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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345130	A. BUILDING ______ B. WING ______	C 07/28/2023

NAME OF PROVIDER OR SUPPLIER: **ACCORDIUS HEALTH AT CONCORD**

STREET ADDRESS, CITY, STATE, ZIP CODE: **515 LAKE CONCORD ROAD NE, CONCORD, NC 28025**

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E 000	Initial Comments An unannounced, recertification and complaint investigation survey was conducted on 7/17/2023 to 7/28/2023. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # FK6F11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 7/17/2023 to 7/21/2023. The exit conference was conducted by phone on 7/28/23. Therefore, the exit date was changed to 7/28/23. Event ID# FK6F11. The following intakes were investigated: NC00204981, NC0000203632, NC00203301, NC00202698, NC00201143, NC00200942, NC00197402, NC00195684, NC00195274, NC00195066, NC00194408, NC00194204, NC00200697, NC00200944, and NC00200675. 8 of 35 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CRF 483.10 at tag F580 at scope and severity J. CFR 483.12 at tag F600 at scope and severity J. CFR 483.25 at tag F697 at scope and severity J. The tags F600 and F697 consituted Substandard Quality of Care. Immediate Jeopardy began on 6/3/2023 and was removed on 7/26/2023. An extended survey was conducted on 7/27/23.	F 000		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes.	F 580		8/26/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/20/2023

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 580	Continued From page 1 (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15)	F 580		

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F 580	Continued From page 2 Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record reviews, resident, family, nurse practitioner (NP), physician (MD), and staff interviews, the facility failed to notify the MD of a resident who experienced pain following a fall for 1 of 3 residents investigated for notification of changes (Resident #94). Resident #94 sustained a fall on 6/2/2023 and reported the fall and right hip pain to Physical Therapist (PT) #1 on 6/3/2023. PT #1 reported the fall and the hip pain to a nurse. Resident #94 reported the fall and right hip pain when she was assessed by NP#2 on 6/5/2023. NP#2 ordered an x-ray of the right hip, which revealed a fractured femur (the long bone in the leg). Resident #94 was sent to the hospital on 6/6/2023 at 12:30 AM and had a partial hip replacement surgery on 6/7/2023. Immediately Jeopardy began on 6/3/2023 when Resident #94 reported the fall and right hip pain to PT #1 and the MD was not notified. Immediate Jeopardy was removed on 7/26/2023when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a scope and severity level of D (not actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure monitoring systems put in place are effective.	F 580	PROBLEM IDENTIFIED: During Annual Survey in July 2023, it was identified based on record reviews, resident, family, nurse practitioner (NP), physician (MD), and staff interviews, the facility failed to notify the MD of a resident who experienced pain following a fall for 1 of 3 residents investigated for notification of changes (Resident #94). Resident #94 sustained a fall on 6/2/23 and reported the fall and right hip pain to Physical Therapist (PT) #1 on 6/3/23. PT #1 reported the fall and the hip pain to a nurse. Resident #94 reported the fall and right hip pain when she was assessed by NP #2 on 6/5/23. NP #2 ordered an x-ray of the right hip, which revealed a fractured femur (the long bone in the leg). Resident #94 was sent to the hospital on 6/6/23 at 12:30am and had partial hip replacement surgery on 6/7/23. Immediate Jeopardy began on 6/3/23 when Resident #94 reported the fall and right hip pain to PT #1 and the MD was not notified. Immediate Jeopardy was removed on	

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The findings included:

Resident #94 was admitted to the facility on 6/2/2023 with diagnoses to include dementia and frequent falls.

The admission nursing assessment recorded by Nurse #6 dated 6/2/2023 documented that Resident #94 was alert and oriented to person and situation.

An interview was conducted with Resident #94 on 7/20/2023 at 3:30 PM. Resident #94 reported the evening of 6/2/2023 she used her call light to get assistance to use the bathroom, but no staff came to help her, so she got up to go to the bathroom on her own. Resident #94 reported she fell on the floor outside of the bathroom and hit her right hip. Resident #94 explained that she started yelling for help immediately, and her roommate (Resident #50) yelled for help, too. Resident #94 said that 2 nurse aides (NAs) came to her room, picked her up and put her back in bed. Resident #94 recalled her leg hurt terribly and she told the NAs her leg was hurting. Resident #94 explained the therapist (PT #1) came in the next day to see her and she told PT #1 she did not think she could stand up because she fell the night before. PT #1 told Resident #94 she would talk to the nurse. Resident #94 reported her right leg "hurt so bad all the time" and every time staff moved her in bed, she told them that it hurt. Resident #94 said the NP #2 came in to see her on Monday morning 6/5/2023 and she told the NP that she had fallen and was having right hip pain.

A follow-up interview was conducted with

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7/26/23 when the facility implemented a credible allegation of Immediate Jeopardy removal.

The facility remains out of compliance at a scope and severity of a level D (not actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure monitoring systems put in place are effective.

ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR RESIDENT(S) HAVING BEEN AFFECTED:

The facility failed to notify the physician and/or resident representative after Resident #94 reported to PT #1 on 6/3/23 that she had fallen in her room on 6/2/23.

On 6/3/23, the PT evaluation revealed that Resident #94 reported to the PT that she had fallen on 6/2/23 in her room and had not reported the incident to the facility staff. The PT also reported that the resident complained of right hip pain and this was reported to the Nurse #1 on the hall who reported she would follow up and obtain an order for an x-ray.

On 7/21/23, the Director of Nursing spoke to Nurse #1 and she denied any knowledge of Resident #94 reporting that she had fallen or that the PT or any other staff member reporting to her that Resident #94 had fallen. In addition, Nurse #1 was asked if Resident #94

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Resident #94 on 7/21/2023 at 1:58 PM. Resident #94 recounted the fall on 6/2/2023 and added that she thought she fell after dinner but could not specifically recall the time. Resident #94 recounted that she "screamed and screamed" (for help) and "2 ladies (NAs) came and got me into bed, I screamed in pain the entire time." Resident #94 reported she had called her family member on 6/2/2023 to report the fall.

The family member of Resident #94 was interviewed by phone on 7/20/2023 at 4:19 PM. The family member reported that Resident #94 called him at 7:10 PM on 6/2/2023 to tell him that she had fallen, and she was having pain in her hip. The family member explained that Resident #94 told him 2 staff members had picked her up off the floor, and he didn't think he needed to call the facility to report the fall. The family member reported he came to visit Resident #94 on 6/3/2023 and talked to Nurse #1 and reported that Resident #94 had fallen and was having pain. The family member explained that he visited again on Sunday, 6/4/2023 and asked the nurse on duty about getting Resident #94 a walker, and he also mentioned the fall and pain to Nurse #8. When asked about the nurse's response, the family member said the nurse did not say anything about the reported fall. The family member reported he had called the admission's staff member and left her a voice mail reporting the fall on Monday, 6/5/2023.

A physical therapy evaluation conducted by PT #1 and dated 6/3/2023 documented that Resident #94 reported right hip pain from a fall 6/2/2023. PT #1 documented that Resident #94 required moderate assistance to stand with right-sided leaning noted. The note documented the physical

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requested pain medication or had signs of symptoms of pain and Nurse #1 reported no.

On 7/20/23, the Therapy Director spoke to the PT that was working on 6/3/23 and she reported that Resident #94 had reported to her that she had fallen on 6/2/23 while attempting to go to the bathroom. The PT reported that the roommate also reported that the resident had fallen on the previous day (6/2/23).

On 6/5/23, after the NP reported that Resident #94 reported a fall on 6/2/23, the Director of nursing completed a follow up interview and Resident #94 reported that she had fallen while attempting to go to the bathroom and had gotten herself up off the floor and had not reported this to the staff.

On 6/5/23, Unit Manager #1 and the Admissions Director spoke to Resident #94□s family member who reported that on 6/2/23 Resident #94 had reported to him that she had fallen on the way to the bathroom and that she was having a lot of pain. The family member reported that he reported that Resident #94 was having pain to the charge nurse.

On 6/5/23 during the NP initial assessment, Resident #94 reported that she had fallen on 6/2/23 in her room while attempting to go to the bathroom and was having right hip pain.

On 7/17/23 the facility investigation by the

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therapist notified the nurse (unnamed) and was told nursing would order an x-ray.

PT #1 was interviewed by phone on 7/21/2023 at 2:49 PM. PT#1 reported she evaluated Resident #94 on 6/3/2023 and she attempted to stand Resident #94 at the bedside, but Resident #94 was unable to stand. The PT explained that Resident #94 and her roommate, Resident #50, told her that Resident #94 fell the night before. Resident #94 reported right hip pain to her with touch. Resident #94 was unable to stand during the evaluation without moderate assistance and was leaning to the right. PT #1 indicated she went to the nursing station and looked for a nurse and reported the fall and the pain that Resident #94 was experiencing. PT #1 reported an unknown nurse and told her she would get an order for an x-ray for Resident #94. PT#1 was not certain the time of day she evaluated Resident #94. PT #1 was unable to provide the name of the nurse or the time she reported to the nurse.

Nurse #1, an agency nurse, was assigned to Resident #94 on 6/3/2023 on the day shift (7:00 AM to 3:00 PM). Multiple attempts to contact Nurse #1 for an interview were unsuccessful including phone calls with voice messages and text messages.

NA #1 was interviewed on 7/20/2023 at 11:57 AM. NA #1 reported she was assigned to Resident #94 on 6/3 and 6/4/2023 for the day shift. NA #1 reported Resident #94 had pain during the weekend when they moved her in bed. NA #1 reported she had reported the pain to Nurse #1 on 6/3/2023. NA #1 reported Resident #94 did not get out of bed on day shift for 6/3/2023 or 6/4/2023 and she required incontinence care in

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Director of Nursing revealed that the Nurse Practitioner was informed of Resident #94sw fall on 6/2/23 during her initial assessment on 6/5/23 by the resident. In addition, further review of the medical record revealed that there was no fall nursing assessment documentation or physician/physician extender notification documentation by the licensed nurse of the 6/2/23 fall until 6/5/23.

The Director of Nursing completed the interviews on 7/23/23. The interviews revealed that the licensed nurses and certified nursing assistants that worked on 6/2/23, 6/3/23, and 6/4/23 reported that Resident #94 did not report to them that she had fallen on 6/2/23.

The licensed nurses, certified nursing assistants, and certified medication aide interviews by the Director of Nursing of staff that worked on 6/2/23, 6/3/23, and 6/4/23 per the nursing assignment sheets revealed that Resident #94 did not report the fall to the assigned nurse, certified nursing assistant, or certified medication aide.

On 7/17/23, Nurse #3 (Weekend Supervisor) interview with the Director of Nursing revealed that Resident #94 did not express pain concerns and she did not observe signs or symptoms of excruciating pain on 6/3/23 and 6/4/23. Nurse #3 also reported that Resident #94 as well as the other nursing staff to include the PT who worked on 6/3/23 and 6/4/23 did not report that Resident #94

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F 580	Continued From page 6 bed because of the right hip pain. An interview was conducted with NA #2 on 7/20/2023 at 2:28 PM. NA #2 reported she was assigned to Resident #94 on 6/3/2023 for the afternoon shift. The NA explained that Resident #94 complained of pain in her hip, but she did not report to any nurse because she had observed PT #1 reporting the pain a nurse. NA #2 explained she did not remember the nurse that received the report from PT #1, but she had seen the two of them talking. Resident #94 was unable to get out of bed during the afternoon shift on 6/3/2023 because of the pain she experienced with moving. NA #2 reported she did not notice bruising on Resident #94's right hip. There was no evidence in the medical record that Nurse #1 or any other staff notified the physician of Resident #94's fall and subsequent pain or that an x-ray was ordered on 6/3/2023. An interview was conducted with NA #4 by phone on 7/25/2023 at 11:10 AM. NA #4 reported she provided Resident #94 with incontinence care on 6/5/2023 during the afternoon shift and Resident #94 was in intense pain all shift. NA #4 reported she attempted to provide incontinence care by herself, and this caused Resident #94 to "scream and scream" in pain. NA #4 explained that she had to get another NA to assist her with care. NA #4 reported she told Nurse #2 that Resident #94 was in pain. Nurse #2 was interviewed on 7/19/2023 at 4:05 PM and she reported that she was assigned to Resident #94 during the afternoon shift on 6/2, 6/3, 6/4, and 6/5/2023 had not expressed she was in pain at all to her when Nurse #2 conducted the pain assessments on those dates.	F 580	had fallen on 6/2/23. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR RESIDENT(S) HAVING POTENTIAL FOR THE SAME ISSUE NEEDING TO BE ADDRESSED: All current residents are at risk because of this deficient practice. Starting on 7/21/23, the Director of Nursing, Unit Managers, and/or designee conducted an audit of the medical records to include progress notes, outside provider notes, incident reports, medication administration records, physician orders, and nursing shift reports of current residents residing in the facility for the last 60 days to ensure the physician/physician extenders and resident representatives have been notified of any resident falls or changes in condition. Identified concerns were addressed and corrected on or before 7/25/23. Starting on 7/21/23, the Director of Nursing and/or designee will complete interviews of the alert current residents to ensure resident concerns within the last 60 days to include incidents and accidents, pain management, medication/treatments and other resident care concerns have been identified and reported to the physician/physician extenders.	

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A follow up interview with Nurse #2 on 7/25/2023 at 1:44 PM revealed no one reported Resident #94 was experiencing pain on 6/3/2023, 6/4/2023, or 6/5/2023 during her afternoon shift. Nurse #2 reported that no one reported Resident #94 had a fall or was experiencing hip pain. Nurse #2 indicated that when she performed the pain assessment for Resident #94 on 6/2/2023, 6/3/2023, 6/4/2023, and 6/5/2023, the resident denied pain. Nurse #2 reported she did not notice swelling or bruising of Resident #94's right leg during any of her shifts. Nurse #2 reported she was aware of the fall when she arrived for work on 6/5/2023 for the afternoon shift. Nurse #2 reported she waited for the x-ray results to call to the physician but was told the results were not sent until after the end of her shift. Nurse #2 denied conducting any assessments on Resident #94, except for the daily shift pain assessment.

Nurse #8 was interviewed by phone on 7/20/2023 at 1:53 PM and she reported she remembered Resident #94's family member requesting a walker during her shift (3:00 PM to 11:00 PM) on 6/4/2023 but denied the family member reporting Resident #94 was experiencing pain.

There was no evidence in the medical record that Nurse #2, Nurse #8, or any other staff notified the physician of Resident #94's fall and subsequent pain or that an x-ray was ordered on 6/4/2023.

NP#1 was interviewed on 7/20/2023 at 12:14 PM. NP #1 reported that a review of the on-call logs revealed no calls came from the facility to report a fall or pain for Resident #94 on 6/2, 6/3, or 6/4/2023.

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Identified concerns were addressed and corrected on or before 7/25/23.

Starting on 7/21/23, the Director of Nursing and/or designee will complete interviews of the facility staff to include licensed nurses, certified nursing assistants, certified medication aides, dietary, housekeeping/laundry, agency, new hire and PRN staff to ensure all resident changes in condition or any reported concerns within the last 60 days were identified and reported to the Director of Nursing, Unit Manager(s), and/or the Nursing Supervisor and subsequently to the physician/physician extenders.

Identified concerns were addressed and corrected on or before 7/25/23.

ADDRESS WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE IDENTIFIED ISSUE DOES NOT OCCUR IN THE FUTURE:

Starting on 7/21/23, the Staff Development Coordinator (SDC), Director of Nursing, and/or designee will complete education with staff including licensed nurses, certified nursing assistants, certified medication aides, dietary, therapy department, housekeeping/laundry, agency, new hire and PRN staff regarding reporting changes in condition including incidents and accidents, pain management changes, medication/treatment concerns, resident

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F 580	Continued From page 8 NA #3 was interviewed on 7/21/2023 at 4:49 PM. NA #3 explained she was working on day shift on 6/2/2023 when Resident #94 was admitted to the facility, and she had assisted her to the bathroom. NA #3 indicated Resident #94 was able to transfer to the wheelchair and to the toilet by standing and pivoting to sit and the resident had no issues with the transfers or any episodes of incontinence on 6/2/2023. NA #3 reported she returned to work on 6/5/2023 and was assigned to Resident #94 on the day shift, and when she attempted to provide care, Resident #94 yelled in pain "my leg, my leg!" NA #3 reported on Monday 6/5/2023 for the day shift Resident #94 was in bed with an incontinence brief on and required incontinence care. NA #3 reported she went to get the nurse, and when they returned to Resident #94's room, NP #2 was at the bedside. NA #3 explained Resident #94 was unable to move in bed without yelling out in pain. NA #3 reported she went to get Nurse #6 and when she returned to Resident #94's room, NP #2 was at the bedside. NA #3 described that Resident #94 experienced pain all day on 6/5/2023 and she had to get another NA to assist her with incontinence care for Resident #94 because of her pain level. NA #3 reported Resident #94 said her pain was in her right hip and it was very sharp and severe with any kind of movement and turning for incontinence care was unbearable painful. NA #3 reported on 6/2/2023 Resident #94 was able to get up to the bathroom, but she stayed in bed all day 6/5/2023 and received incontinence care in the bed. A progress note written by NP #2 dated 6/5/2023 documented Resident #94 reported to her that on 6/2/2023 she attempted to go to the bathroom and had a fall with pain in her right hip since (the	F 580	care concerns and any resident/family reported concern to the licensed nurse and to the Director of Nursing, Unit Manager(s), and Nursing Supervisor(s) and subsequently to the physician/physician extenders as indicated. Education was completed with staff on or before 7/25/23. Education will be ongoing with newly hired staff and agency staff. Starting on 7/21/23, the Staff Development Coordinator (SDC), Director of Nursing, and/or designee will complete education with staff including licensed nurses, including agency nurses, newly hired nurses, and PRN nurses, regarding immediate notification and documentation of resident changes in condition including incidents and accidents, pain management changes, medication/treatment concerns, resident care concerns and any resident/family reported concerns to the physician/physician extenders and the resident representatives and to document notifications in the medical record. After hours, licensed nurses will notify the on-call provider and document notification in the medical record. Education was completed with staff on or before 7/25/23. Education will be ongoing with newly hired staff and agency staff. On 7/21/23, the Staff Development	

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	345130	A. BUILDING ______ B. WING ______	C 07/28/2023

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fall).
The NP documented Resident #94 had increased pain/discomfort with touch, no bruising was noted, and the hip appeared to be swollen. The NP documented Resident #94 had pain to the right hip/thigh that Resident #94 rated as "4" and described as "aching". The note documented Resident #94 had "as needed (acetaminophen) at this time", and staff were to continue to monitor Resident #94 until an x-ray result were received.

NP #2 was interviewed on 7/21/2023 at 2:45 PM. NP #2 reported she was performing the admission assessment on Resident #94 on 6/5/2023 when Resident #94 reported the hip pain and fall. NP #2 explained she ordered an x-ray of Resident #94's hip and when the x-ray was read and it was determined Resident #94 had a fracture, she was sent to the hospital for evaluation. NP #2 reported she had not received notification of the fall or reports of pain prior to 6/5/2023. NP #2 reported she would have ordered an x-ray on 6/3/2023 of Resident #94's hip if she had been notified of the fall with pain.

A hip x-ray dated 6/5/2023 and read at 9:39 PM read a right subcapital fracture with moderate displacement (acute right hip fracture).

A nursing note dated 6/6/2023 at 12:31 AM documented the results of the hip x-ray were received by the facility at 11:45 PM on 6/5/2023. The on-call NP was paged, and the nurse received an order to send Resident #94 to the hospital for evaluation for the right hip fracture. The note documented that Resident #94 left the facility by ambulance at 12:30 AM.

The emergency department (ED) provider note

F 580

Coordinator was made aware by the Director of Nursing that she will be responsible for verifying that education has been completed by the required staff members by using the facility personnel roster and the nursing, dietary, therapy and housekeeping/laundry staffing schedules to include new hires, agency staff, and PRN staff.

Staff members will not be permitted to work in the facility until they have received the appropriate education.

Education will be ongoing with newly hired staff and agency staff.

Ongoing education will be provided by the Staff Development Coordinator, Director of Nursing, Unit Manager(s), Nursing Supervisor(s) and/or designee.

On 7/25/23, the Director of Nursing educated the Therapy manager to ensure that therapists, including occupational therapists, occupational therapy assistants, physical therapist, physical therapy assistants, and speech therapists, including weekend therapists, newly hired therapists, and PRN therapists report resident observed and reported falls to the therapy manager and the Director of Nursing immediately.

Starting on 7/25/23, the therapy manager will educate therapists including occupational therapists, occupational therapy assistants, physical therapist, physical therapy assistants, and speech

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dated 6/6/2023 at 1:28 AM documented Resident #94 presented with right hip pain that was found to be fractured on an x-ray obtained outpatient earlier that day. Resident #94 reported she fell three days ago and has had right hip pain ever since. The note documented the x-ray obtained by the facility showed a right hip fracture. On exam the ED physician noted tenderness to the right hip without deformity. Repeat x-rays obtained confirmed a closed subcapital right femoral neck fracture. There was no pain rating, or documentation of medications administered for pain. Orthopedic surgery was consulted and at 3:05 AM recommended for Resident #94 to be admitted and make her NPO (nothing by mouth) status.

An orthopedic trauma consult note dated 6/6/2023 at 10:40 AM documented: Patient (Resident #94) reported on Friday 6/2/2023 she was attempting to get up to the bathroom and fell, landing on her right hip. She reported immediate pain in the right hip and being unable to get up after the fall. The history and physical noted: "Right lower extremity: skin intact without (redness). Leg length short in comparison to contralateral leg (left leg) and hip held in external rotation (leg was rotated to the right). Endorses (agreed) hip pain with heel strike (touching heel to the floor during mobility)." Details in the assessment and plan included the right femoral neck fracture was discussed with Resident #94 and the recommendation was to proceed with the hip hemiarthroplasty, to which she agreed. This plan was also discussed with a family member who agreed and stated Resident #94 was competent to sign her own consents.

An orthopedic trauma operative (surgical) report

therapists, including weekend therapists, newly hired therapists, and PRN therapists report resident observed and reported falls immediately to the therapy manager and the Director of Nursing.

Staff members will not be permitted to work in the facility until they have received the appropriate education.

Education will be ongoing with newly hired staff and agency staff.

INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS:

The facility will monitor its performance by the Director of Nursing, Unit Managers, and/or designee conducted an audit of medical records including progress notes, outside provider notes, incident reports, medication administration records, physician orders, and nursing shift reports of current residents residing in the facility since the last audit to ensure the physician/physician extenders and resident representatives have been notified of any resident falls or changes in condition and that documentation of notifications can be found in the resident record.

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dated 6/7/2023 documented Resident #94 had a right partial hip replacement performed on that date for a right hip fracture.

An interview was conducted with the MD on 7/21/2023 at 11:54 AM. The MD reported that his medical group has an on-call triage line where a NP was available 24 hours a day to answer medical questions and provide orders. The MD reported that the facility had not contacted the on-call triage for anything related to Resident #94 on 6/2, 6/3, or 6/4/2023. The MD reported that delaying treatment for a fractured large bone could have resulted in many complications for Resident #94.

The Director of Nursing (DON) was interviewed on 7/21/2023 at 3:21 PM. The DON explained that she had thought Resident #94 had not reported the fall to anyone until 6/5/2023 when NP #2 assessed her. The DON reported she was not aware of the physical therapy assessment conducted on 6/3/2023 and that PT #1 reported to Nurse #1 that Resident #94 had a fall and was experiencing pain. The DON explained staff should have immediately contacted the on-call NP and reported the fall and pain. The DON reported she was not certain why this had not happened on 6/3/2023.

The Administrator was notified of Immediate Jeopardy on 7/21/2023 at 6:42 PM.

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

The facility failed to notify the physician and/or the resident representative after Resident #94

F 580

Beginning on Monday 8/14/2023, Audits will be conducted by the Director of Nursing, Unit Managers, and/or designee five (5) times weekly during Morning Clinical Meeting and 1 time weekly on the weekend by the weekend supervisor for a period of four (4) weeks, then three (3) times weekly and 1 time weekly on the weekend by the weekend supervisor for a period of four (4) weeks, then one (1) time weekly and 1 time weekly on the weekend by the weekend supervisor for a period of four (4) weeks or until 100% compliance is achieved and maintained.

The Administrator and/or designee will review these audits for compliance on a weekly basis.

The DON and/or designee will bring results of audits to monthly QAPI meeting for review with the interdisciplinary team (IDT).

The IDT will discuss the need for changes/continuation of this plan during monthly QAPI meetings to achieve 100% compliance.

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reported to the Physical Therapist on 6/3/23 that she had fallen in her room on 6/2/23.

On 6/3/23, the physical therapy evaluation revealed that Resident #94 reported to the physical therapist that she had fallen on 6/2/23 in her room and had not reported the incident to the facility staff. The physical therapist also reported that the resident complained of right hip pain, and this was reported to the Nurse #1 on the hall who reported that she would follow up and obtain an order for an x-ray.

On 7/21/23, the Director of Nursing spoke to Nurse #1, and she denied any knowledge of Resident #94 reporting that she had fallen or that the physical therapist or any other staff member reporting to her that Resident #94 had fallen. In addition, Nurse #1 was asked if Resident #94 requested pain medication or had signs or symptoms of pain and Nurse #1 reported no.

On, 7/20/23, the Therapy Director spoke to the physical therapist that was working on 6/3/23 and she reported that Resident #94 had reported to her that she had fallen on 6/2/23 while attempting to go to the bathroom. The physical therapist reported that the roommate also reported that the resident had fallen on the previous day (6/2/23).

On 6/5/23, after the Nurse Practitioner reported that Resident #94 reported a fall on 6/2/23, the Director of Nursing completed a follow up interview and Resident #94 reported that she had fallen while attempting to go to the bathroom and had gotten herself up off the floor and had not reported this to the staff.

On 6/5/23, Unit Manager #1 and the Admissions

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Director spoke to Resident #94's family member who reported that on 6/2/23, Resident #94 had reported to him that she had fallen on the way to the bathroom and that she was having a lot of pain. The family member reported that he reported that Resident #94 was having pain to the charge nurse.

On 6/5/23, during the Nurse Practitioner initial assessment, Resident #94 reported that she had fallen on 6/2/23 in her room while attempting to go to the bathroom and was having right hip pain. On 7/17/23, the facility investigation by the Director of Nursing revealed that the Nurse Practitioner was informed of Resident #94's fall on 6/2/23 during her initial assessment on 6/5/23 by the resident. In addition, further review of the medical record revealed that there was no fall nursing assessment documentation or physician/physician extender notification documentation by the licensed nurse of the 6/2/23 fall until 6/5/2023.

The Director of Nursing completed the interviews on 7/21/23. The interviews revealed that the licensed nurses and the certified nursing assistants that worked on 6/2/23, 6/3/23, and 6/4/23 reported that Resident #94 did not report to them that she had fallen on 6/2/23.

The licensed nurses, certified nursing assistants, and certified medication aide interviews by the Director of Nursing of staff that who worked on 6/2/23, 6/3/23, and 6/4/23 per the nursing assignment sheets revealed that Resident #94 did not report the fall to the assigned licensed nurse, certified nursing assistant or certified medication aide.

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F 580	Continued From page 14 On 7/17/23, Nurse #3 (Weekend Supervisor) interview with the Director of Nursing revealed that Resident #94 did not express pain concerns and she did not observe signs or symptoms of excruciating pain on 6/3/23 and 6/4/23. Nurse # 3 also reported that Resident #94 as well as the other nursing staff to include the physical therapist who worked on 6/3/23 and 6/4/23, did not report that Resident #94 has fallen on 6/2/23. Nurse #3 reported that Resident #94's family member did not report to her that the resident was having pain and that the resident had fallen on 6/2/23. All current residents are also at risk as a result of this deficient practice. Starting 7/21/23, the Director of Nursing/the Unit Managers and designee will complete an audit of the medical records to include review of progress notes, outside provider notes, incident reports, medication administration records, physician orders, and nursing shift reports of all the current residents for the last 60 days to ensure the physician/ physician extenders and resident representatives have been notified of any resident falls or changes in condition and identified concerns have been address by 7/25/23. Starting 7/21/23 the Director of Nursing / designee will complete interviews of the alert current residents to ensure resident concerns to include incident and accidents, pain management, medication/ treatments and other resident care concerns have been identified and reported to the physician/ physician extenders in the last 60 days by 7/25/23. Starting 7/21/23, the Director of Nursing/ designee will complete interviews of the facility	F 580		

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F 580	Continued From page 15 staff to include licensed nurses, certified nursing assistants, certified medication aides, dietary, housekeeping/laundry, agency, new hire and prn staff to ensure all resident changes in condition or any reported concerns in the last 60 days have been reported to the DON, Unit Manager and/or the Nursing supervisor by 7/25/23. 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 Starting 7/21/23, the Staff Development Coordinator/ designee will complete education by 7/25/23 of the facility staff to include licensed nurses, certified nursing assistants, certified medication aides, dietary, therapy department, housekeeping/laundry, agency, new hire and prn staff related to ensuring resident changes in condition to include incident and accidents, pain management changes, medication/treatment concern, resident care concerns and any resident/families reported concerns have been reported to the licensed nurse and to the physician and/or DON, Unit Managers and nursing supervisor. Starting 7/21/23, the Staff Development Coordinator/ designee will complete education with the licensed nurses to include agency, new hire, and prn licensed nurses related to immediate notification and documentation of resident changes in condition to include incident and accidents, pain management changes, medication/treatment concern, resident care concerns and any resident/ families reported concerns to the physician/ physician extenders and resident representatives and document in the	F 580		

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F 580	Continued From page 16	F 580		

medical record by 7/25/23. After hours the licensed nurse will notify the on-call provider and document in the medical record.

Starting 7/21/23, the Staff Development Coordinator was made aware by the Director of Nursing that she will be responsible for verifying that the education has been completed by the required staff members by using the facility personal roster and the nursing, dietary, therapy and housekeeping/laundry staffing schedules to include new hires, agency and prn staff and ongoing education by 7/25/23. No staff will be allowed to work until they have received this education. The SDC/ designee which includes the DON, Unit Managers, and Nursing supervisors will be responsible for providing all of the education.

On 7/25/23, The Director of Nursing educated the therapy manager to ensure that all therapists to include occupational therapist, physical therapist, speech therapist, weekend therapist, new hire, and prn therapist report resident observed and reported falls to the therapy manager and the Director of Nursing immediately.

Starting 7/25/23, the therapy manager will educate the therapists to include occupational therapist, physical therapist, speech therapist, weekend therapist, new hire, and prn therapist related to ensuring resident observed and reported falls are immediately reported to the therapy manager and the Director of Nursing. Therapy staff to include prn and new hire staff will not be allowed to until they receive this education.

Effective 7/21/2023 the Administrator will be responsible for ensuring implementation of this

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immediate jeopardy removal for this alleged non-compliance.

Alleged Date of IJ Removal: 7/26/2023

On 7/27/2023, the facility's credible allegation for immediate jeopardy removal was validated by the following:

The facility's documentation to support the Credible Allegation for F580 was reviewed. The facility's Director of Nursing (DON) evaluated the named resident after she was notified the resident complained of pain due to a fall on 6/5/2023 and a pain assessment was completed. The Nurse Practitioner assessed the named resident on 6/5/2023 and sent her to the hospital for evaluation due to right hip pain due to a fall the previous Friday, 6/2/2023. The facility completed chart reviews for all residents and interviews were conducted with all cognitively intact residents and family members of residents that were not able to be interviewed. An in-service education which included the facility's policy for staff to notify the supervisor, provider, and responsible party of any falls. The education also included the nurse who was responsible for the resident would complete a post fall review with all resident falls. The facility provided the education all staff (nursing, housekeeping, therapy, dietary, and all agency staff) receive when they are oriented to the facility. Staff were interviewed to ensure their understanding of the education. The facility completed the assessment of the named resident, review and monitoring of all resident's charts and interviews with residents and family members of residents, and education of all staff by 7/25/2023.

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F 580	Continued From page 18 The facility's date of the immediate jeopardy removal plan of 7/26/2023 was validated on 7/27/2023.	F 580		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		8/26/23

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F 584	Continued From page 19 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, and interviews with staff, the facility failed to maintain the exterior facility grounds clean, free of broken equipment and trash and repair broken floor tiles in the kitchen. This failure occurred for one to nine months. The findings included: 1. On 7/19/23 at 1:42 PM, an observation of the exterior facility grounds revealed two commercial dumpsters. One dumpster was open without a lid, filled with cardboard and no room for additional storage. The second commercial dumpster's lid was closed with room for additional storage. The following broken items were observed stored on the ground or propped against the facility: " Multiple boards of sheet rock, propped against the facility. " One broken shower chair stored on the ground. " Four cement stairs stored on the ground. " Five wooden pallets, broken, stored on the ground. " One black leather chair, broken and stored on the ground. " One used surgical face mask, stored on the ground. " Four particle board headboards and footboards, broken, propped against the facility shed.	F 584	F584 Dumpster #1 lid was closed on 7/12/23 by the Maintenance Director. The multiple boards of sheet rock, broken shower chair, four cement stairs, black leather chair, used surgical mask, four particle board headboards, used glove, two recliner chairs, three empty cardboard boxes that were stored on the ground or propped against the facility were discarded by the Maintenance staff on 7/12/23. The broken and missing tiles in the dish pit area were replaced on 8/21/23 by the Maintenance Staff. The current residents have the potential to be impacted by this deficient practice. An audit of the facility grounds to include areas with tile will be completed by 8/25/23 to ensure items are not propped against the facility, stored on the ground, and tile is being repaired or replaced if needed. The Maintenance Director and maintenance staff will be educated by the Administrator by 8/25/26 related to ensuring that items are not propped against the facility, stored on the ground, and tile is being repaired or replaced if needed.	

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	345130	A. BUILDING ______ B. WING ______	C 07/28/2023

NAME OF PROVIDER OR SUPPLIER: **ACCORDIUS HEALTH AT CONCORD**

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F 584	Continued From page 20 " One used glove, laying on the ground. " Two recliner chairs, broken, stored on the ground next to the open commercial dumpster. " Three empty cardboard boxes, stored on the ground. An interview with the Maintenance Director occurred on 7/19/23 at 1:45 PM. The Maintenance Director stated he started this role in November 2022, and he had been waiting several months for the broken items stored outside to be picked up by the waste removal company. He stated that the cement stairs had been stored outside since the previous year. He stated the stairs were used to access a mobile kitchen the facility used in the summer of 2022. He stated he placed the broken black leather chair from the facility's van outside about a month ago. He stated that all the other broken items were placed outside a few weeks ago. He stated that he was in the process of moving the broken items to the dumpster, but he was waiting on the commercial dumpsters to be emptied. He stated that typically the commercial dumpsters were emptied once every two weeks, but that he had been waiting several weeks now for the waste removal company to empty them. The Maintenance Director stated he was aware these items were left on the ground and that it was his responsibility to maintain the grounds of the facility clean. The Administrator stated in an interview on 7/20/23 at 3:07 PM that he was aware that broken equipment and other items were stored on the ground outside the facility and that these items should be placed in the commercial dumpster. He stated that the facility was currently undergoing renovations and so they secured a second commercial dumpster to store trash, but	F 584	Maintenance staff will not be allowed to work until the education is completed. New hire maintenance staff will be required to complete the education. The Maintenance staff will complete facility rounds weekly for 12 weeks to ensure that items are not propped against the facility, stored on the ground, and tile is being repaired or replaced if needed. The Administrator will submit the findings to the Quality Assurance Program Interdisciplinary (QAPI) committee meeting monthly for 3 months for review and follow up with recommendations to ensure the facility's continued compliance.	

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F 584	Continued From page 21	F 584		

that emptying the commercial dumpster was not on a schedule. He stated that the waste removal company emptied the commercial dumpsters at will, and that the facility was currently waiting for the dumpsters to be emptied so that the broken items could be placed in the dumpster for removal.

2. An observation of the kitchen on 7/17/23 at 11:28 AM revealed multiple broken and missing floor tiles in the dish pit area with water pooling on the floor.

A second observation of the same occurred on 7/19/23 at 1:10 PM.

During an interview on 7/19/23 at 1:10 PM the Dietary Manager (DM) stated the floor tiles in the dish pit area had been broken/missing for a while, since piping was replaced in the kitchen last year. The DM stated that as a result, water pooled on the floor where the tiles were broken/missing and staff mopped this area daily, but water still pooled there.

The Maintenance Director stated in an interview on 7/19/23 at 1:45 PM that he was aware of the broken/missing floor tiles in the kitchen. He stated the floor tiles were in disrepair since piping underneath the kitchen floor was repaired in the summer of 2022, when the facility had a mobile kitchen. He stated repairs to the piping took a while and he just needed to identify a time when we could get in the kitchen and repair the broken tiles and replace the missing tiles when there was no activity going on in the kitchen.

The Administrator stated in an interview on 7/20/23 at 3:07 PM that the piping underneath the

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F 584	Continued From page 22 kitchen floor was repaired in the summer of 2022 and as a result a few floor tiles still needed repair. He stated that he expected these repairs to be made.	F 584		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record reviews, and resident, family member, Physical Therapist (PT) #1, Nurse Practitioner #2, Director of Rehab Services, Physician (MD), and staff interviews, the facility neglected to protect a resident from the right to be free from deprivation of goods and services related to pain management and initiating medical care and treatment after a fall on 6/2/2023 for 1 of 4 residents investigated for abuse/neglect (Resident #94). Nurse Practitioner (NP) #2 completed Resident #94's admission assessment on 6/5/2023 and Resident #94 reported the fall on 6/2/2023 and pain in her right hip since the fall. An x-ray of the right hip revealed a right femoral	F 600	The facility failed to notify the physician of Resident #94 changes in condition related to an unwitnessed fall on 6/2/23 until 6/5/23 which resulted in a delay of provision of necessary medical care, treatment and services for a right hip fracture. All current residents are at risk for this deficient practice. Social Services completed interviews of the alert and interviewable residents to ensure that any concerns related to resident abuse/neglect have been identified and addressed on 7/25/23.	8/26/23

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F 600	Continued From page 23 neck fracture (type of hip fracture of the thigh bone). Resident #94 was sent to the hospital on 6/6/2023 and had a partial hip replacement surgery on 6/7/2023. Immediately Jeopardy began on 6/3/2023 when Resident #94 reported right hip pain after a fall and was not assessed by nursing staff to determine what medical care and services were needed. Immediate Jeopardy was removed on 7/26/2023 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a scope and severity level of D (not actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure monitoring systems put in place are effective. The findings included: Resident #94 was admitted to the facility on 6/2/2023 with diagnoses to include dementia and frequent falls. The admission nursing assessment recorded by Nurse #6 dated 6/2/2023 at 2:03 PM documented that Resident #94 was alert and oriented to person and situation. Resident #94 was always continent of bowels and bladder and required a wheelchair for mobility. Resident #94 was oriented to her room and demonstrated correct use of the call light. A review of the admission medication orders dated 6/2/2023 did not include orders for pain medication. An interview was conducted with Resident #94 on	F 600	Skin assessments were completed on 7/25/23 by the Unit Managers on all the current residents to identify any bruising, redness, or swelling that has not been reported or that might require further investigation. On 7/24/23, the Activities Director meet with the Resident Council President to request a short Resident Council Meeting to review resident rights and reporting Abuse/Neglect. Starting 7/21/23, the Staff Development Coordinator/ Unit Manager/ Director of Nursing/ Nursing supervisor educated facility staff to include licensed nurses, certified nursing assistants (CNA), certified medication aide (CMA), dietary, housekeeping/ laundry, therapy staff, maintenance, administrative staff, agency and prn staff on the abuse policy and procedures to include examples of Abuse/neglect, abuse prevention, reporting and identifying Abuse and Neglect. The staff will also be made aware that all reports of Abuse and Neglect to include resident care concerns, fall concerns, unaddressed pain, and resident bruising should be reported to the Administrator immediately 7 days a week regardless of the time of the event. The Administrator contact information will be posted at each nursing station, at the time clock and at the receptionist desk. The Staff Development Coordinator and the Director of Nursing will be responsible for ensuring all staff to include licensed nurses, housekeeping/ laundry, dietary, administrative, CNA, and CMA receive the Abuse and Neglect education through	

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F 600	Continued From page 24 7/20/2023 at 3:30 PM. Resident #94 reported the evening of 6/2/2023 she used her call light to get assistance to use the bathroom, but no staff came to help her, so she got up to go to the bathroom on her own. Resident #94 reported she fell on the floor outside of the bathroom and hit her right hip. Resident #94 explained that she started yelling for help immediately, and her roommate (Resident #50) yelled for help, too. Resident #94 said that 2 nurse aides (NAs) came to her room, picked her up and put her back in bed. Resident #94 recalled her leg hurt terribly and she told the NAs her leg was hurting. Resident #94 was unable to identify the NAs who put her back in bed. Resident #94 explained the therapist (PT #1) came in the next day to see her and she told PT #1 she did not think she could stand up because she fell the night before. PT #1 told Resident #94 she would talk to the nurse. Resident #94 reported her right leg "hurt so bad all the time" and every time staff moved her in bed, she told them that it hurt. Resident #94 denied that a nurse assessed her after the fall and reported she had not received pain medication. Resident #94 said the NP #2 came in to see her on Monday morning 6/5/2023 and she told the NP that she had fallen and was having right hip pain. A follow-up interview was conducted with Resident #94 on 7/21/2023 at 1:58 PM. Resident #94 recounted the fall on 6/2/2023 and added that she thought she fell after dinner but could not specifically recall the time. Resident #94 explained that she couldn't recall if the lights were on in the bathroom. Resident #94 reported she was wearing slippers on her feet, and she fell against the wall opposite to the bathroom door and hit her right hip. Resident #94 recounted that	F 600	validation by the facility employee roster and nursing, housekeeping/laundry, therapy, and dietary schedules. Staff including new hires and prn staff will not be allowed to work without completing this education. The education will be ongoing after 7/25/23 to include new hires and prn staff. The Director of Nursing/Unit Managers will complete audits weekly for 4 weeks and monthly for 2 months to ensure that staff reports of Abuse and Neglect to include resident care concerns, fall concerns, unaddressed pain, and resident bruising be reported to the Administrator immediately 7 days a week regardless of the time of the event. The Administrator contact information will be posted at each nursing station, at the time clock and at the receptionist desk. The Director of Nursing will submit the findings to the Quality Assurance Performance Improvement committee meeting monthly for 3 months for review to ensure the facilities continued compliance.	

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F 600	Continued From page 25 she "screamed and screamed" (for help) and "2 ladies (NAs) came and got me into bed, I screamed in pain the entire time." Resident #94 reported "I screamed every time I was touched or moved after the fall. I never got pain medication." Resident #94 reported she had called her family member on 6/2/2023 to report the fall. Resident #94 said her pain was "10 out of 10 all the time, they did not do anything for it." Resident #94 explained she had an x-ray that showed her right hip was fractured and she was sent to the hospital. Resident #94 reported she cried about the right leg pain every time someone came into her room and that it was "horrible pain." The family member of Resident #94 was interviewed by phone on 7/20/2023 at 4:19 PM. The family member reported that Resident #94 called him at 7:10 PM on 6/2/2023 to tell him that she had fallen, and she was having pain in her hip. The family member explained that Resident #94 told him 2 staff members had picked her up off the floor, and he didn't think he needed to call the facility to report the fall. The family member reported he came to visit Resident #94 on 6/3/2023 and talked to Nurse #1 and reported that Resident #94 had fallen and was having pain. The family member reported that the nurse got acetaminophen (an over-the-counter pain reliever) and administered the medication to Resident #94. The family member explained that he visited again on Sunday, 6/4/2023 and asked the nurse on duty about getting Resident #94 a walker, and he also mentioned the fall and pain to Nurse #8. When asked about the nurse's response, the family member said the nurse did not say anything about the reported fall. The family member reported he had called the admission's staff member and left her a voice	F 600		

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mail reporting the fall on Monday, 6/5/2023. The family member explained that an x-ray wasn't ordered until Monday 6/5/2023 after NP #2 examined Resident #94.

A pain assessment was ordered on 6/2/2023 to be conducted 3 times per day.

A review of the medication orders for Resident #94 revealed no scheduled or as needed pain medications were prescribed for her 6/2/2023, 6/3/2023, 6/4/2023, or 6/5/2023.

The medication administration record for June 2023 was reviewed. No administration of acetaminophen was documented for Resident #94 on 6/2/2023, 6/3/2023, 6/4/2023, or 6/5/2023.

No nursing assessments related to pain after a fall were conducted on 6/2/2023.

NA #3 was interviewed on 7/21/2023 at 4:49 PM. NA #3 explained she was working on day shift (7:00 AM to 3:00 PM) on 6/2/2023 when Resident #94 was admitted to the facility, and she had assisted her to the bathroom. NA #3 indicated Resident #94 was able to transfer to the wheelchair and to the toilet by standing and pivoting to sit and the resident had no issues with the transfers or any episodes of incontinence on 6/2/2023.

The pain assessment for the afternoon shift on 6/2/2023, 6/3/2023, 6/4/2023, and 6/5/2023 was recorded by Nurse #2 and she documented a pain level of "0". (0-10 with 10 being the most intense pain).

An interview was conducted on 7/21/2023 at

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12:04 PM with NA #7 and she reported she provided care to Resident #94 on 6/2/2023 for the afternoon shift. NA #7 reported Resident #94 experienced urinary incontinence, but she did not report pain and she did not report a fall during her shift. When asked if she had assisted Resident #94 off the floor after a fall, NA #7 reported that no, she had not picked Resident #94 up off the floor after a fall.

Nurse #2 was interviewed on 7/19/2023 at 4:05 PM and she reported that she was assigned to Resident #94 during the afternoon shift on 6/2, 6/3, 6/4, and 6/5/2023 had not expressed she was in pain at all to her when Nurse #2 conducted the pain assessments on those dates.

A follow up interview with Nurse #2 on 7/25/2023 at 1:44 PM revealed no one reported Resident #94 was experiencing pain on 6/3/2023, 6/4/2023, or 6/5/2023 during her afternoon shift. Nurse #2 reported that no one reported Resident #94 had a fall or was experiencing hip pain. Nurse #2 indicated that when she performed the pain assessment for Resident #94 on 6/2/2023, 6/3/2023, 6/4/2023, and 6/5/2023, the resident denied pain. Nurse #2 reported she did not notice swelling or bruising of Resident #94's right leg during any of her shifts. Nurse #2 reported she was aware of the fall when she arrived for work on 6/5/2023 for the afternoon shift. Nurse #2 reported she waited for the x-ray results to call to the physician but was told the results were not sent until after the end of her shift. Nurse #2 denied conducting any assessments on Resident #94, except for the daily shift pain assessment.

Night shift (11:00 PM to 7:00 AM) 6/2/2023 pain assessment was recorded as "0" by Nurse #9.

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An interview was conducted with Nurse #9 by phone on 7/21/2023 at 11:33 AM. Nurse #9 explained that she did not frequently work Resident #94's hallway (C), but she was assigned to that hallway on 6/2/2023. Nurse #9 indicated Resident #94 did not report pain when she performed the pain assessment or at any other time during the shift, and Nurse #9 stated, "No, if a resident reported pain, I would have written a note or addressed it in the pain assessment."

There was no evidence in the medical record that any nurse notified the physician of Resident #94's fall and subsequent pain, completed an assessment of Resident #94 or that an x-ray was ordered on 6/2/2023.

Day shift on 6/3/2023 pain assessment recorded by Nurse #1 documented a pain level of "0'. Nurse #1, an agency nurse, was assigned to Resident #94 on 6/3/2023 on the day shift (7:00 AM to 3:00 PM). Multiple attempts to contact Nurse #1 for an interview were unsuccessful including phone calls with voice messages and text messages.

NA #1 was interviewed on 7/20/2023 at 11:57 AM. NA #1 reported she was assigned to Resident #94 on 6/3/2023 and 6/4/2023 for the day shift. NA #1 reported Resident #94 had pain during the weekend when they moved her in bed. NA #1 reported she had reported the pain to Nurse #1 on 6/3/2023. NA #1 reported Resident #94 did not get out of bed on day shift for 6/3/2023 or 6/4/2023 and she required incontinence care in bed because of the right hip pain.

NA #6 was interviewed on 7/19/2023 at 1:05 PM.

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NA #6 reported that he was not assigned to Resident #94, but had provided care to her roommate, Resident #50 for day shift on 6/3/2023. NA #6 reported that he found out Resident #94 fell on 6/5/2023.

NA #6 was interviewed again on 7/20/2023 at 12:01 PM and he reported he worked day and evening shift on 6/2/2023, 6/3/2023 and 6/4/2023 and he had not picked up Resident #94 from the floor on 6/2/2023 and if Resident #94 had reported pain, he would have reported the pain.

The weekend supervisor Nurse #3 was interviewed by phone on 7/20/2023 at 1:39 PM. Nurse #3 reported she worked 6/3/2023 and 6/4/2023 from 7:00 AM until 11:00 PM and no staff reported that Resident #94 was experiencing pain.

A physical therapy evaluation performed by PT #1 and dated 6/3/2023 documented that Resident #94 reported right hip pain from a fall 6/2/2023. The note documented the physical therapist notified the nurse (unnamed) Resident #94 was having pain in her right hip.

PT #1 was interviewed by phone on 7/21/2023 at 2:49 PM. PT#1 reported she evaluated Resident #94 on 6/3/2023 and she attempted to stand Resident #94 at the bedside, but Resident #94 was unable to stand. The PT explained that Resident #94 and her roommate, Resident #50, told her that Resident #94 fell the night before. Resident #94 reported right hip pain to her with touch. Resident #94 was unable to stand during the evaluation without moderate assistance and was leaning to the right. PT #1 indicated she went to the nursing station and looked for a nurse

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and reported the fall and the pain that Resident #94 was experiencing. PT #1 reported an unknown nurse and told her she would get an order for an x-ray for Resident #94. PT#1 was not certain the time of day she evaluated Resident #94. PT #1 was unable to provide the name of the nurse or the time she reported to the nurse.

The Director of Rehabilitation was interviewed on 7/25/2023 at 8:59 AM by phone. The Director of Rehabilitation reported that PT #1 clocked in to work on 6/3/2023 at 3:46 PM.

An occupational therapy evaluation dated 6/3/2023 was reviewed. The evaluation note documented that Resident #94 had pain that interfered or limited functional activity (no location) and that nursing would address pain management. The note documented that Resident #94 reported she had a fall on 6/2/2023 and she had pain in her right leg.

The Occupational Therapist (OT) #1 was interviewed on 7/25/2023 at 9:19 AM by phone. OT #1 reported she also assessed Resident #94 on 6/3/2023 and Resident #94 reported she had fallen on 6/2/2023. OT #1 explained that she did not report to the nurse because Resident #94 had told her that the NA staff had helped her get up off the floor. OT #1 indicated that Resident #94 did not have pain during the evaluation, but she had not gotten Resident #94 out of bed.

An interview was conducted with NA #2 on 7/20/2023 at 2:28 PM. NA #2 reported she was assigned to Resident #94 on 6/3/2023 for the afternoon shift. The NA explained that Resident #94 complained of pain in her hip, but she did not report to any nurse because she had observed

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PT #1 reporting the pain a nurse. NA #2 explained she did not remember the nurse that received the report from PT #1, but she had seen the two of them talking. Resident #94 was unable to get out of bed during the afternoon shift on 6/3/2023 because of the pain she experienced with moving. NA #2 reported she did not notice bruising on Resident #94's right hip.

There was no evidence in the medical record that any nurse notified the physician of Resident #94's fall and subsequent pain, completed an assessment of Resident #94, or that an x-ray was ordered on 6/3/2023.

The pain assessment for day shift on 6/4/2023 was recorded by Nurse #8 as "0".

Nurse #8 was interviewed by phone on 7/20/2023 at 1:53 PM and she reported she was assigned to Resident #94 during the day shift on 6/4/2023 and reported Resident #94 had not expressed she was in pain at all to her when Nurse #8 conducted the pain assessment on 6/4/2023. Nurse #8 reported she remembered Resident #94's family member requesting a walker during the day shift on 6/4/2023. Nurse #8 reported she recalled that Resident #94 was very pleasant and not in any pain. Nurse #8 reported that no staff reported a fall to her.

The pain assessment for night shift on 6/3/2023 and 6/4/2023 were recorded by Nurse #7 as "0".

Nurse #7 was interviewed by phone on 7/21/2023 at 3:15 PM. Nurse #7 reported that Resident #94 had not complained of pain when Nurse #7 conducted the pain assessment during 6/3/2023 or 6/4/2023 on the night shifts. Nurse #7

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explained that Resident #94 had an order to administer acetaminophen at 6:00 AM daily and she did administer the medication to her. Nurse #7 reported the resident had not complained of pain, and she had received scheduled acetaminophen at 6:00 AM on 6/3 and 6/4/2023.

NA #5 was interviewed on 7/21/2023 at 11:33 AM. NA #5 reported she was assigned to Resident #94 on 6/4/2023 for the night shift. NA #5 was unable to recall if Resident #94 required incontinence care during her shift and reported that Resident #94 did not complain of pain to her during the night shift.
There was no evidence in the medical record that any staff notified the physician of Resident #94's fall and subsequent pain, completed an assessment or that an x-ray was ordered on 6/4/2023.

The pain assessment day shift on 6/5/2023 recorded by Nurse #6 documented a pain level of "0".
Nurse #6 was interviewed on 7/21/2023 at 12:10 PM. Nurse #6 reported she was the nurse who admitted Resident #94 on 6/2/2023 and she was also assigned to her during the day shift on 6/5/2023. Nurse #6 reported Resident #94 did not report pain to her when Nurse #6 conducted the pain assessment on 6/5/2023, and if she had reported pain, there were facility standing orders she could have activated for administering acetaminophen to Resident #94. Nurse #6 explained that because Resident #94 did not report pain to her, she did not activate the standing orders.

During an interview conducted on 7/21/2023 at 4:49 PM, NA #3 reported she returned to work on

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6/5/2023 and was assigned to Resident #94 on the day shift, and when she attempted to provide care, Resident #94 yelled in pain "my leg, my leg!" NA #3 reported on Monday 6/5/2023 for the day shift Resident #94 was in bed with an incontinence brief on and required incontinence care. NA #3 explained she went to get Nurse #6, and when they returned to Resident #94's room, NP #2 was at the bedside. NA #3 described that Resident #94 was unable to move in bed without yelling out in pain. NA #3 explained that Resident #94 experienced pain all day on 6/5/2023 and she had to get another NA to assist her with incontinence care for Resident #94 because of her pain level. NA #3 reported Resident #94 said her pain was in her right hip and it was very sharp and severe with any kind of movement and turning for incontinence care was unbearably painful. NA #3 reported on 6/2/2023 Resident #94 was able to get up to the bathroom, but she stayed in bed all day 6/5/2023 and received incontinence care in the bed.

A progress note written by NP #2 dated 6/5/2023 documented Resident #94 reported to her that on 6/2/2023 she attempted to go to the bathroom and had a fall with pain in her right hip since (the fall). The NP documented Resident #94 had increased pain/discomfort with touch, no bruising was noted, and the hip appeared to be swollen. The NP documented Resident #94 had pain to the right hip/thigh that Resident #94 rated as "4" and described as "aching". The note documented Resident #94 had "as needed (acetaminophen) at this time, and staff were to continue to monitor Resident #94 until an x-ray result were received.

NP #2 was interviewed on 7/21/2023 at 2:45 PM. NP #2 reported she was performing the

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admission assessment on Resident #94 on 6/5/2023 when Resident #94 reported the hip pain and fall. NP #2 explained she ordered an x-ray of Resident #94's hip and when the x-ray was read and it was determined Resident #94 had a fracture, she was sent to the hospital for evaluation.

An interview was conducted with NA #4 by phone on 7/25/2023 at 11:10 AM. NA #4 reported she provided Resident #94 with incontinence care on 6/5/2023 during the afternoon shift and Resident #94 was in intense pain all shift. NA #4 reported she attempted to provide incontinence care by herself, and this caused Resident #94 to "scream and scream" in pain. NA #4 explained that she had to get another NA to assist her with care. NA #4 reported she told Nurse #2 that Resident #94 was in pain.

A hip x-ray dated 6/5/2023 and read at 9:39 PM read a right subcapital fracture with moderate displacement (acute right hip fracture).

A nursing note dated 6/6/2023 at 12:31 AM documented the results of the hip x-ray were received by the facility at 11:45 PM on 6/5/2023. The on-call NP was paged, and the nurse received an order to send Resident #94 to the hospital for evaluation for the right hip fracture. The note documented that Resident #94 left the facility by ambulance at 12:30 AM.

There was no evidence in the medical record that pain medication was ordered on 6/5/2023.

The emergency department (ED) provider note dated 6/6/2023 at 1:28 AM documented Resident #94 presented with right hip pain that was found

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F 600	Continued From page 35 to be fractured on an x-ray obtained outpatient earlier that day. Resident #94 reported she fell three days ago and has had right hip pain ever since. The note documented the x-ray obtained by the facility showed a right hip fracture. On exam the ED physician noted tenderness to the right hip without deformity. Repeat x-rays obtained confirmed a closed subcapital right femoral neck fracture. There was no pain rating, or documentation of medications administered for pain. Orthopedic surgery was consulted and at 3:05 AM recommended for Resident #94 to be admitted and make her NPO (nothing by mouth) status. An orthopedic trauma consult note dated 6/6/2023 at 10:40 AM documented: Patient (Resident #94) reported on Friday 6/2/2023 she was attempting to get up to the bathroom and fell, landing on her right hip. She reported immediate pain in the right hip and being unable to get up after the fall. The history and physical noted: "Right lower extremity: skin intact without (redness). Leg length short in comparison to contralateral leg (left leg) and hip held in external rotation (leg was rotated to the right). Endorses (agreed) hip pain with heel strike (touching heel to the floor during mobility)." Details in the assessment and plan included the right femoral neck fracture was discussed with Resident #94 and the recommendation was to proceed with the hip hemiarthroplasty, to which she agreed. This plan was also discussed with a family member who agreed and stated Resident #94 was competent to sign her own consents. An orthopedic trauma operative (surgical) report dated 6/7/2023 documented Resident #94 had a right partial hip replacement performed on that	F 600		

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date for a right hip fracture.

An interview was conducted with the MD on 7/21/2023 at 11:54 AM. The MD reported that his medical group has an on-call triage line where a NP is available 24 hours a day to answer medical questions and provide orders. The MD reported that the facility had not contacted the on-call triage for anything related to Resident #94 6/2/2023, 6/3/2023, 6/4/2023 or 6/5/2023. The MD reported that delaying treatment for a fractured large bone could have resulted in many complications for Resident #94 and would have been very painful for Resident #94, and he was not aware she did not have an order for pain medication.

The Director of Nursing (DON) was interviewed on 7/21/2023 at 3:21 PM. The DON explained that she had thought Resident #94 had not reported the fall to anyone until 6/5/2023 when NP #2 assessed her. The DON reported she was not aware of the physical therapy assessment conducted on 6/3/2023 and that PT #1 reported to an unknown nurse that Resident #94 had a fall and was experiencing pain. The DON stated she interviewed Resident #94 on 6/5/2023 after the NP evaluation and Resident #94 reported she had fallen and gotten herself up off the floor and did not report the fall to staff. The DON explained staff should have immediately contacted the on-call NP and reported the fall and pain and assessed Resident #94. The DON reported she was not certain why this had not happened on 6/3/2023.

The Administrator was notified of Immediate Jeopardy on 7/21/2023 at 6:42 PM.

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

The facility failed to ensure that Resident #94 was free from neglect.

The facility failed to notify the physician of resident changes in condition related to an unwitnessed fall on 6/2/23 until 6/5/23 which resulted in a delay of provision of necessary medical care, treatment, and services for a right hip fracture. The facility failed to address resident pain from 6/2/23 to 6/5/23 that would be associated with a hip fracture. The facility staff failed to follow up on resident reported pain resulting in resident unaddressed pain from 6/3/23 to 6/5/23. Review of Resident #94's Medication Administration revealed no documentation of pain medication being provided to the resident from 6/2/23 through 6/6/23. The facility failed to complete all the facility admission assessments on 6/2/23 for a new admission to ensure preventative measures are in place. There was no evidence from record review and staff interviews that nursing staff completed an assessment of the resident after the fall on 6/2/23 until she was seen by the Nurse Practitioner on 6/5/23.

Resident #94's roommate stated she reported Resident #94's fall on 6/2/23 to Nurse #2 on 6/2/23. Nurse #2 denied knowledge of the fall on 6/2/23.

On 6/3/23, the physical therapy evaluation revealed that Resident #94 reported to the physical therapist that she had fallen on 6/2/23 in her room and had not reported the incident to the

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facility staff. The physical therapist also reported that the resident complained of right hip pain, and this was reported to the Nurse #1 on the hall who reported that she would follow up and obtain an order for an x-ray.

Review of the medical record revealed that Nurse #1 did not complete any documentation related to the fall and did not complete a nursing assessment of Resident #94.

On 6/5/23, during the Nurse Practitioner initial assessment, resident #94 reported that she had fallen on 6/2/23 in her room while attempting to go to the bathroom and was having right hip pain. The Nurse Practitioner assessed the resident and noted pain/discomfort to the right hip area, but no bruising was noted. The Nurse Practitioner also noted swelling to the right hip and reported that it appeared that the hip was dislocated. New orders for stat x-ray was given to the nursing staff and to send the resident to the emergency room if x ray results reveal a fracture.

On 6/5/23, Resident #94 reported to the Director of Nursing that she had fallen while attempting to go to the bathroom and had gotten herself up off the floor and had not reported this to the staff on 6/2/23.

On 6/5/23, the right hip x-ray was obtained.

On 6/5/23 at 11:45pm, the licensed nurse received the x ray results which revealed an acute right hip fracture.

On 6/6/23 at about 12:30am resident #94 was transported to the emergency room by Emergency Transportation per stretcher for

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F 600	Continued From page 39 further evaluation. On 6/6/23, Resident #94 was admitted to the hospital and a right hemiarthroplasty was performed on 6/7/23. On 7/20/23, the 3-11 nursing supervisor and the Staff Development Coordinator interviewed Resident #94 and she reported that two black females came into her room and picked her up and put her back in bed after the fall on 6/2/23. Resident #94 reported that she could not remember who they were. All the current residents are at risk as a result of this deficient practice. Starting 7/21/23, Social Services will interview the alert and interviewable residents to ensure that any concerns related to resident abuse/neglect have been identified and addressed by 7/25/23. Starting 7/21/23 a skin assessment will be completed by the Unit Managers on all the current residents to identify any bruising, redness, or swelling that has not been reported or that might require further investigation by 7/25/23. On 7/24/23, the Activities Director will meet with the Resident Council President to request a short Resident Council Meeting to review resident rights and reporting Abuse/Neglect. 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. Starting 7/21/23, the Staff Development Coordinator/ Unit Manager/ Director of Nursing/	F 600		

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Nursing supervisor will educate facility staff to include licensed nurses, certified nursing assistants (CNA), certified medication aide (CMA), dietary, housekeeping/ laundry, therapy staff, maintenance, administrative staff, agency and prn staff on the abuse policy and procedures to include examples of Abuse/neglect, abuse prevention, reporting and identifying Abuse and Neglect. The staff will also be made aware that all reports of Abuse and Neglect to include resident care concerns, fall concerns, unaddressed pain, and resident bruising should be reported to the Administrator immediately 7 days a week regardless of the time of the event. The Administrator contact information will be posted at each nursing station, at the time clock and at the receptionist desk.

The Staff Development Coordinator and the Director of Nursing will be responsible for ensuring all staff to include licensed nurses, housekeeping/ laundry, dietary, administrative, CNA, and CMA receive the Abuse and Neglect education through validation by the facility employee roster and nursing, housekeeping/laundry, therapy, and dietary schedules. Staff including new hires and prn staff will not be allowed to work without completing this education. The education will be ongoing after 7/25/23 to include new hires and prn staff.

Effective 7/21/23, the Administrator will be responsible for ensuring implementation of this immediate jeopardy removal for this alleged non-compliance.

Alleged Date of IJ Removal: 7/26/2023

On 7/27/2023, the facility's credible allegation for

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F 600	Continued From page 41 immediate jeopardy removal was validated by the following: The facility provided documentation to support their credible allegation for Abuse, Neglect and Exploitation. The named resident was assessed by the Nurse Practitioner on 6/5/2023 and sent to the hospital for evaluation of pain from a fall sustained on 6/2/2023. The facility also provided documentation of their investigation of the residents fall. The facility interviewed all alert and oriented residents regarding any issues regarding abuse and neglect and completed skin assessments for each resident by 7/25/2023. The facility also had a resident council meeting to review all residents' rights regarding abuse and neglect. The facility provided documentation of audits of resident interviews and skin assessments to ensure continued monitoring for abuse and neglect. All staff (dietary, housekeeping, maintenance, therapy, and nursing) received an in-service education regarding abuse, neglect, and exploitation by 7/25/2023. A sample of staff across these disciplines revealed understanding of the in-service provided for abuse and neglect. The facility further provided the in-service education provided to all facility staff, new orientees, and agency staff before they are allowed to work in the facility. The facility completed the initial skin assessments and interviews, monitoring of all residents, and education for abuse and neglect by 7/25/2023. The facility's date of the immediate jeopardy removal plan of 7/26/2023 was validated on 7/27/2023.	F 600		
F 655 SS=D	Baseline Care Plan	F 655		8/26/23

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CFR(s): 483.21(a)(1)-(3)

§483.21 Comprehensive Person-Centered Care Planning
§483.21(a) Baseline Care Plans
§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and

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	345130	A. BUILDING ______ B. WING ______	C 07/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CONCORD	515 LAKE CONCORD ROAD NE CONCORD, NC 28025

(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 655	Continued From page 43 dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to develop a baseline care plan within 48 hours of admission that addressed the needs of a resident with a history of frequent falls for 1 of 29 residents reviewed for baseline care plans (Resident #94). The findings included: Resident #94 was admitted to the facility on 6/2/2023. Diagnoses for Resident #94 included difficulty walking, frequent falls, and Parkinson's disease. A review of the medical record revealed no baseline care plan was in place for Resident #94 dated 6/2, 6/3, 6/4 or 6/5/2023. Resident #94 was discharged to the hospital on 6/5/2023. The discharge Minimum Data Set (MDS) assessment dated 6/6/2023 documented Resident #94 had a fall since admission with a major injury. A review of the medical record revealed Resident #94 was readmitted to the facility on 6/12/2023. A review of the medical record for Resident #94 revealed a baseline care plan was created on	F 655	PROBLEM IDENTIFIED: During Annual & Complaint Survey with exit date July 28, 2023, deficient practice was cited. Based on record reviews and staff interview, the facility failed to develop a baseline care plan within 48 hours of admission that addressed the needs of a resident with a history of frequent falls for 1 of 29 residents reviewed for baseline care plans (Resident #94). ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR RESIDENT(S) FOUND TO HAVE BEEN AFFECTED: Resident #94□s care plan was initiated on 6/6/23 by the MDS coordinator. Resident #94□s baseline care plan assessment/UDA was completed on 7/2/23. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ISSUE NEEDING TO BE ADDRESSED:	

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F 655	Continued From page 44 7/2/2023. An interview was conducted with Nurse #6 on 7/21/2023 at 12:10 PM. Nurse #6 reported she admitted Resident #94 from home on 6/2/2023 and it was about 2:00 PM when Resident #94 arrived at the facility. Nurse #6 reported she had not initiated the baseline care plan for Resident #94 because she had arrived late in her shift (7:00 AM to 3:00 PM). Nurse #2 was interviewed on 7/19/2023 at 4:05 PM and she reported she was assigned to Resident #94 on 6/2/2023, 6/3/2023, 6/4/2023, and 6/5/2023 during the afternoon shift (3:00 PM to 11:00 PM). Nurse #2 reported she was not aware a baseline care plan had not been initiated on admission for Resident #94. An interview was conducted with the MDS nurse on 7/26/2023 at 2:44 PM. The MDS nurse reported the admission nurse should initiate the baseline care plan on admission. The Unit Manager, Nurse #5 was interviewed on 7/27/2023 at 10:53 AM. Nurse #5 reported the interdisciplinary team discusses new admissions in the morning meeting, but because Resident #94 was admitted on a Friday afternoon, they did not discuss her until Monday 6/5/2023. Nurse #5 explained the facility had just learned Resident #94's fall on 6/2/2023 and the team was focusing on getting her treatment and did not address the baseline care plan. An interview was conducted at the same time with the Director of Nursing (DON) and she reported a baseline care plan should have been initiated by the admission nurse or the nurse after	F 655	All residents have the potential to be affected by the same issue. The Director of Nursing, Unit Manager(s) and/or designee will complete an audit on or before Wednesday August 16, 2023 of residents currently residing in the facility who were admitted within the last 60 days to ensure that a Baseline Care Plan assessment/UDA was completed within 48 hours of admission. Residents without a Baseline Care Plan assessment/UDA within 48 hours or admission will have a Baseline Care Plan assessment/UDA completed on/before Wednesday August 16, 2023. The were no additional current residents identified in the initial audit without a baseline care plan completed in 48 hours of admission. ADDRESS WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO SURE THAT THE IDENTIFIED ISSUE DOES NOT OCCUR IN THE FUTURE: Starting on Monday August 14, 2023, the Director of Nursing will educate Unit Managers, Staff Development Coordinator (SDC) and Nursing Supervisors regarding completing a resident□s baseline care plan assessment/UDA promptly upon admission and ensuring completion within the first 48 hours of admission and their responsibility to verify timely completion on the next working day following resident admission and address identified/incomplete baseline care plan	

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F 655	Continued From page 45 and she was not certain why a baseline care plan had not been started for Resident #94. The DON reported she expected all new admissions to have a baseline care plan in place within 24 hours of admission.	F 655	assessment/UDAs promptly. Education will be complete on or before Wednesday August 16, 2023. Starting on Monday August 14, 2023, the Staff Development Coordinator (SDC), Director of Nursing, and/or designee will complete education with licensed nurses, including agency and PRN nurses, regarding completing a resident□s baseline care plan assessment/UDA promptly upon admission, and ensuring completion within the first 48 hours of admission. Education will be completed on or before Wednesday August 16, 2023. Licensed nurses will not be permitted to work in the facility until they have received the appropriate education regarding baseline care plans being completed in a timely manner. Education will be ongoing with newly hired licensed nurses and agency nurses. INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT THE SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS: The facility will monitor its performance by	

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F 655	Continued From page 46	F 655	the Director of Nursing, Unit Managers, and/or designee conducted an audit of new admissions since the most recent audit to ensure that baseline care plan assessment/UDAs have been completed within 48 hours of admission and to ensure that residents at risk for falls have this addressed appropriately in their baseline care plan assessment/UDA. Beginning on Monday 8/14/2023, Audits will be conducted by the Director of Nursing, Unit Managers, and/or designee five (5) times weekly during Morning Clinical Meeting for a period of four (4) weeks, then three (3) times weekly for a period of four (4) weeks, then one (1) time weekly for a period of four (4) weeks or until 100% compliance is achieved and maintained. The weekend supervisor will audits of the weekend admissions for 12 weeks to ensure continual compliance. The Administrator and/or designee will review these audits for compliance on a weekly basis. The DON and/or designee will bring results of audits to monthly QAPI meeting for review with the interdisciplinary team (IDT). The IDT will discuss the need for changes/continuation of this plan during monthly QAPI meetings to achieve 100% compliance.	
F 697 SS=J	Pain Management CFR(s): 483.25(k)	F 697		8/26/23

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F 697	Continued From page 47 §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident, family, nurse practitioner, physician, and staff interviews, the facility failed to effectively manage pain for a resident after she experienced a fall and reported pain for 1 of 5 residents investigated for pain management (Resident #94). Resident #94 experienced pain that caused her to yell and scream. The pain affected her ability to go to the bathroom and she became incontinent. Immediately Jeopardy began on 6/3/2023 when Resident #94 reported hip pain to Physical Therapist (PT) #1 and nursing did not effectively manage her pain. Immediate Jeopardy was removed on 7/26/2023 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a scope and severity level of D (not actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure monitoring systems put in place are effective. The findings included: Resident #94 was admitted to the facility on 6/2/2023 with diagnoses to include dementia and frequent falls. The admission nursing assessment recorded by	F 697	On 7/23/23, Resident #94 pain assessment was completed by the Unit Manager revealing a pain level of 4 with the resident expressing occasional pain. On 6/30/23, Resident #94 pain care plan was reviewed and revised by the Minimum Data Set licensed nurse. All the current residents are at risk as a result of this deficient practice. Starting 7/21/23, the Director of Nursing and Nursing Unit Manager observed and interviewed the current residents and completed new pain assessments to include review of progress notes, care plans and resident pain regiments to ensure resident pain is being managed and/or prevented by 7/25/23. There were no additional issues identified. On 7/21/23, the Chief Nursing Officer reviewed the Maple Health Pain Management Program with the Director of Nursing to include identifying resident pain, signs and symptoms of pain, pain assessment, reporting resident pain, pain documentation, pain medication management, and pain care plans. On 7/21/23, the Director of Nursing reviewed the Maple Health Pain	

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Nurse #6 dated 6/2/2023 documented that Resident #94 was alert and oriented to person and situation. Resident #94 was always continent of bowels and bladder and required a wheelchair for mobility. Resident #94 was oriented to her room and demonstrated correct use of the call light.

An interview was conducted with Resident #94 on 7/20/2023 at 3:30 PM. Resident #94 reported the evening of 6/2/2023 she used her call light to get assistance to use the bathroom, but no staff came to help her, so she got up to go to the bathroom on her own. Resident #94 reported she fell on the floor outside of the bathroom and hit her right hip. Resident #94 explained that she started yelling for help immediately, and her roommate (Resident #50) yelled for help, too. Resident #94 said that 2 nurse aides (NAs) came to her room, picked her up and put her back in bed. Resident #94 recalled her leg hurt terribly and she told the NAs her leg was hurting. Resident #94 was unable to identify the NAs who put her back in bed. Resident #94 explained the therapist (PT #1) came in the next day to see her and she told PT #1 she did not think she could stand up because she fell the night before. PT #1 told Resident #94 she would talk to the nurse. Resident #94 reported her right leg "hurt so bad all the time" and every time staff moved her in bed, she told them that it hurt. Resident #94 denied that a nurse assessed her after the fall and reported she had not received pain medication. Resident #94 said the NP #2 came in to see her on Monday morning 6/5/2023 and she told the NP that she had fallen and was having right hip pain.

A follow-up interview was conducted with

F 697

Management Program with the Staff Development Coordinator to include identifying resident pain, signs and symptoms of pain, pain assessment, reporting resident pain, pain documentation, pain medication management, and pain care plans.

The licensed nurses, certified nursing assistances, certified medication aids to include agency staff, new hires, and prn nursing staff educated was completed on 7/25/23 by the Staff Development Coordinator (SDC)/ Director of Nursing on the Pain Management Program to include identifying resident pain, signs and symptoms of pain, pain assessment, reporting resident pain, pain documentation, pain medication management, and pain care plans. No staff will be allowed to work until they have received this education. The SDC/ designee which includes the DON, Unit Managers, and Nursing supervisors will be responsible for providing all of the education. The SDC will continue to review the daily staff assignment sheets to ensure nursing staff completes the required education.

On 7/25/23, The Director of Nursing educated the therapy manager to ensure that therapists to include occupational therapist, physical therapist, speech therapist, new hires, weekend staff and prn report resident pain concerns to the therapy manager and the Director of Nursing immediately. The DON is available 24/7 and contact information is

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F 697	Continued From page 49 Resident #94 on 7/21/2023 at 1:58 PM. Resident #94 recounted the fall on 6/2/2023 and added that she thought she fell after dinner but could not specifically recall the time. Resident #94 explained that she couldn't recall if the lights were on in the bathroom. Resident #94 reported she was wearing slippers on her feet, and she fell against the wall opposite to the bathroom door and hit her right hip. Resident #94 recounted that she "screamed and screamed" (for help) and "2 ladies (NAs) came and got me into bed, I screamed in pain the entire time." Resident #94 reported "I screamed every time I was touched or moved after the fall. I never got pain medication." Resident #94 reported she had called her family member on 6/2/2023 to report the fall. Resident #94 said her pain was "10 out of 10 all the time, they did not do anything for it." Resident #94 explained she had an x-ray that showed her right hip was fractured and she was sent to the hospital. Resident #94 reported she cried about the right leg pain every time someone came into her room and that it was "horrible pain." The family member of Resident #94 was interviewed by phone on 7/20/2023 at 4:19 PM. The family member reported that Resident #94 called him at 7:10 PM on 6/2/2023 to tell him that she had fallen, and she was having pain in her hip. The family member explained that Resident #94 told him 2 staff members had picked her up off the floor, and he didn't think he needed to call the facility to report the fall. The family member reported he came to visit Resident #94 on 6/3/2023 and talked to Nurse #1 and reported that Resident #94 had fallen and was having pain. The family member reported that the nurse got acetaminophen (an over-the-counter pain reliever) and administered the medication to	F 697	located at each nursing state. On 7/25/23, the therapy manager completed education with the therapists related to ensuring resident pain concerns are immediately reported to the therapy manager and the Director of Nursing. Therapy staff to include occupational therapist, physical therapist, speech therapist, new hires, weekend staff and prn staff will not be allowed to work until they receive this education. On 7/21/23, the Unit Managers and Weekend supervisor were educated by the Director of Nursing that they are responsible to complete daily audits to ensure that resident progress notes, physician orders, therapy notes and medication records are being reviewed to ensure resident pain concerns have been addressed and intervention for management and prevention of pain are in place. The Director of Nursing will complete audits on at least 10 current residents weekly for 4 weeks and monthly for 2 months to ensure that residents continue to be assessed for signs and symptoms of pain, resident pain concern continues to be addressed, pain care plans developed, and pain documentation is completed. The Director of Nursing will submit the findings to the Quality Assurance Performance Improvement (QAPI) committee monthly meeting for 3 months for review and follow up with recommendations to ensure the facility□s	

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Resident #94. The family member explained that he visited again on Sunday, 6/4/2023 and asked the nurse on duty about getting Resident #94 a walker, and he also mentioned the fall and pain to Nurse #8. When asked about the nurse's response, the family member said the nurse did not say anything about the reported fall. The family member reported he had called the admission's staff member and left her a voice mail reporting the fall on Monday, 6/5/2023. The family member explained that an x-ray wasn't ordered until Monday 6/5/2023 after NP #2 examined Resident #94.

A pain assessment was ordered on 6/2/2023 to be conducted 3 times per day.

A review of the medication orders for Resident #94 revealed no scheduled or as needed pain medications were prescribed for her 6/2/2023, 6/3/2023, 6/4/2023, or 6/5/2023. Standing orders for the facility, which included acetaminophen, were not transcribed to Resident #94's medical record.

The medication administration record for June 2023 was reviewed. No administration of acetaminophen was documented for Resident #94 on 6/2, 6/3, 6/4, or 6/5/2023.

No nursing assessments related to pain after a fall were conducted on 6/2/2023.

NA #3 was interviewed on 7/21/2023 at 4:49 PM. NA #3 explained she was working on day shift (7:00 AM to 3:00 PM) on 6/2/2023 when Resident #94 was admitted to the facility, and she had assisted her to the bathroom. NA #3 indicated Resident #94 was able to transfer to the

continued compliance.

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F 697	Continued From page 51 wheelchair and to the toilet by standing and pivoting to sit and the resident had no issues with the transfers or any episodes of incontinence on 6/2/2023. An interview was conducted on 7/21/2023 at 12:04 PM with NA #7 and she reported she provided care to Resident #94 on 6/2/2023 for the afternoon shift. NA #7 reported Resident #94 experienced urinary incontinence, but she did not report pain and she did not report a fall during her shift. The pain assessment for the afternoon shift on 6/2/2023, 6/3/2023, 6/4/2023, and 6/5/2023 was recorded by Nurse #2 and she documented a pain level of "0". (0-10 with 10 being the most intense pain). Nurse #2 was interviewed on 7/19/2023 at 4:05 PM and she reported that she was assigned to Resident #94 during the afternoon shift on 6/2/2023, 6/3/2023, 6/4/2023, and 6/5/2023 had not expressed she was in pain at all to her when Nurse #2 conducted the pain assessments on those dates. A follow up interview with Nurse #2 on 7/25/2023 at 1:44 PM revealed no one reported Resident #94 was experiencing pain on 6/3/2023, 6/4/2023, or 6/5/2023 during her afternoon shift. Nurse #2 reported that no one reported Resident #94 had a fall or was experiencing hip pain. Nurse #2 indicated that when she performed the pain assessment for Resident #94 on 6/2/2023, 6/3/2023, 6/4/2023, and 6/5/2023, the resident denied pain. Nurse #2 reported she did not notice swelling or bruising of Resident #94's right leg during any of her shifts. Nurse #2 reported	F 697		

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she was aware of the fall when she arrived for work on 6/5/2023 for the afternoon shift. Nurse #2 reported she waited for the x-ray results to call to the physician but was told the results were not sent until after the end of her shift. Nurse #2 denied conducting any assessments on Resident #94, except for the daily shift pain assessment.

Night shift (11:00 PM to 7:00 AM) 6/2/2023 pain assessment was recorded as "0" by Nurse #9. An interview was conducted with Nurse #9 by phone on 7/21/2023 at 11:33 AM. Nurse #9 explained that she did not frequently work Resident #94's hallway (C), but she was assigned to that hallway on 6/2/2023.

Nurse #9 indicated Resident #94 did not report pain when she performed the pain assessment or at any other time during the shift, and Nurse #9 stated, "No, if a resident reported pain, I would have written a note or addressed it in the pain assessment."

There was no evidence in the medical record that any nurse notified the physician of Resident #94's fall and subsequent pain, completed an assessment of Resident #94 or that an x-ray was ordered on 6/2/2023.

Day shift (7:00 AM to 3:00 PM) on 6/3/2023 pain assessment recorded by Nurse #1 documented a pain level of "0'.

Nurse #1, an agency nurse, was assigned to Resident #94 on 6/3/2023 on the day shift (7:00 AM to 3:00 PM). Multiple attempts to contact Nurse #1 for an interview were unsuccessful including phone calls with voice messages and text messages.

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F 697	Continued From page 53 NA #1 was interviewed on 7/20/2023 at 11:57 AM. NA #1 reported she was assigned to Resident #94 on 6/3/2023 and 6/4/2023 for the day shift. NA #1 reported Resident #94 had pain during the weekend when they moved her in bed. NA #1 reported she had reported the pain to Nurse #1 on 6/3/2023. NA #1 reported Resident #94 did not get out of bed on day shift for 6/3/2023 or 6/4/2023 and she required incontinence care in bed because of the right hip pain. NA #6 was interviewed on 7/20/2023 at 12:01 PM and he reported he worked day and evening shift on 6/2/2023, 6/3/2023 and 6/4/2023 and if Resident #94 had reported pain, he would have reported the pain. The weekend supervisor Nurse #3 was interviewed by phone on 7/20/2023 at 1:39 PM. Nurse #3 reported she worked 6/3/2023 and 6/4/2023 from 7:00 AM until 11:00 PM and no staff reported that Resident #94 was experiencing pain. A physical therapy evaluation performed by PT #1 and dated 6/3/2023 documented that Resident #94 reported right hip pain from a fall 6/2/2023. The note documented the physical therapist notified the nurse (unnamed) Resident #94 was having pain in her right hip. PT #1 was interviewed by phone on 7/21/2023 at 2:49 PM. PT#1 reported she evaluated Resident #94 on 6/3/2023 and she attempted to stand Resident #94 at the bedside, but Resident #94 was unable to stand. The PT explained that Resident #94 and her roommate, Resident #50, told her that Resident #94 fell the night before.	F 697		

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F 697	Continued From page 54 Resident #94 reported right hip pain to her with touch. Resident #94 was unable to stand during the evaluation without moderate assistance and was leaning to the right. PT #1 indicated she went to the nursing station and looked for a nurse and reported the fall and the pain that Resident #94 was experiencing. PT #1 reported an unknown nurse and told her she would get an order for an x-ray for Resident #94. PT#1 was not certain the time of day she evaluated Resident #94. PT #1 was unable to provide the name of the nurse or the time she reported to the nurse. The Director of Rehabilitation was interviewed on 7/25/2023 at 8:59 AM by phone. The Director of Rehabilitation reported that PT #1 clocked in to work on 6/3/2023 at 3:46 PM. An occupational therapy evaluation dated 6/3/2023 was reviewed. The evaluation note documented that Resident #94 had pain that interfered or limited functional activity (no location) and that nursing would address pain management. The note documented that Resident #94 reported she had a fall on 6/2/2023 and she had pain in her right leg. The Occupational Therapist (OT) #1 was interviewed on 7/25/2023 at 9:19 AM by phone. OT #1 reported she also assessed Resident #94 on 6/3/2023 and Resident #94 reported she had fallen on 6/2/2023. OT #1 explained that she did not report to the nurse because Resident #94 had told her that the NA staff had helped her get up off the floor. OT #1 indicated that Resident #94 did not have pain during the assessment, but she had not gotten Resident #94 out of bed. An interview was conducted with NA #2 on	F 697		

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F 697	Continued From page 55 7/20/2023 at 2:28 PM. NA #2 reported she was assigned to Resident #94 on 6/3/2023 for the afternoon shift. The NA explained that Resident #94 complained of pain in her hip, but she did not report to any nurse because she had observed PT #1 reporting the pain a nurse. NA #2 explained she did not remember the nurse that received the report from PT #1, but she had seen the two of them talking. Resident #94 was unable to get out of bed during the afternoon shift on 6/3/2023 because of the pain she experienced with moving. NA #2 reported she did not notice bruising on Resident #94's right hip. There was no evidence in the medical record that any nurse notified the physician of Resident #94's fall and subsequent pain, completed an assessment of Resident #94, or that an x-ray was ordered on 6/3/2023. The pain assessment for day shift on 6/4/2023 was recorded by Nurse #8 as "0". Nurse #8 was interviewed by phone on 7/20/2023 at 1:53 PM and she reported she was assigned to Resident #94 during the day shift on 6/4/2023 and reported Resident #94 had not expressed she was in pain at all to her when Nurse #8 conducted the pain assessment on 6/4/2023. Nurse #8 reported she remembered Resident #94's family member requesting a walker during the day shift on 6/4/2023. Nurse #8 reported she recalled that Resident #94 was very pleasant and not in any pain. Nurse #8 reported that no staff reported a fall to her. The pain assessment for night shift on 6/3/2023 and 6/4/2023 were recorded by Nurse #7 as "0". Nurse #7 was interviewed by phone on 7/21/2023	F 697		

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at 3:15 PM. Nurse #7 reported that Resident #94 had not complained of pain when Nurse #7 conducted the pain assessment during 6/3/2023 or 6/4/2023 on the night shifts. Nurse #7 explained that Resident #94 had an order to administer acetaminophen at 6:00 AM daily and she did administer the medication to her. Nurse #7 reported the resident had not complained of pain, and she had received scheduled acetaminophen at 6:00 AM on 6/3 and 6/4/2023.

NA #5 was interviewed on 7/21/2023 at 11:33 AM. NA #5 reported she was assigned to Resident #94 on 6/4/2023 for the night shift. NA #5 was unable to recall if Resident #94 required incontinence care during her shift and reported that Resident #94 did not complain of pain to her during the night shift.
There was no evidence in the medical record that any staff notified the physician of Resident #94's fall and subsequent pain, completed an assessment or that an x-ray was ordered on 6/4/2023.

The pain assessment day shift on 6/5/2023 recorded by Nurse #6 documented a pain level of "0".

Nurse #6 was interviewed on 7/21/2023 at 12:10 PM. Nurse #6 reported she was the nurse who admitted Resident #94 on 6/2/2023 and she was also assigned to her on 6/5/2023. Nurse #6 reported Resident #94 did not report pain to her when Nurse #6 conducted the pain assessment., and if she had reported pain, there were facility standing orders she could have activated for administering acetaminophen to Resident #94. Nurse #6 explained that because Resident #94 did not report pain to her, she did not activate the

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F 697	Continued From page 57 standing orders. During an interview conducted on 7/21/2023 at 4:49 PM, NA #3 reported she returned to work on 6/5/2023 and was assigned to Resident #94 on the day shift, and when she attempted to provide care, Resident #94 yelled in pain "my leg, my leg!" NA #3 reported on Monday 6/5/2023 for the day shift Resident #94 was in bed with an incontinence brief on and required incontinence care. NA #3 explained she went to get Nurse #6, and when they returned to Resident #94's room, NP #2 was at the bedside. NA #3 described that Resident #94 was unable to move in bed without yelling out in pain. NA #3 explained that Resident #94 experienced pain all day on 6/5/2023 and she had to get another NA to assist her with incontinence care for Resident #94 because of her pain level. NA #3 reported Resident #94 said her pain was in her right hip and it was very sharp and severe with any kind of movement and turning for incontinence care was unbearably painful. NA #3 reported on 6/2/2023 Resident #94 was able to get up to the bathroom, but she stayed in bed all day 6/5/2023 and received incontinence care in the bed. A progress note written by NP #2 dated 6/5/2023 documented Resident #94 reported to her that on 6/2/2023 she attempted to go to the bathroom and had a fall with pain in her right hip since (the fall). The NP documented Resident #94 had increased pain/discomfort with touch, no bruising was noted, and the hip appeared to be swollen. The NP documented Resident #94 had pain to the right hip/thigh that Resident #94 rated as "4" and described as "aching". The note documented Resident #94 had "as needed (acetaminophen) at this time, and staff were to continue to monitor	F 697		

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F 697	Continued From page 58 Resident #94 until an x-ray result were received. NP #2 was interviewed on 7/21/2023 at 2:45 PM. NP #2 reported she was performing the admission assessment on Resident #94 on 6/5/2023 when Resident #94 reported the hip pain and fall. NP #2 explained she ordered an x-ray of Resident #94's hip and when the x-ray was read and it was determined Resident #94 had a fracture, she was sent to the hospital for evaluation. An interview was conducted with NA #4 on 7/25/2023 at 11:10 AM. NA #4 reported she provided her with incontinence care on 6/5/2023 during the afternoon shift and Resident #94 was in intense pain all shift. NA #4 reported she attempted to provide incontinence care by herself, and this caused Resident #94 to "scream and scream" in pain. NA #4 explained that she had to get another NA to assist her with care. NA #4 reported she told Nurse #2 that Resident #94 was in pain. A hip x-ray dated 6/5/2023 and read at 9:39 PM read a right subcapital fracture with moderate displacement (acute right hip fracture). A nursing note dated 6/6/2023 at 12:31 AM documented the results of the hip x-ray were received by the facility at 11:45 PM on 6/5/2023. The on-call NP was paged, and the nurse received an order to send Resident #94 to the hospital for evaluation for the right hip fracture. The note documented that Resident #94 left the facility by ambulance at 12:30 AM. There was no evidence in the medical record that pain medication was ordered on 6/5/2023.	F 697		

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The emergency department (ED) provider note dated 6/6/2023 at 1:28 AM documented Resident #94 presented with right hip pain that was found to be fractured on an x-ray obtained outpatient earlier that day. Resident #94 reported she fell three days ago and has had right hip pain ever since. The note documented the x-ray obtained by the facility showed a right hip fracture. On exam the ED physician noted tenderness to the right hip without deformity. Repeat x-rays obtained confirmed a closed subcapital right femoral neck fracture. There was no pain rating, or documentation of medications administered for pain. Orthopedic surgery was consulted and at 3:05 AM recommended for Resident #94 to be admitted and make her NPO (nothing by mouth) status. It was unknown if Resident #94 received pain medication during transport to the hospital for evaluation on 6/6/2023.

An orthopedic trauma consult note dated 6/6/2023 at 10:40 AM documented: Patient (Resident #94) reported on Friday 6/2/2023 she was attempting to get up to the bathroom and fell, landing on her right hip. She reported immediate pain in the right hip and being unable to get up after the fall. The history and physical noted: "Right lower extremity: skin intact without (redness). Leg length short in comparison to contralateral leg (left leg) and hip held in external rotation (leg was rotated to the right). Endorses (agreed) hip pain with heel strike (touching heel to the floor during mobility)." Details in the assessment and plan included the right femoral neck fracture was discussed with Resident #94 and the recommendation was to proceed with the hip hemiarthroplasty, to which she agreed. This plan was also discussed with a family member

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who agreed and stated Resident #94 was competent to sign her own consents.

An interview was conducted with the MD on 7/21/2023 at 11:54 AM. The MD reported that his medical group has an on-call triage line where a NP is available 24 hours a day to answer medical questions and provide orders. The MD reported that the facility had not contacted the on-call triage for anything related to Resident #94 6/2/2023, 6/3/2023, 6/4/2023, or 6/5/2023. The MD reported that delaying treatment for a fractured large bone would have been very painful for Resident #94, and he was not aware she did not have an order for pain medication.

The Director of Nursing (DON) was interviewed on 7/21/2023 at 3:21 PM. The DON explained that she had thought Resident #94 had not reported the fall to anyone until 6/5/2023 when NP #2 assessed her. The DON reported she was not aware of the physical therapy assessment conducted on 6/3/2023 and that PT #1 reported to an unknown nurse that Resident #94 had a fall and was experiencing pain. The DON stated she interviewed Resident #94 on 6/5/2023 after the NP evaluation and Resident #94 reported she had fallen and gotten herself up off the floor and did not report the fall to staff. The DON explained staff should have immediately contacted the on-call NP and reported the fall and pain and assessed Resident #94. The DON reported she was not certain why this had not happened on 6/3/2023.

The Administrator was notified of Immediate Jeopardy on 7/21/2023 at 6:42 PM.

o Identify those recipients who have suffered, or

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F 697	Continued From page 61 are likely to suffer, a serious adverse outcome as a result of the noncompliance The facility failed to notify the physician and/or the resident representative after Resident #94 reported to the Physical Therapist on 6/3/23 that she had fallen in her room on 6/2/23. On 6/3/23, the physical therapy evaluation revealed that Resident #94 reported to the physical therapist that she had fallen on 6/2/23 in her room and had not reported the incident to the facility staff. The physical therapist also reported that the resident complained of right hip pain, and this was reported to the Nurse #1 on the hall who reported that she would follow up and obtain an order for an x-ray. On 7/21/23, the Director of Nursing spoke to Nurse #1, and she denied any knowledge of Resident #94 reporting that she had fallen or that the physical therapist or any other staff member reporting to her that Resident #94 had fallen. In addition, Nurse #1 was asked if Resident #94 requested pain medication or had signs or symptoms of pain and Nurse #1 reported no. On, 7/20/23, the Therapy Director spoke to the physical therapist that was working on 6/3/23 and she reported that Resident #94 had reported to her that she had fallen on 6/2/23 while attempting to go to the bathroom. The physical therapist reported that the roommate also reported that the resident had fallen on the previous day (6/2/23). On 6/5/23, after the Nurse Practitioner reported that Resident #94 reported a fall on 6/2/23, the Director of Nursing completed a follow up interview and Resident #94 reported that she had	F 697		

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fallen while attempting to go to the bathroom and had gotten herself up off the floor and had not reported this to the staff.

On 6/5/23, Unit Manager #1 and the Admissions Director spoke to Resident #94's family member who reported that on 6/2/23, Resident #94 had reported to him that she had fallen on the way to the bathroom and that she was having a lot of pain. The family member reported that he reported that Resident #94 was having pain to the charge nurse.

On 6/5/23, during the Nurse Practitioner initial assessment, Resident #94 reported that she had fallen on 6/2/23 in her room while attempting to go to the bathroom and was having right hip pain.

On 7/17/23, the facility investigation by the Director of Nursing revealed that the Nurse Practitioner was informed of Resident #94's fall on 6/2/23 during her initial assessment on 6/5/23 by the resident. In addition, further review of the medical record revealed that there was no fall nursing assessment documentation or physician/physician extender notification documentation by the licensed nurse of the 6/2/23 fall until 6/5/2023.

The Director of Nursing completed the interviews on 7/21/23. The interviews revealed that the licensed nurses and the certified nursing assistants that worked on 6/2/23, 6/3/23, and 6/4/23 reported that Resident #94 did not report to them that she had fallen on 6/2/23.

The licensed nurses, certified nursing assistants, and certified medication aide interviews by the Director of Nursing of staff that who worked on

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6/2/23, 6/3/23, and 6/4/23 per the nursing assignment sheets revealed that Resident #94 did not report the fall to the assigned licensed nurse, certified nursing assistant or certified medication aide.

On 7/17/23, Nurse #3 (Weekend Supervisor) interview with the Director of Nursing revealed that Resident #94 did not express pain concerns and she did not observe signs or symptoms of excruciating pain on 6/3/23 and 6/4/23. Nurse # 3 also reported that Resident #94 as well as the other nursing staff to include the physical therapist who worked on 6/3/23 and 6/4/23, did not report that Resident #94 has fallen on 6/2/23. Nurse #3 reported that Resident #94's family member did not report to her that the resident was having pain and that the resident had fallen on 6/2/23.

All current residents are also at risk as a result of this deficient practice.

Starting 7/21/23, the Director of Nursing/the Unit Managers and designee will complete an audit of the medical records to include review of progress notes, outside provider notes, incident reports, medication administration records, physician orders, and nursing shift reports of all the current residents for the last 60 days to ensure the physician/ physician extenders and resident representatives have been notified of any resident falls or changes in condition and identified concerns have been address by 7/25/23.

Starting 7/21/23 the Director of Nursing / designee will complete interviews of the alert current residents to ensure resident concerns to include incident and accidents, pain

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F 697	Continued From page 64 management, medication/ treatments and other resident care concerns have been identified and reported to the physician/ physician extenders in the last 60 days by 7/25/23. Starting 7/21/23, the Director of Nursing/ designee will complete interviews of the facility staff to include licensed nurses, certified nursing assistants, certified medication aides, dietary, housekeeping/laundry, agency, new hire and prn staff to ensure all resident changes in condition or any reported concerns in the last 60 days have been reported to the DON, Unit Manager and/or the Nursing supervisor by 7/25/23. 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 Starting 7/21/23, the Staff Development Coordinator/ designee will complete education by 7/25/23 of the facility staff to include licensed nurses, certified nursing assistants, certified medication aides, dietary, therapy department, housekeeping/laundry, agency, new hire and prn staff related to ensuring resident changes in condition to include incident and accidents, pain management changes, medication/treatment concern, resident care concerns and any resident/families reported concerns have been reported to the licensed nurse and to the physician and/or DON, Unit Managers and nursing supervisor. Starting 7/21/23, the Staff Development Coordinator/ designee will complete education with the licensed nurses to include agency, new hire, and prn licensed nurses related to	F 697		

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F 697	Continued From page 65 immediate notification and documentation of resident changes in condition to include incident and accidents, pain management changes, medication/treatment concern, resident care concerns and any resident/ families reported concerns to the physician/ physician extenders and resident representatives and document in the medical record by 7/25/23. After hours the licensed nurse will notify the on-call provider and document in the medical record. Starting 7/21/23, the Staff Development Coordinator was made aware by the Director of Nursing that she will be responsible for verifying that the education has been completed by the required staff members by using the facility personal roster and the nursing, dietary, therapy and housekeeping/laundry staffing schedules to include new hires, agency and prn staff and ongoing education by 7/25/23. No staff will be allowed to work until they have received this education. The SDC/ designee which includes the DON, Unit Managers, and Nursing supervisors will be responsible for providing all of the education. On 7/25/23, The Director of Nursing educated the therapy manager to ensure that all therapists to include occupational therapist, physical therapist, speech therapist, weekend therapist, new hire, and prn therapist report resident observed and reported falls to the therapy manager and the Director of Nursing immediately. Starting 7/25/23, the therapy manager will educate the therapists to include occupational therapist, physical therapist, speech therapist, weekend therapist, new hire, and prn therapist related to ensuring resident observed and	F 697		

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F 697	Continued From page 66	F 697		

reported falls are immediately reported to the therapy manager and the Director of Nursing. Therapy staff to include prn and new hire staff will not be allowed to until they receive this education.

Effective 7/21/2023 the Administrator will be responsible for ensuring implementation of this immediate jeopardy removal for this alleged non-compliance.

Alleged Date of IJ Removal: 7/26/2023

On 7/227/2023, the facility's credible allegation for immediate jeopardy removal was validated by the following:

The facility provided documentation to support the Credible Allegation for F697. The facility's Nurse Practitioner assessed the named resident and sent her to the hospital for evaluation of a right subcapital fracture. The facility further provided documentation of pain assessment for all residents in the facility. The facility further provided auditing of pain assessments, pain documentation, pain medication management, and pain care plan updates for all residents in the facility. An in-service education was completed with the nursing and therapy staff regarding resident pain identification, signs of pain, management of pain medication, documentation of pain, and update of the care plan. The facility further provided the education that will be provided to all new hires and agency staff regarding pain management before being allowed to work in the facility. Facility nursing staff were interviewed regarding their understanding of the education provided. The assessment of the named resident and all other residents; the auditing of pain assessments, documentation,

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F 697	Continued From page 67 medication management, and care plan update; and the education of staff were completed by 7/25/2023. The facility's date of the immediate jeopardy removal plan of 7/26/2023 was validated on 7/27/2023.	F 697		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to maintain one of one freezer free of accumulated ice and remove pooled water on the kitchen floor. This failure occurred for approximately four months and had the potential to affect food served to residents.	F 812	The Maintenance Director removed the accumulated ice from the freezer on 7/18/23. The Freezer compressor was repaired by an outside contractor on 7/25/23. The current residents have the potential to be affected. The Maintenance department	8/26/23

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F 812	Continued From page 68 The findings included: 1. An observation of the walk-in freezer occurred on 7/17/23 at 11:45 AM. A metal storage rack approximately 11 inches in height was observed with milk crates stored on top. The milk crates were approximately 11 inches in height. Multiple cases of carrot coins, crinkle cut French fries and garlic bread were stored on top of the milk crates. Ice was observed on top of these cases of food items and the ice extended to the floor, approximately 22 inches and pooled on the floor around the base of the metal storage rack. The ice was also observed inside the cases of food items and on the food. The freezer compressor was observed with ice accumulation and water dripping. The Dietary Manager (DM) stated in an interview on 7/17/23 at 11:45 AM that compressor had been leaking for the past two weeks, the Maintenance Director was aware and ordered a part for repair, but that the part had not arrived yet. The DM stated that she and the Maintenance Director were trying to remove the ice buildup in the interim, but that due to amount of water leaking from the compressor, the ice accumulation was hard to keep removed. An interview with the Maintenance Director occurred on 7/17/23 at 12:12 PM. He stated that in February 2023 he called for a repair service to repair the freezer because the compressor was leaking. He stated part of the repairs were completed, but that a part that was needed to complete the repairs had been ordered, but had not arrived. He stated the repair service came to the facility a few weeks ago to complete the repairs, and identified a part that was needed and	F 812	and/or the dietary staff will check on the freezer ice accumulation daily and ensure that the ice accumulation is removed until the new freezer compressor can be installed. The Maintenance Department staff and the dietary staff will be educated by 8/25/23 by the Administrator related to ensuring that freezer ice accumulation is checked daily, and ice accumulation is removed until the new freezer compressor can be installed. The maintenance department staff and the dietary staff, to include agency dietary staff, will not be allowed to work until the education is completed. New hires also will be required to complete the education. The Administrator/ Dietary Manager will check the ice accumulation daily until the new freezer compressor is installed and then monthly for 2 months to ensure that ice is not accumulating in the freezer. The Administrator/ Dietary Manager will submit the findings to the Quality Assurance Performance Improvement (QAPI) committee monthly meeting for 3 months for review and follow up with recommendations to ensure the facility's continued compliance.	

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F 812	Continued From page 69	F 812		

ordered the part. The Maintenance Director stated that the compressor was leaking and that he tried to remove the ice accumulation as often as possible. He said he saw the ice accumulation on Friday, 7/14/23 and spoke to the DM about coming up with a plan to remove the ice build-up, but that he had not had a chance to address it yet. He stated that he would start checking for ice accumulation more frequently and develop a plan for removing the ice accumulation until the part came in for repair.

The Maintenance Director provided a copy of the invoice from the repair service provider. The date of the invoice was 2/5/23 and recorded the reason for the call was to repair the walk-in freezer and add refrigerant to the walk-in cooler. The lock to the compressor of the walk-in freezer was recorded as rusted and leaking and broke off during the repair. It was replaced. The drain line heater to the compressor was also in need of repair allowing the drain to freeze up. This repair was still incomplete.

The Administrator was interviewed on 7/20/23 at 3:10 PM and stated he was aware that the facility was waiting on a part to repair the compressor in the freezer. He stated that the ice should be removed in the interim while the facility waited on the part for repair.

2. An observation of the kitchen on 7/17/23 at 11:28 AM revealed puddles of brown colored water pooled on the floor in the dish pit area where missing/broken floor tiles were observed.

A second observation of the same occurred on 7/19/23 at 1:10 PM.

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F 812	Continued From page 70 Review of vendor service reports dated 3/27/23 and 6/19/23 recorded kitchen sanitation recommendations to remove excess water noted in the dish pit area, and to keep the area clean/dry. During an interview on 7/19/23 at 1:10 PM the Dietary Manager (DM) stated the floor tiles in the dish pit area had been broken/missing for a while, since piping was replaced in the kitchen last year. The DM stated that as a result, water pooled on the floor where the tiles were broken/missing and staff mopped this area daily, but water still pooled there. The Administrator stated in an interview on 7/20/23 at 3:07 PM that the piping underneath the kitchen floor was repaired in the summer of 2022 and as a result a few floor tiles still needed repair. He stated that he expected the dish pit area to be kept clean and the floor dry.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that	F 867		8/26/23

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are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;

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(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

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F 867	Continued From page 73 §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the 8/31/2021 infection control and complaint investigation survey, 2/14/2022 recertification and complaint investigation, 7/29/2022 complaint investigation survey. The facility had deficiencies previously cited in the areas of notification of change (F580), baseline care plans (F655) and kitchen sanitation (F812). F580 was cited on 8/31/2021 during a complaint investigation and infection control survey, on 2/14/2022 during a recertification and complaint investigation survey, and on 7/29/2022 during a complaint investigation survey; F655 was cited on 2/14/2022 during recertification and complaint investigation survey and F812 was cited on 2/14/2022 during a recertification and complaint investigation and on 7/29/2022 during a	F 867	Quality Assessment and Assurance (QAA) Committee will be held on 8/24/23 by the Administrator related to ensuring the facility has effective systems to obtain information and/or feedback from facility staff, residents and residents□ representatives to identify problems and opportunities for improvement. The identified tags will be reviewed to include the repeat tags. The current residents are at risk related to this deficient practice. The Administrator was educated on 8/23/23 by the Director of Operations related to ensuring the QAA Committee maintain and implement processes to obtain information and/or feedback from facility staff, residents and residents	

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F 867	Continued From page 74 complaint investigation. These deficiencies were cited again during the facility's current recertification and complaint investigation survey of 7/28/2023. The continued failure of the facility during four federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA Program. The findings included: This tag is cross referenced to: F580-Based on record reviews, resident, family, nurse practitioner (NP), physician (MD), and staff interviews, the facility failed to notify the MD of a resident who experienced pain following a fall for 1 of 3 residents investigated for notification of changes. The resident sustained a fall on 6/2/2023 and reported the fall and right hip pain to Physical Therapist (PT) #1 on 6/3/2023. PT #1 reported the fall and the hip pain to a nurse. The resident reported the fall and right hip pain when she was assessed by NP#2 on 6/5/2023. NP#2 ordered an x-ray of the right hip, which revealed a fractured femur (the long bone in the leg). She was sent to the hospital on 6/6/2023 at 12:30 AM and had a partial hip replacement surgery on 6/7/2023. During the focused infection control and complaint investigation survey conducted on 7/29/22 the facility was cited for failing to notify a Resident's Physician when two doses of an anticonvulsant (anti-seizure) medication were not available to administer on 03/18/22. The resident had two episodes of seizure activity and required two hospitalizations to control the seizure activity on 03/19/22-03/21/22 and 03/24/22-03/28/22 for 1 of 3 residents reviewed for medication	F 867	representatives to identify problems and opportunities for improvement. The interdisciplinary team to include the Director of Nursing, Administrator, Social Services, Dietary Manager, Housekeeping Manager, Maintenance Director, Business Office Manager, Therapy Manager, Staff Development Coordinator, Medical Records, Admission, Activity Director, and Medical Director will be educated on 8/24/23 by the Administrator related to ensuring the QAA Committee maintain and implement processes to obtain information and/or feedback from facility staff, residents and residents representatives to identify problems and opportunities for improvement. The Administrator will be responsible for monitoring the Quality Assurance Performance Improvement Plan process monthly for 3 months to ensure that the facility remains in compliance for identified deficiencies. The Administrator will report the findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least 3 months for review to ensure compliance.	

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F 867	Continued From page 75	F 867		

management.

During the recertification and complaint investigation survey conducted on 2/14/22 the facility was cited for failing to notify a Resident's Physician when two different blood pressure medications were not available for administration on 07/21/21 and 07/22/21; and when the blood pressure reading was out of normal range for 1 of 3 residents reviewed for medication management.

During the focused infection control and complaint investigation survey conducted on 8/31/22 the facility was cited for failing to notify the provider of skin assessment changes for 1 of 3 residents reviewed for pressure ulcers.

F655- Based on record reviews and staff interviews, the facility failed to develop a baseline care plan within 48 hours of admission that addressed the needs of a resident with a history of frequent falls for 1 of 29 residents reviewed for baseline care plans.

During the recertification and complaint investigation survey conducted on 2/14/22 the facility was cited for failing to develop a baseline care plan within 48 hours of admission to address the immediate needs of a resident for enteral feedings or identify the correct smoking status for 1 of 2 residents reviewed for baseline care plans.

F812-Based on observations, staff interviews, and review of facility records, the facility failed to maintain one of one freezer free of accumulated ice and remove pooled water on the kitchen floor. This failure occurred for approximately four months and had the potential to affect food

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F 867	Continued From page 76 served to residents. During the recertification and complaint investigation survey conducted on 2/14/22 the facility was cited for failing to 1) thaw a potentially hazardous food with an effective food safety system, and 2) store cold/frozen foods sealed and with a label and date of opening. The facility thawed frozen diced ham, that was not submerged, under running water with a temperature of 93.4 degrees Fahrenheit (F). The facility stored hot dogs, sliced ham, sliced turkey, French fries, pancakes, sliced cheese and chicken tenders without a label and date of opening and open to air. This failure occurred in 2 of 3 cold storage units and had the potential to affect food served to residents. During the focused infection control and complaint investigation survey conducted on 7/29/22 the facility was cited for failing to perform hand hygiene for 1 of 3 dietary staff (Dietary Aide #1), monitor refrigerator temperatures for 1 of 1 reach-in refrigerators, store potentially hazardous cold foods at least 41 degrees Fahrenheit (milk, pimento cheese sandwiches and a bologna sandwich), and store pans (muffin pans, sheet pans) and a cutting board clean. This deficient practice had the potential to affect food served to residents. During an interview with the Administrator on 7/27/2023 at 1:43 pm he stated the Quality Assurance Performance Improvement (QAPI) committee meets monthly and the Medical Director and Pharmacist are present for the meeting every 3 months. The Administrator stated the other members of the QAPI team are at the monthly meeting, which includes the	F 867		

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F 867	Continued From page 77 Director of Nursing, Infection Preventionist, Maintenance Director, Housekeeping Director, Therapy Manager, and Dietary Manager. The Administrator stated the facility uses their quality measures, grievances, resident weights, wounds, and trends for infections as areas to improve. The Administrator stated he was not sure of why the facility had repeated concerns in the current survey since he had just started in the facility on 12/1/2022. He stated the facility would continue to work on the issues brought up during the survey and strive to improve.	F 867		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to maintain an effective pest control program as evidenced by observations of current pest activity in 3 of 3 resident rooms, on two of two units, and the conference room. The facility failed to utilize insect light traps and implement pest service recommendations for four months to prevent reoccurring pest activity. The findings included: 1 a. Observations of live pest activity occurred on the following: - On 7/17/23 at 12:33 PM, flies were observed flying around the covered lunch meal tray that was stored on the over bed table in room 116 on the A/B unit.	F 925	On 8/8/23, the pest control service treated the C/D and the A/B units for flies to include rooms 116, 151, and 154. The conference room was treated for pests to include spiders on 8/8/3 by the pest control service. On 7/19/23, the Maintenance Director plugged the two wall mount insect light traps in the receptacle and notified the dietary manager. All current residents are at risk for this deficient practice. The Administrator followed up with Eco Lab on 8/8/23 to update the facility's current contract to include small flies pest services. Two Additional insect light traps were	8/26/23

POC NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345130	A. BUILDING ______ B. WING ______	C 07/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CONCORD	**515 LAKE CONCORD ROAD NE** **CONCORD, NC 28025**

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F 925	Continued From page 78 - On 7/17/23 at 12:55 PM, multiple small flying insects were observed flying around the nightstand in room 151 on the C/D unit. - On 7/17/23 at 12:59 PM, flies were observed in room 154 on the C/D unit. - On 7/19/23 at 11:21 AM, multiple flies were observed on the C/D unit flying around the open food cart. - On 7/19/23 at 11:44 AM a spider was observed crawling on the floor in the conference room. - On 7/19/23 from 12:35 PM to 12:49 PM, flies were observed on the C/D unit around an open food cart. 1 b. On 7/19/23 at 1:10 PM, two wall mounted insect light traps were observed unplugged in the kitchen. The Dietary Manager (DM) was interviewed during the observation and stated that she had not noticed these wall mounted insect light traps before and that she did not know what they were for. The DM stated she had not noticed that the insect light traps were unplugged. During an interview on 7/19/23 at 1:12 PM, dietary staff #1 stated that she unplugged the insect light trap in the cook's prep area to use the electrical outlet and forgot to plug it back in. The Maintenance Director stated in an interview on 7/19/23 at 1:45 PM, that he noticed that the two insect light traps in the kitchen were unplugged, but that he was not sure who unplugged them or why. He stated they should be plugged in to deter pest activity. 1 c. An observation of the kitchen on 7/17/23 at 11:28 AM revealed puddles of brown colored water pooled on the floor in the dish pit area where missing/broken floor tiles were observed.	F 925	scheduled to be added to the facility on 8/18/23 by the Maintenance department. Additional electrical receptacles will be added to the kitchen by 8/25/23 to prevent unplugging of the current mounted wall receptacles. The Administrator by 8/25/23 will educate the Maintenance Director and Maintenance Staff related to ensuring that pest service recommendations are implemented, follow up recommendations completed, and insect light traps are plugged into the receptacle. The Administrator by 8/25/23 will educate the Dietary Manager related to ensuring that insect light traps are plugged into the receptacle. The Dietary Manager by 8/25/23 will educate the dietary staff related to ensuring that insect light traps are plugged into the receptacle. The Administrator will complete audits weekly for 4 weeks and monthly for 2 months to ensure that insect light traps are plugged in the receptacles and pest service recommendations are being addressed and the facility is following up on pest concerns. The Administrator will submit the findings to the Quality Assurance Performance Improvement committee meeting monthly for 3 months for review to ensure the facilities continued compliance.	

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F 925	Continued From page 79	F 925		

A second observation of the same occurred on 7/19/23 at 1:10 PM.

Pest control service reports dated 3/27/23 and 6/19/23, both recommended to remove excess water noted in the dish pit area, and to keep the area clean/dry to reduce pest activity.

During an interview on 7/19/23 at 1:10 PM the DM stated she was aware of the pest service reports and recommendations. The DM stated that the floor tiles in the dish pit area had been broken/missing for a while, since piping was replaced in the kitchen floor last year. The DM stated that as a result, water pooled on the floor where the tiles were broken/missing and staff mopped this area daily, but water still pooled there.

1 d. On 7/19/23 at 1:42 PM, an observation of the exterior facility grounds revealed multiple broken items stored on the ground or propped against the facility:

" Multiple boards of sheet rock, propped against the facility.
" One broken shower chair stored on the ground.
" Four cement stairs stored on the ground.
" Five wooden pallets, broken, stored on the ground.
" One black leather chair, broken and stored on the ground.
" One used surgical face mask, stored on the ground.
" Four particle board headboards and footboards, broken, propped against the facility shed.
" One used glove, laying on the ground.

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F 925	Continued From page 80	F 925		

" Two recliner chairs, broken, stored on the ground next to the open commercial dumpster.
" Three empty cardboard boxes, stored on the ground.

A pest control service report dated 4/19/23, recommended the removal of medical equipment left outside, against the building to reduce the number of pests entering the facility.

An interview with the Maintenance Director occurred on 7/19/23 at 1:45 PM. The Maintenance Director stated he started this role in November 2022, and he had been waiting several months for the broken items stored outside to be picked up by the waste removal company. He stated that the cement stairs had been stored outside since the previous year and were used to access a mobile kitchen the facility used in the summer of 2022. He stated he placed the broken black leather chair from the facility's van outside about a month ago. He stated that all the other broken items were placed outside a few weeks ago. He stated that he was in the process of moving the broken items to the dumpster, but he was waiting on the commercial dumpsters to be emptied. He stated that typically the commercial dumpsters were emptied once every two weeks, but that he had been waiting several weeks now for the waste removal company to empty them. The Maintenance Director stated he was aware these items were left on the ground and that it was his responsibility to maintain the grounds of the facility clean.

The Administrator stated in an interview on 7/20/23 at 3:07 PM that the insect light traps should be plugged in for use. He stated that the piping underneath the kitchen floor was repaired

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F 925	Continued From page 81 in the summer of 2022 and as a result a few floor tiles still needed repair. He stated that he expected the dish pit area to be kept clean and the floor dry. He stated that he was aware that broken equipment and other items were stored on the ground outside the facility and that these items should be placed in the commercial dumpster. He stated that the facility was currently undergoing renovations and so they secured a second commercial dumpster to store trash, but that emptying the commercial dumpster was not on a schedule. He stated that the waste removal company emptied the commercial dumpsters at will, and that the facility was currently waiting for the dumpsters to be emptied so that the broken items could be placed in the dumpster for removal.	F 925		