: stand and pivot with either an assist of 1 or assist of 2, sit to stand lift, or full lift. The information was triggered to the Kardex for nursing staff that do not have access to the care plans. The number of staff required for the different types of lifts is in the policy and training that the staff have completed. This process was completed on 8/5/2022. 3. What will the facility do to prevent this from recurring The facility reeducated nursing and therapy staff who assist with safe transfer processes such as: stand and pivot transfers, sit to stand lift process, and the full lift process. Reeducation of staff also included training on stopping transfers if there were any difficulties and seek help and nursing assessment once the resident is safe.If the resident had a noticeable decline prior to the transfer that makes the current transfer status unsafe then that staff member will notify a nurse for assessment and follow the nurses guidance to use a total lift for	

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	345381	A. BUILDING _____ B. WING _____	C 08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

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F 689	Continued From page 13 therapy. Interventions included administration of medications as ordered and avoidance of activities that may cause injury. Documentation in a physician's progress note for Resident #1 written by MD #1 dated 4/13/2022 revealed in the assessment and plan portion of the note, "Hematoma - This appears to be a hematoma in the subcutaneous fat layer. The fat it ruptured and bled for 2 days after it was first noted suggested that she might be over anticoagulated. Perhaps there is some venous malformation in this area that makes her prone to do this. She is on Xarelto for stroke prevention. I am hoping that if we put a dressing on it that applies some pressure, stop her Xarelto for 24 hours, and then started at a reduced dose that the leak will clot and then heal. I am afraid that if we stop it for too long, she may become transiently hypercoagulable and that this would put her at risk for stroke or [deep vein thrombosis]." Documentation in the physician orders dated as initiated on 4/14/2022 revealed Resident #1 was receiving 10 milligrams of Xarelto (anticoagulant) as one tablet given by mouth one time a day for atrial fibrillation. Documentation in the nursing notes for Resident #1 revealed on 6/1/2022 in a late entry for 9:00 PM stated, "This nurse was notified that this resident had a hematoma on right lower leg. Assessment done. Skin was intact but there was a large blister type of hematoma on lower lateral side of shin. Notified [Doctor] and received orders to apply Betadine to area. Resident was intolerant of any touching of wound. [As needed] pain [medication] given on request. Hematoma was	F 689	any transfers unless changes by therapy after an evaluation. This education was provided by the Director of Therapy, the Director of Nursing, the Assistant Director of Nursing, Unit Managers,and nurses who had been reeducated. This education was completed by 8/9/2022. There was a return demonstration using the different transfer types used during reeducation. The return demonstrations were completed for all of nursing and therapy staff by 8/9/2022. The updated transfer status is found in the care plan or Kardex that is accessible by nursing staff and therapists.The updated transfer status for residents was done by the Director of Rehabilitation and completed 8/5/2022. Agency nursing staff and new hire nursing staff will receive this education as part of their orientation. 4. How will the Facility Monitor and maintain ongoing compliance The Director of Therapy and/or designee started observing transfers 5 times a week starting the week of 8/8/2022 to validate that the education process was effective. This included knowing the transfer status of the residents', no concerns	

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	345381	A. BUILDING _____ B. WING _____	C 08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

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F 689	Continued From page 14 approximately 4 ½ inch in length, 2 ½ inches in width and 2-3 inches high. Hematoma continued to increase in size and resident continued to complain. Now approximately 45 minutes later hematoma had increased in size to extend from the ankle and up to bottom of knee and expanded across [front] of calf of leg, and approximately 3-4 inches high. Resident request to go to hospital, notified [Doctor], received orders to transfer to hospital, [family] notified, Administrator notified, transported to hospital approximately [10:30 PM]." NA #8 was interviewed on 8/4/2022 at 11:15 AM. NA #8 explained she knew Resident #1 well and had transferred her previously with a sit to stand lift quite a few times. NA #8 described the following events of 6/1/2022. NA #8 stated she arrived on the hall Resident #1 resided at approximately 8:00 PM and went to her room to prepare Resident #1 for a shower. Resident #1 agreed to have a shower. NA #8 set up the sit to stand lift and positioned the resident on the side of the bed with her feet on the lift. NA #8 stated that as she lifted Resident #1 with the sit to stand lift and turned the lift toward the shower chair the foot of Resident #1 slipped and was pinched between the bed and the lift. Resident #1 cried out and said, "Ow!" NA #8 lowered Resident #1 back onto the bed with the sit to stand lift. NA #8 asked Resident #1 if she was okay to which she replied that she was fine. NA #8 again transferred Resident #1 from the bed to the shower chair using the sit to stand lift. NA #8 took Resident #1 to the shower room in the shower chair and gave her a shower. NA #8 noticed while she was in the shower room that there was a bruise on the right leg of Resident #1. NA #8 took Resident #1 back to her room and requested the help of NA #4 and	F 689	with the transfers, and the ability to communicate that an assessment by the nurse will be completed if there is an incident prior to transfer. This will be documented for 12 weeks. 5. QAPI This plan was reviewed in facility QAPI meeting on 8/10/2022. The Director of Therapy and the Director of Nursing will report the results of monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. The Director of Nursing, the Director of Therapy, and/or designees are responsible for the Corrective Action Plan Dated: 8/10/2022.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345381	A. BUILDING _____ B. WING _____	C 08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 15	F 689		

NA #10. NA #4 and NA #10 put Resident #1 back into the bed by lifting her up under the arms and then they went to get a nurse. NA #8 stated she did not think the bruise was that bad, so she went back to work to give another shower.

NA #4 was interviewed on 8/3/2022 at 3:45 PM. NA #4 revealed he was assigned to care for Resident #1 on the 3:00 PM to 11:00 PM shift on 6/1/2022. NA #4 explained Resident #1 was a bed bound resident who he had never transferred out of the bed. NA #4 described the following events as occurring on 6/1/2022. NA #4 said he was doing incontinent care rounds with the help of NA #10 on the hallway which Resident #1 resided. NA #8 did not ask NA #4 for help in transferring Resident #1 to the shower chair. When NA #4 and NA #10 were on the last person they needed to provide incontinent care, NA #8 came to the room and asked for help transferring Resident #1 because she had hit her leg. NA #4 stated when he got to the room of Resident #1, he could not believe the size of the bump on her leg. NA #4 described it as, "really big." NA #4 did not want to use the sit to stand lift so, NA #4 and NA #10 "strong armed and pivoted" Resident #1 into the bed. NA #4 went to get Nurse #3 after they got her in the bed. Nurse #3 came in and saw the leg and then went to get pain medication for Resident #1 because she was in a lot of pain. NA #4, NA #10, and NA #8 attempted to get Resident #1 comfortable in the bed while Nurse #3 went for the pain medication. NA #4 revealed he kept checking on Resident #1 but within half an hour the area increased from around her ankle up to her knee.

Nurse #3 was interviewed on 8/3/2022 at 4:24 PM. Nurse #3 described the following events as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345381	A. BUILDING _____ B. WING _____	C 08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 16	F 689		

happening on 6/1/2022. Nurse #3 did not see NA #8 take Resident #1 to the shower. Nurse #3 revealed she was coming back onto the hall and she knew something was wrong as NA #8 and NA #4 approached her. Nurse #3 stated she went to the room of Resident #1 and observed she was in the bed. Nurse #3 revealed she saw a hematoma on the right leg of Resident #8 that was the size of an orange. Resident #1 did not want anyone to touch the hematoma and was in a lot of pain. Nurse #3 went to get pain medication for Resident #1 as NA #4, NA #10, and NA #8 were in the room with Resident #1. Nurse #3, about 5 minutes later, gave the pain medication to Resident #1. Nurse #3 went to get Nurse #5 to assist in the assessment of Resident #1. The nurse practitioner was contacted, and instruction was given to put Betadine on the hematoma and ice. Nurse #3 went to check on Resident #1 again approximately half an hour later and realized the hematoma was increasing in size. Nurse #3 revealed she called the Nurse Practitioner, the family of Resident #1, and Emergency Medical Services so, Resident #1 could be sent to the emergency room. Nurse #3 stated she did not know how Resident #1 acquired the hematoma, but she assumed it happened prior her getting a shower. Nurse #3 revealed she was not thinking about Resident #1 being on Xarelto at the time of the incident to communicate this to the nurse practitioner.

Resident #1 had a physician's order initiated on 3/4/2022 for a Norco tablet 5-325 milligrams (mg) (Hydrocodone-Acetaminophen) to be administered as 1 tablet by mouth every 12 hours as needed for pain.

Documentation on the Controlled Medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345381	A. BUILDING _____ B. WING _____	C 08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 17	F 689		

Utilization Record for the administration of Hydrocodone-Acetaminophen 5-325 mg (Norco) tablets revealed Resident #1 was administered one tablet of Norco on 6/1/2022 at 9:20 PM.

Nurse #5 was interviewed on 8/4/2022 at 2:59 PM. Nurse #5 stated she was on another hallway when Nurse #3 approached her on 6/1/2022 and asked her to come look at a big bruise on the leg of Resident #1. Nurse #5 explained that it did not seem to her that anybody knew how the injury had occurred. Nurse #5 explained that at the time all she knew was that Resident #1 was taken for a shower and put back to bed with a bruise on her right leg. Nurse #5 stated she went to the room of Resident #1 and saw she had a blood blister under the skin that was 3 to 4 inches long on the right lower leg, above the ankle and below the calf, with 2 inches rounded on top. Nurse #5 stated she was afraid if the blister was wrapped with gauze it would have popped and Resident #1 did not want them to touch it. Nurse #5 revealed Resident #1 complained about her leg hurting. Nurse #5 stated she called the Nurse Practitioner to ask her what to do and was advised to apply Betadine and ice. Nurse #5 stated they did put Betadine on it but Resident #1 did not tolerate ice. Nurse #5 revealed about 20 minutes later Nurse #3 came to get her on the other hallway again because the hematoma was getting bigger on Resident #1. Nurse #5 said she saw at this point the hematoma had increased in size up to the knee of Resident #1 and she knew she had to be sent to the hospital. Nurse #5 stated the Nurse Practitioner was contacted again and permission was given to send Resident #1 to the hospital.

An interview was conducted with the Medical Director and physician (MD #1) for Resident #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345381	A. BUILDING _____ B. WING _____	C 08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 18	F 689		

on 8/4/2022 at 3:23 PM. MD #1 stated he was made aware of Resident #1 being sent to the hospital for a pinched lateral leg that developed into a bruise and kept growing. MD #1 explained that he had decreased the Xarelto (anticoagulant) for Resident #1 from 15 milligrams per day to 10 milligrams per day on 4/14/2022. MD #1 further explained Resident #1 had a blood blister on her left buttock that had ruptured and bled for two days causing him to initially put her Xarelto on hold and then decreasing the dose of the anticoagulant to 10 milligrams. MD #1 stated usually a hematoma will stop growing but in this very unusual case the hematoma for Resident #1 did not stop growing necessitating her to be sent out.

An interview was conducted with the facility Administrator on 8/4/2022 at 12:07 PM. The Administrator revealed she was notified on 6/2/2022 in the early morning hours Resident #1 being sent to the hospital. The Administrator stated she began her investigation into what happened on 6/2/2022 which included contacting NA #8. The Administrator revealed she spoke with the family of Resident #1 and the events as told to the family by Resident #1 in the hospital concurred with the events of 6/1/2022 as described by NA #8. The Administrator confirmed NA #8 told her the leg of Resident #1 was pinched between the bed and the sit to stand lift when NA #8 turned the lift to position the resident on the shower chair. The Administrator revealed she gave additional instruction to NA #8 on how to use the sit to stand lift. The Administrator stated she was not aware Nurse #3 was not notified immediately by NA #8 when the leg of Resident #1 was pinched.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345381	A. BUILDING _____ B. WING _____	C 08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 19	F 689		

Documentation on the discharge summary from the hospital dated 6/15/2022 revealed in the history of present injury stated in part, "Patient presented from skilled facility after receiving a trauma to her right lower extremity causing a development of very large hematoma. After she arrived at the hospital the hematoma erupted with significant blood loss per [emergency department] provider." Documentation in the hospital course revealed Resident #1 had hemorrhagic shock secondary to ruptured hematoma of her right lower extremity. Ultimately Resident #1 had respiratory failure, her left lung collapsed, transitioned to Hospice care, and expired on 6/15/2022.

Documentation on the death certificate for Resident #1, dated as signed on 6/16/2022, listed the immediate cause of death as "complications traumatic right calf hematoma." Under the description of how the injury occurred the death certificate stated, "traumatic injury to right calf while using lift to transfer patient."

The Administrator was notified of the immediate jeopardy on 8/5/2022 at 10:15 AM.

The facility provided the following credible allegation:

F 689
o Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

Resident #1 was receiving the anticoagulant Rivaroxaban 10 milligrams daily. Nurse aide (NA #8) transferred Resident #1 from the bed to the shower chair pinching her leg between the bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345381	A. BUILDING _____ B. WING _____	C 08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 20	F 689		

and the sit to stand lift. NA #8 then sat Resident #1 back down on the bed when she expressed pain. NA #8 used the sit to stand lift to transfer the resident to the shower chair. NA #8 gave Resident #1 a shower and then noticed a bruise on the right leg of Resident #1. NA #8 returned Resident #1 to her room. NA #8 sought help from NA #4 and NA #10. NA #4 and NA #10 then lifted Resident #1 from the shower chair onto the bed without the use of a lift. NA #4 went to notify Nurse #3 of a large, raised blister on the leg of Resident #1. Resident #1 later died, and this injury was listed on her death certificate as a contributing factor.

All residents who require assistance with transfers are at risk for this issue.

There has been a 30-day look back of incidents to identify any where a lift was involved. There were no incidents involving lists.

The current residents have been reviewed and assessments have been completed as need to determine the appropriate transfer status. This review was done by the Director of Rehabilitation and completed 8/5/22

Care plans have been reviewed and any change identified by the Director of Rehabilitation has been updated in the resident care plan by the nurses that perform the Minimum Data Set assessments. The transfer information was placed into the care plans in instructive language of either stand pivot with either an assist of 1 or assist of 2, sit to stand lift, or full lift. This information was triggered to the Kardex for nursing staff that do not have access to the care plans. The number of staff required for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345381	A. BUILDING _____ B. WING _____	C 08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 21	F 689		

different types of lifts is in the policy and training that the staff have completed. This process was completed on 8/5/22.

o 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 facility will reeducate nursing and therapy staff who assist with transfers of residents concerning safe transfer processes. Part of their training was to stop a transfer if there were any difficulties and seek help and nursing assessment once the resident is safe. If the resident has had noticeable decline prior to the transfer that makes the current transfer status unsafe, the staff member will notify a nurse for assessment and follow the nurse's guidance to use a total lift for any transfers unless changed by therapy after an evaluation.

The transfer status is found in the care plan or Kardex that is accessible by nursing staff and therapists.

The stand pivot transfer must use a gait belt and the number of staff members designated in the resident's transfer status.

The sit to stand lift process includes how to apply the straps of the lift pad and the lift and work the lift to elevate the resident, then how to move the lift to safely transfer to the next surface, and then lower the resident with the lift to a seated position.

The full lift process includes that there must be two staff members at all times during the lifting process. How to place the lift pad, attach the pad

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345381	A. BUILDING _____ B. WING _____	C 08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 22	F 689		

to the lift, to lift the resident off the surface and successfully pivot the lift to place the resident onto the next surface.

There will be a return demonstration using each of the transfer types with the reeducation. The reeducation has been completed for all nursing and therapy staff who are in the building on 8/5/22 and will be completed ongoing as nursing staff arrive for work. This includes facility staff and agency staff. No one will take an assignment prior to training.

The Director of Nursing began tracking the education and return demonstration for staff as soon as it began. She will be reviewing the upcoming assignment sheets to ensure that the training is completed before the staff take their next assignment.

Any new hired staff will receive this training during orientation prior to working with any resident.

The transfer status for each resident will be completed on admission, quarterly, or with a change of condition. This is the responsibility of the Director of the Rehabilitation department on admission, staff nurse in the identification of a change of condition, and the Director of the Rehabilitation department during the quarterly review of the resident.

Care plans will be updated by the MDS nurses or administration nurses as changes are made.

8/6/22 is the date of the immediate jeopardy removal.

The credible allegation was validated on 8/9/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345381	A. BUILDING _____ B. WING _____	C 08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 23 as evidenced by: Surveyor was present on 08/09/22 to review the evidence for removal of the IJ for F 689 during this visit. Interviews with alert residents indicated no issues. Interviews were conducted with several staff from each hall who revealed knowledge of the training on lift skill and education training. All staff had been trained and educated by 08/05/22. Observations of staff using the sit to stand lift to transfer residents revealed no issues were identified.	F 689		