STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345358	A. BUILDING ______ B. WING ______	C 01/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 1/12/23 through 1/23/23. Event ID# CC5111. The following intake was investigated: NC00196829. NC00196829 resulted in immediate jeopardy. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tag F689 constituted Substandard Quality of Care. Non-noncompliance began on 12/23/22. The facility came back in compliance effective 12/31/22. A partial extended survey was conducted.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with Orthopedic Surgeon, Nurse Practitioner (NP), Medical Director, and staff, the facility failed to safely transfer a dependent resident for 1 of 3 residents reviewed for supervision to prevent	F 689	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 01/25/2023

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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F 689	Continued From page 1	F 689		

accidents (Resident #1). On 12/23/22 Resident #1, a resident totally dependent for 2 staff's assistance and a mechanical lift for transfers, fell while being transferred by Nursing Assistant #1 and Nursing Assistant #2 without a mechanical lift. Resident #1 experienced pain rated a 10 out of 10 (with 10 representing the worst pain imaginable), she suffered femur (thigh bone) fractures to both legs, and she underwent two orthopedic surgeries to address the fractures.

Findings included:

Resident #1 was most recently readmitted to the facility on 8/12/22 with diagnoses that included dementia, end stage renal disease with dialysis, difficulty in walking, and muscle weakness.

Resident #1's annual Minimum Data Set (MDS) assessment dated 12/15/22 coded Resident #1 as being moderately cognitively impaired and totally dependent on two persons for transfers. She was not steady and only able to stabilize with staff assistance when moved from seated to standing position and with surface-to-surface transfers. Resident #1 was not coded for any falls since the prior assessment.

Review of Resident #1's care plan active care plan on 12/23/22 revealed the following:
- A focus area dated 4/8/21 revealed she was at increased risk for falls and had a fall in the past related to confusion, deconditioning, gait/balance problems, and poor communication/comprehension. Interventions included a stand-up lift with 2-person assistance for all transfers.
- A focus area was added on 11/23/20 for activities of daily living (ADL) self-care

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F 689	Continued From page 2	F 689		

performance deficit related to confusion, dementia, weakness, deconditioning, and impaired balance. Interventions included total assistance of 2 staff members using a mechanical lift for all transfers.

Review of the Nursing Assistant task list history active on 12/23/22 for Resident #1 concerning transfers (last updated on 8/13/22) revealed the following:
- Sit to stand lift required for transfers on non-dialysis days
- Total mechanical lift required for transfers on dialysis days with dialysis pad
- Use 2 staff members for designated lift transfer.

A health status note written by Nurse #1 dated 12/23/22 at 6:01 AM read in part; she heard Resident #1 yelling and when she went to the room, she observed her in front of the wheelchair with Nursing Assistant (NA) #1 and NA #2 on either side of her. Resident #1 told her she was trying to slide back in the wheelchair, but her leg gave out on her. NA #1 and NA #2 stated they had assisted the resident to the floor. A pain assessment was performed with a 4/10 and Tylenol 650 milligrams (mg) was administered. Resident #1 stated she was hurt, but not that bad. There were no open areas or bleeding observed. After she was wheeled up to the front door for dialysis transportation, Resident #1 stated her knee was hurting worse. When Nurse #1 picked up her pant leg to assess, Resident #1 yelled out in pain. She requested to go to the hospital. An order was obtained, and Emergency Medical Services (EMS) was called.

An Emergency Department (ED) report dated 12/23/22 revealed a computerized tomography

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F 689	Continued From page 3	F 689		

(CT) scan (x-ray images from different angles) of Resident #1's right leg showed a distal (away from the center) femur acute extra-articular (outside of the joint) fracture with mild posterior medial (back midline) displacement. There was not any documentation regarding a scan performed to the left leg and no irregularities were documented of the left leg during the physical examination.

A health status note written by a Nurse #5 on 12/23/22 at 2:31 PM indicated, in part, the nurse spoke with the hospital regarding Resident #1 and was told the resident had a femur fracture. Surgery was planned for the next day.

A phone interview was conducted with Nurse #1 on 1/12/23 at 10:32 AM. She revealed she was getting ready to start passing medication on the morning of 12/23/22, and she heard Resident #1 scream. Nurse #1 stated she went to her room and saw Resident #1 on her knees on the floor. NA #1 and NA #2 were in the room with the resident. After she performed an assessment of Resident #1, NA #1 and NA #2 told her they were trying to transfer her from the bed to the wheelchair. Resident #1 started to slide, so they assisted her to the floor. At the time (12/23/22), Nurse #1 revealed she did not know what assistance and equipment was required for transferring Resident #1. Right after the fall, Nurse #1 indicated Resident #1 was able to perform range of motion but did complain of pain (4/10) to her right knee. All 3 staff members assisted her up into the wheelchair, and Nurse #1 went back to passing medications. Resident #1 ate a snack and watched TV until NA #1 went into her room and wheeled her up to the front for transport to dialysis. When Nurse #1 was

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F 689	Continued From page 4	F 689		

wheeling her medication cart to the front area, she stated she had heard Resident #1 moan and said her knee pain had increased to 10/10. Nurse #1 indicated that she had tried to perform another assessment to the right knee, but when she pulled the pant leg up Resident #1 grimaced/yelled with pain. Nurse #1 stated she contacted the physician on call because Resident #1 requested to go to the hospital. When Nurse #1 received the order for transfer, she called 911 and Resident #1 was picked up by EMS.

During a follow-up interview with Nurse #1 on 1/12/23 at 12:44 PM, she revealed she may have seen a mechanical lift outside the door to Resident #1's room but not inside the room when she entered after the incident on 12/23/22.

During a phone interview with NA #1 on 1/12/23 at 10:57 AM, she revealed she gave Resident #1 a bath the morning of 12/23/22. She then dressed her and asked for help from NA #2 to transfer Resident #1 to the wheelchair. NA #1 indicated that she and NA #2 were getting ready to put Resident #1 in the wheelchair, and she started to yell/resist, so they guided her to the floor. Nurse #1 then came into the room and helped put Resident #1 in the wheelchair. After she was in her chair, Resident #1 seemed fine. Nurse #1 and NA #2 left the room, and she placed Resident #1 in front of the TV. After about 10 minutes, NA #1 stated she brought the resident in the wheelchair to the front door for dialysis transport. At that time, Resident #1 did not complain of any pain/discomfort, and that was the last time she saw the resident. NA #1 stated prior to transferring the resident on 12/23/22 she found care details for Resident #1 in the electronic care plan where it instructed for the

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F 689	Continued From page 5 mechanical lift to be used for all transfers. Before she asked for help from NA #2, she retrieved the mechanical lift and placed it in Resident #1's room. However, NA #2 told her that they did not use the lift for Resident #1, and he did not tell her why. NA #1 stated this was her first-time asking NA #2 for assistance and guidance. NA #2 was interviewed on 1/12/23 at 2:23 PM. He revealed on Resident #1's scheduled dialysis days, he assisted the NA assigned to Resident #1 with transfers. On 12/23/22, NA #2 stated Resident #1 was on the edge of her bed, and he performed a 2-person assist with NA #1 to the wheelchair like he had always done for the past 3 years. When they got her up to turn from the bed, her leg gave out and he and NA #1 assisted her to the floor. He stated he then went to get Nurse #1, who assessed Resident #1, and all 3 staff members helped her get back into the wheelchair. NA #2 indicated he then left the room and went back to his assignment. He stated there was a mechanical lift in the room, but he never had to use a lift when transferring Resident #1 in the last 3 years he had worked with her. NA #2 indicated he told this to NA #1 on 12/23/22 before transferring Resident #1. NA #2 stated he had heard of the care plan but never looked at Resident #1's care plan before, and no one had ever instructed him to use a mechanical lift with Resident #1. Hospital #1's record dated 12/24/22 indicated Resident #1 was sent to a secondary hospital (Hospital #2) for surgery on 12/24/22. Hospital #2's record from 12/24/22 through 12/29/22 revealed that on 12/24/22 the initial physical exam performed on Resident #1 noted	F 689		

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F 689	Continued From page 6	F 689		

no lower extremity edema, swelling of the right knee, and sensation/motion intact distally (away from where the bone or muscle is attached). An x-ray of Resident #1's right knee and right femur (leg) was performed on 12/24/22 and showed an impacted fracture of the distal femoral diaphysis (central part of the bone). Surgery was performed on 12/27/22 of the closed bicondylar (2 plateaus of the bone) fracture of the right distal femur. After the initial physical therapy evaluation on 12/28/22, x-rays of the left lower extremity revealed a closed left distal femur fracture. It was initially discovered during the tertiary trauma survey (a prospective study of missed injury) on 12/28/22. Orthopedic surgery was performed on 12/29/22.

A Review to Ensure Quality (the facility's investigation for review of risk management) initiated on 12/23/22 and signed/completed by the Director of Nursing on 12/29/22 was reviewed. It revealed Resident #1 sustained a fall with a femur fracture. Nurse #1, NA #1, and NA #2 were interviewed and suspended pending the investigation. The RP and physician were notified on 12/23/22 at the time of the incident. Nurse #1 completed and documented her assessment of the resident after the incident. Resident #1 received medication for pain of 4/10 and sent to the ED for complaint of right knee pain. The following timeline of the fall incident on 12/23/22 was included:

- 4:30 AM: NA #1 had resident dressed and ready for transfer to wheelchair
- 4:40 AM: While transferring, Resident #1 began resisting and/or went limp. She was assisted to the floor.
- 4:50 AM: Resident #1 was assisted back to the wheelchair.

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F 689	Continued From page 7 - 5:00 AM: Resident #1 was left in her room to watch television. - 5:20 AM: Resident #1 complained of knee pain 4/10. She was given Tylenol by Nurse #1 without Medication Administration Record (MAR) documentation. Corrective action included an in-service that began on 12/26/22 by the Director of Nursing to all nursing staff regarding safe transfers, utilizing the care plan/Kardex (a task list for NAs), falls, and handling residents with challenging behaviors. All staff who had not participated in the training as of 12/30/22 were not allowed to return to work until completed. A telephone interview was conducted with the NP on 1/12/23 at 10:42 AM. She revealed Resident #1 did not typically stand and bear weight, and she was not sure if that was because she did not want to or was not capable. The NP stated she had called over to the ED on 12/23/22 and was informed Resident #1 had a right leg fracture but was then sent out to another hospital. At that time, medical staff had not found the left leg fracture yet. After the right leg surgery, Resident #1 began physical therapy at the second hospital, the NP indicated she complained of pain and an x-ray was performed where a fracture in the left leg was found as well. During a telephone interview with the Medical Director on 1/12/23 at 11:49 AM, she revealed she could not confirm the left leg fracture was a result of the fall, since it was not discovered initially. An interview was conducted on 1/18/23 at 2:24 PM with the Orthopedic Surgeon, who operated on Resident #1 in the secondary hospital	F 689		

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	345358	A. BUILDING ______ B. WING ______	C **01/23/2023**

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F 689	Continued From page 8	F 689		

(Hospital #2) on 12/27/22. He stated he believed with great certainty the left femur fracture was related to the fall on 12/23/22, and the second injury was missed by both hospitals. Physician #1 stated he had fixed the right femur and noticed Resident #1 was having pain on the other side. During follow-up exams, Resident #1 was having pain on the left side as a result, which was an identical injury to the right leg fracture. Physician #1 stated a fracture would begin to heal within 2-4 weeks (subacute), which could be identified with imaging. From Resident #1's operation and imaging results, both leg fractures appeared fresh (acute) with similar timelines. Resident #1 did not want anyone touching her anywhere, and all the medical attention was placed on her right leg. Usually, Physician #1 indicated that localized pain to a leg held the focus of the treatment.

An interview was attempted with the Radiologist who performed an x-ray on 12/24/22 of Resident #1's right leg at Hospital #2, but she was unable to be reached during the investigation.

The Director of Nursing (DON) was interviewed via telephone on 1/13/23 at 4:28 PM, and she revealed her expectation was that all nursing assistants be skilled on how to use the mechanical lift and to utilize the care plan/task list before assisting with any ADL care.

During a telephone interview with the Administrator on 1/13/23 at 4:19 PM, she revealed her expectation was for all nursing staff to follow the care plan in each resident's medical record and to follow the tasks as listed. The Administrator stated Resident #1's care plan listed mechanical lift with transfers, but she was not sure if the care plan was updated properly.

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F 689	Continued From page 9 She reported that the lift was added for Resident #1 after she underwent a mastectomy surgery in April of 2021. She explained that the mastectomy surgery caused Resident #1 to have more difficulty with using a bar to stand up. The Administrator revealed the NA care tasks did specify a 2-person assist and the use of the mechanical lift on dialysis days and that nursing staff assigned to Resident #1 were to use the mechanical lift only on dialysis days. She reported that the dialysis center where Resident #1 was treated required a lift pad underneath all patients prior to entry. She acknowledged that on that 12/23/22, the day of the fall, NA #1 and NA #2 were preparing the resident for dialysis when they transferred her from the bed to her wheelchair without the mechanical lift. The Administrator was notified of Immediate Jeopardy on 1/18/23 at 4:56 PM. The facility provided the following Plan of Correction (POC) with a completion date of 12/31/22: Resident #1 was discharged from the facility; therefore, no further corrective action could be obtained for Resident #1. On 12/28/2022 and 12/29/2022, a meeting to discuss Root Cause Analysis was held with the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Support Nurse, Administrator, Nurse Consultant, and Regional Director of Operations. Results of the investigation were discussed during the root cause meeting and shared with Quality Assurance Committee (QA) members and with the facility Medical Director (MD). On 12/29/2022 a final root cause was identified as: employee knowledge of residents transfer status,	F 689		

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F 689	Continued From page 10	F 689		

efficiency while providing resident care, and residents medical complexities and diagnosis related to weak and brittle bones. On 12/29/2022 a final root cause was identified.

On 12/28/2022, the DON, ADON, and the Unit Support Nurse reviewed 100% of the current resident's most recently completed nursing assessments and observations to identify the correct transfer status, whether a lift was required, what type of lift was required, and the number of individuals required to complete a transfer. This audit was completed on 12/28/2022.

On 12/28/2022, the DON reviewed the care plans for 100% of current residents. This audit consisted of a review to ensure the identified transfer status was accurately reflected on the resident's plan of care including the correct transfer status, whether a lift was required, what type of lift was required, and the number of individuals required to complete a transfer. This audit was completed on 12/29/2022. The results included: 5 out of 68 care plans required updating. On 12/29/2022, the DON implemented corrective action for those residents which included: Updating the 5 resident care plans that required updating to include the correct transfer status, whether a lift was required, what type of lift was required, and the number of individuals required to complete a transfer. This care plan update was completed on 12/29/2022 by the DON.

On 12/28/2022, the Nurse Consultant audited the falls for the last 30 days. This audit consisted of review of falls to identify if there were any other residents who had a fall where the plan of care

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F 689	Continued From page 11 wasn't followed for transfers. This audit was completed on 12/28/2022. The results included: There were no other residents who had a fall where the plan of care wasn't followed. No corrective action was required. On 12/26/2022, the Director of Nursing in serviced all Licensed Nurses, Registered Nurses (RN's) and Licensed Practical Nurses (LPN's) and Certified Nursing Assistants (Full time, Part time, and PRN staff) on Safe Transfers, falls process which included falls prevention, falls risk, and what to do if a fall occurs. This training included all current staff including agency. This training included education on: Safe Transfers, Utilizing the Kardex, when to utilize the Kardex, and the falls process. Additionally, on 12/26/2022, the DON began validation of competency of certified nursing assistants and nurses on how to access the Kardex and care plan. This competency included staff demonstration of how to view the plan of care/Kardex and verbalization of the need to review the plan of care prior to providing care. This was completed on 12/30/2022 by the DON. Since 12/28/2022, the DON, ADON, Unit Support Nurse, and the Minimum Data Set nurse (MDS) and the nurse management team have reviewed residents at the time of admission, quarterly, and with significant changes to ensure that the transfer status was accurately reflected on the resident's plan of care including the correct transfer status, whether a lift was required, what type of lift was required, and the number of individuals required to complete a transfer. The Director of Nurses has ensured that all	F 689		

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(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 licensed nurses, RN's and LPN's and CNA's (full time, part time, and as needed) who do not complete the in-service training will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training. As of 12/30/2022, any staff required to receive scheduled in-service training will not be allowed to work until training has been completed. On 01/02/2023, the Director of Nurses or a designee began monitoring for compliance to identify if staff could verbalize or demonstrate how to access the plan of care, direct observation of the care provided, and if the correct number of caregivers was used to provide the care. The monitoring is being completed using the Transfers QA Tool weekly for 4 weeks and monthly for 2 months monitoring 5 random staff completing transfers/care on various shifts and days to ensure care is being complete according to the plan of care. There have been no concerns identified from any of the monitors that were completed. The monitoring will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored, and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager. Additionally, reports will be presented at the quarterly QA Meeting. The Quarterly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, Health information Manager (HIM), Medical Director, Infection Preventionist, and the Dietary Manager.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345358	A. BUILDING ______ B. WING ______	C 01/23/2023

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F 689	Continued From page 13 Onsite validation was completed on 1/23/23 through staff interviews, observation, and record review. Staff were interviewed to validate in-services completed on safe transfers, fall prevention, falls risk, and fall intervention/reporting/notification/action. Observation of a transfer with mechanical lift for Resident #4 revealed no issues, and a review of audits for transfers/lifts/staff required for transfers with lifts/care plans and Kardex were implemented. Review of residents audited for falls/transfers and resident interviews verified no additional issues were identified. The facility's action plan was validated to be completed as of 12/31/22.	F 689		