STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted at the facility from 9/13/23 through 9/15/23. Event ID # 23CS11. The following intakes were investigated: NC00206339 and NC00207179. 2 of the 6 complaint allegations resulted in deficiencies. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity (G)	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff and Physician interviews, the facility failed to provide a bed bath safely for a dependent resident for residents reviewed for falls. Resident #2 sustained a fall off the bed during care, fracturing her left femur (thighbone) and tibia (shinbone) for 1 of 2 residents reviewed for falls (Resident #2). The findings included: Resident #2 was admitted to the facility on 3/22/13 with diagnoses which included in part: history of stroke, blindness, right below knee amputation, left sided paralysis and left lower	F 689	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 10/03/2023

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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extremity contracture.

Review of the care plan initiated on 11/15/18 and revised on 4/13/23 for Resident #2 revealed a plan of care for activities of daily living (ADL) self-care performance deficit related to dependence. The following intervention was listed for Resident # 2's care plan: I am totally dependent on staff with 2-person assistance for repositioning and turning in bed.

Review of the 7/19/23 quarterly Minimum Data Set (MDS) assessment revealed Resident # 2 was severely cognitively impaired, had impaired vision and required extensive assistance of 2 people with bed mobility, transfers, and toileting, and required extensive assistance of 1 staff member for bed bath and personal hygiene. Resident # 2's height was listed as 68 inches (5 feet 8 inches) and her weight was 245 pounds. Resident had functional limitations in range of motion of the upper extremity on 1 side and lower extremity impairment on both sides.

Review of the electronic medical record for Resident #2 revealed a Nursing Health Status Note on 9/6/23 at 8:28 PM written by Nurse #1 which stated in part: nurse was called to resident's room by the nursing assistant (NA). Resident #2 was noted to be lying on her back on the floor in the middle of the room with her head on the base of the roommate's bedside table. Resident #2's bed was noted to be in the high position at this time. Assessment performed. No visible injuries were noted. Resident #2 complained of head pain. Emergency Medical Services were called, and the resident was transported to the hospital.

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F 689	Continued From page 2 Review of a witness statement completed on 9/7/23 by NA #1 revealed she provided care to Resident #2 prior to the incident. NA #1 stated she went to take the water in the bathroom and by the time she came back Resident #2 was falling on the floor. An interview was conducted with NA #1 on 9/14/23 at 2:25 PM. NA #1 stated she worked at the facility for about 13 years, left and then returned about a year ago. NA#1 stated she knew Resident #2 from when she worked at the facility previously but had not worked with her much recently. NA #1 stated on the evening of 9/6/23 she had not checked the Kardex for Resident #2 to see her care needs because she knew her from before and stated she was not aware that she was expected to do so. NA #1 stated she was instructed after the incident on 9/6/23 that she was supposed to check the Kardex for the residents daily. NA #1 stated on 9/6/23 Resident #2 had not received her bath on day shift as she was scheduled, so she gave her a bed bath that evening by herself. NA #1 stated she raised the bed up to a high level to not have to bend while she provided care to the resident. NA#1 stated she walked out of the room while providing care to get a brief. NA #1 stated she came back in, was providing the bath and walked into the bathroom to pour out the basin of bath water leaving Resident #2 unattended on her right side. NA #1 stated Resident #2 was in the middle of the bed and had her hand on the small loop grab rail at the head of the bed on the right side. NA#1 stated she was coming out of the bathroom when Resident #2 fell out of the bed. NA#1 stated she was unable to stop Resident #2 from falling. NA #1 stated she left the bed in the high position when she went to pour out the water	F 689		

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because she was not done providing care. NA#1 stated she usually put the bed down to the lowest position after providing care, but she was not thinking when she went to pour the water out in the bathroom.

Review of the witness statement completed on 9/7/23 by Nurse #1 revealed it was her first night working at the facility on 9/6/23. Nurse #1stated she was at the medication cart preparing medications when NA #1 came to the doorway and said Resident #2 was on the floor. Nurse #1 stated she entered the room and observed Resident #2 on the floor on her back with her head towards the roommates' side of the bed on the bedside table and her legs were positioned towards the window. Resident #2 was without clothing. The bed was in the high position above waist level. Nurse #1 stated NA #1 was not present in the room when Resident #2 fell. Nurse #1stated she heard someone say, "Don't move I don't want you to fall." and then NA #1 walked out of the room and left. When NA #1 went back in she called out to the nurse and told her Resident #2 was on the floor.

Interview was conducted on 9/14/23 at 10:50 AM with Nurse # 1. Nurse # 1 stated she was an agency nurse; it was her first time at the facility the night of 9/6/23 and she was assigned to Resident #2. Nurse # 1 stated she was outside Resident #2's room at the medication cart when NA #1 was in the room giving the resident a bed bath. Nurse #1 stated she heard NA #1 state to Resident #1, "You stay right there and don't you fall now. I'll be right back." NA #1 then exited Resident #2's room. NA #1 went back into the room, came out and stated to Nurse #1 that Resident #2 was on the floor. Nurse #1 stated

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she entered the room and observed the bed in the high position and Resident #2 was on the floor on her back facing the bed. Nurse #1 stated Resident #2 was yelling in pain, holding her head, and stating it hurt. Nurse #1 assessed Resident #2 and determined she needed to be evaluated at the hospital due to the unwitnessed fall with possible head injury complaint of head pain. Nurse #1 stated Resident #2 was yelling that her head hurt and that was what she was concerned about at the time.

An interview was completed with NA #2 on 9/14/23 at 11:15 AM. NA #2 revealed she was assigned to the 200- hall on 9/6/23 on 3PM-11PM shift. NA #2 recalled her coworker NA # 1 yelled for her, so she entered Resident #2's room to see what the matter was. NA #2 observed Resident # 2 on the floor with the bed in the high position. Resident # 2 was yelling that her head hurt. NA #2 stated NA #1 told her she went to get something from the cart and when she went back into the room Resident #2 was on the floor.

Review of the electronic medical record for Resident #2 revealed the following entries:

9/7/23 at 6:37 AM resident returned to the facility from the hospital with no new orders. Head CT was completed and was negative.

9/7/23 at 10:00 AM resident assessed by the Assistant Director of Nursing (ADON) and Director of Nursing (DON). Resident #2 verbalized pain to multiple areas. Range of motion to all joints revealed discomfort to the right arm, right hip and leg and left knee. Swelling was observed to the left leg and knee region. The physician was made aware and ordered x-rays of

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F 689	Continued From page 5 the right elbow, right femur, right hip, left knee and right knee. The physician changed the order for acetaminophen from as needed to scheduled for pain management. Resident #2's responsible party was made aware of assessment findings and new orders. 9/7/23 Physician order for acetaminophen extra strength 500 milligrams. Give 2 tablets every 8 hours for acute pain concerns for 7 days. 9/7/23 Medication Administration Record (MAR) entry initiated for pain assessment every shift. Ask the resident if she is in pain according to a 1-10 scale every shift. Review of the MAR from 9/6/23 through 9/8/23 revealed Resident #2's pain was monitored and documented every shift. Acetaminophen was administered every 8 hours as ordered and was effective at managing Resident #2's pain. Resident #2 also continued to receive her routine gabapentin 100 milligrams for diabetic nerve pain and diclofenac sodium topical gel 1% to her left knee three times per day as ordered. 9/7/23 at 6:30 PM Interact summary change in condition note indicated Resident #2 was sent to the hospital due to a fracture noted on the x ray. Further review of the electronic medical record for Resident #2 revealed the final mobile x ray report dated 9/7/23 at 8:21 PM which indicated x rays of the right elbow, right femur, right hip, left knee and right knee were completed. The result of the left knee x ray indicated in part "examination was significantly limited by the patient rotation. There is a moderately displaced fracture of the left femur of indeterminate age. Clinical follow up is	F 689		

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recommended."

9/7/23 at 6:35 PM A change in condition progress note indicated Resident #2 was sent to the hospital for evaluation of a fracture to the left leg.

Review of the emergency department note with admission date of 9/7/23 and discharge date of 9/8/23 indicated Resident #2 presented due to left hip pain from the fall on 9/6/23. Emergency department note indicated Resident #2 demonstrated left hip pain and x rays of the left elbow, left hip, left humerus, and left shoulder were completed. X ray of the left hip was suboptimal with the impression listed as inadequate evaluation and CT scan of the left hip upper femur was performed with no acute fracture observed. X rays of the left elbow and left shoulder were negative, and no new orders were written.

9/8/23 at 1:47 AM Health Status Note indicated Resident #2 returned to the facility from the hospital with no orders. Resident #2 was medicated with acetaminophen due to pain all over.

Review of the 9/8/23 Nurse Practitioner comprehensive encounter note for Resident #2 revealed resident was seen for follow up after 2 recent emergency room visits following a fall. Resident #2 complained of persistent left knee pain. The NP's physical exam indicated Resident #2 had tenderness of the left upper knee area with mild swelling and right shoulder swelling and discomfort. The NP indicated the distal femur was not imaged during the recent emergency room visits. Results of the mobile x rays were faxed to

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F 689	Continued From page 7 a local orthopedic physician for review with request for consult stat. The local orthopedic physician reviewed the x rays and advised another visit to the hospital for further evaluation of the left distal femur fracture. A telephone interview was conducted with the Nurse Practitioner (NP) on 9/14/23 at 3:50 PM. The NP indicated Resident #2 required total assistance with all care including bathing, hygiene, toileting, and bed mobility. The NP stated she did not know how Resident #2 could have fallen from bed with her limited mobility. The NP stated she was informed that Resident #2 fell while being bathed. The NP stated Resident #2 was sent to the hospital initially due to head pain and returned with a negative exam. The NP revealed she examined Resident #2 on 9/7/23, ordered x rays due to pain and swelling of her left leg and right shoulder. The NP stated she was concerned about the pain and swelling of Resident #2's left leg and followed up on 9/8/23 reviewing the x rays and consulting a local orthopedic specialist who determined resident had a femur and tibia fracture. On 9/8/23 the Nurse Practitioner gave an order to transfer Resident #2 to the emergency department due to a left distal femur fracture and continued left leg pain. Review of the hospital records for Resident # 2 revealed resident presented to the emergency room on 9/8/23 with left leg and thigh pain following a fall from bed during a bed bath at 9/6/23 at the skilled nursing facility. Resident had an outpatient x ray at the skilled nursing facility that showed a distal femur fracture and was sent to the hospital for further evaluation and	F 689		

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management. X rays were repeated at the hospital on 9/8/23 which revealed an acute distal left femur fracture and proximal tibial fracture. As interventions for managing the fractures Resident #2 was placed in a long leg molded splint and medicated with intravenous morphine for pain management in the emergency room. Resident #2 had lab studies obtained in the emergency room and was admitted to the hospital for further evaluation and management. Resident #2 remained in the hospital as of 9/15/23.

An interview was conducted with Medication Aide (Med Aide) # 1 on 9/14/23 at 12:20 PM. Med Aide #1 stated she was assigned to Resident #2 from 7:00 AM to 7:00 PM on 9/7/23 and 9/8/23. Med Aide #1 recalled Resident #2 complained of pain all over and she administered acetaminophen as ordered which was effective. Med Aide #1 stated Resident #2 was normally alert with confusion, impaired vision and required total care of 2 people assist with bathing, bed mobility and transfers. Med Aide #1 stated the Kardex listed the amount of assistance each resident required, and Resident #2 was listed as a 2 person assist. Med Aide #1 stated the Nursing Assistants were to check the Kardex daily for each of the residents they were assigned. Med Aide #1 stated that the beds were not to be left in high position for any resident after care was provided due to safety risk.

An interview was conducted with NA #4 on 9/14/23 at 1:30 PM. NA #4 stated she was working the night of 9/6/23 but was not assigned to Resident #2. NA #4 stated she was familiar with Resident #2's care and was assigned to her sometimes. NA #4 stated Resident #2 required 2- person assist with bed mobility, transfers,

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F 689	Continued From page 9 bathing, and hygiene. An interview was conducted on 9/14/23 at 9:56 A.M. with the Director of Nursing (DON). The DON revealed she was in the position of DON for 2 weeks but had been working at the facility in the position of Assistant Director of Nursing prior to that. The DON revealed she was informed of Resident #2's fall during care on 9/6/23 and assisted with the investigation beginning on 9/7/23. The DON stated she and the ADON met with Resident #2's daughter on the morning of 9/7/23. Resident #2's daughter expressed concern regarding the resident's pain level. The DON stated she and the ADON assessed Resident #2 on 9/7/23. The physician was notified of the findings and ordered x-rays and scheduled acetaminophen for pain. The DON indicated that on 9/7/23 immediate reeducation of all nursing staff regarding preventing falls during care and from bed and following the Kardex. The DON stated the root cause analysis of the incident was not utilizing 2- person assist as the Kardex indicated and leaving the resident unattended while the NA stepped away during care. During an interview on 9/15/23 at 12:40 PM with the Administrator she revealed she was notified on 9/7/23 of Resident #2's fall during care. The Administrator stated NA #1 made a poor judgment call by not having another staff member assist her and by leaving the resident unattended during care with the bed in the high position. The Administrator stated a resident should not fall during care. The Administrator stated NA #1 was immediately suspended pending the investigation. The facility provided the following Corrective Action Plan with a completion date of 9/12/23:	F 689		

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F 689	Continued From page 10 1. The facility identified the following system issue regarding falls from bed: Resident care plan indicated 2-person assistance required for bed mobility. NA #1 failed to utilize the Kardex to safely provide care to the resident and failed to utilize safety measures when care was being provided. 2. An audit was conducted by the DON of all residents' care needs to assess the need for additional interventions such as 2-person assistance with bed mobility. All concerns including update of the care plan and Kardex were completed by 9/8/23. 3. The DON and Unit Manager audited all incident reports for the last 14 days for any similar incidents with no identified concerns. 4. On 9/7/23 the DON educated all nurses, medication aides, and nursing assistants on preventing falls from bed, accessing the Kardex, positioning, gathering supplies and ensuring residents are in a safe position prior to leaving the resident. This education was completed by 9/11/23 with all current staff and was added to the orientation for all new hires. 5. On 9/7/23 it was determined that as part of the plan of correction, an audit completed by the DON or designee including observation of at 3 NAs for provision of care to prevent falls will be conducted on all different shifts. The audits will be conducted weekly for 2 weeks and then monthly for 3 months or until resolved. The results of the audits will be reviewed at the weekly Quality Assurance meeting.	F 689		

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F 689	Continued From page 11 The Corrective Action Plan was validated on 9/15/23 and concluded the facility had implemented an acceptable corrective action plan with a completion date of 9/12/23. Interviews with the nursing staff, DON and Administrator revealed the facility had provided education and training regarding prevention of falls from bed, accessing and following the Kardex. Review of the monitoring tools for audits that began on 9/7/23 revealed the tools were completed as outlined in the corrective action plan. All concerns with preventing falls, accessing, and utilizing the Kardex were identified and addressed. The facility's correcive action completion date of 9/12/23 was verified.	F 689		
F 867 SS=G	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 are high risk, high volume, or problem-prone, and opportunities for improvement.	F 867		9/27/23

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F 867	Continued From page 12 §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; (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	F 867		

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	345207	A. BUILDING ______ B. WING ______	C 09/15/2023

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F 867	Continued From page 13 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. §483.75(g) Quality assessment and assurance.	F 867		

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F 867	Continued From page 14 §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, observations, and staff and physician interviews, the facility's Quality Assurance and Performance Improvement (QAPI) Program failed to maintain implemented procedures and effective monitoring of interventions the committee put into place following the recertification and complaint investigation survey of 5/4/23. This was for one recited deficiency in the area of supervision to prevent accidents (F689). During the 5/4/23 survey, deficient practice was cited for failing to provide incontinence care safely to a dependent resident when the resident fell off the bed during care and fractured her right femur (thighbone) in two places. During the current complaint investigation survey of 9/15/23, deficient practice was cited for failing to provide a bed bath safely to a dependent resident when Resident #2 fell off the bed during care and fractured her left femur and tibia (shinbone). The continued failure during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance program.	F 867	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F867 1. Corrective action for resident(s) affected by the alleged deficient practice: The facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and effective monitoring of interventions the committee put into place following the	

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F 867	Continued From page 15 Findings included: This tag is cross referenced to: F689 Based on record review, observations, staff and Physician interviews, the facility failed to provide a bed bath safely for a dependent resident for residents reviewed for falls. Resident #2 sustained a fall off the bed during care, fracturing her left femur (thighbone) and tibia (shinbone) for 1 of 2 residents reviewed for falls (Resident #2). During the 5/4/23 recertification and complaint investigation survey, the facility failed to provide incontinence care safely to a dependent resident. The resident fell out of bed during care and fractured her right femur in 2 places. An interview on 9/15/23 at 12:40 PM with the Administrator revealed ongoing monitoring and education was required to ensure that residents did not sustain falls during resident care. The Administrator stated the required audits and monitoring from the plan of correction for the previous citation had just recently ended. The Administrator indicated maybe the audits and monitoring should have continued for longer to ensure the change had been sustained.	F 867	recertification and complaint investigation on 5/4/23 in which a resident fell during incontinent care from the bed with resultant fractures. On 9/7 /23 the facility failed to provide a bed bath safely for a dependent resident as the resident fell off the bed during care with resultant fractures. The facility implemented a plan of correction after that fall on 9/7/23 to include root cause analysis , education and monitoring with alleged compliance of 9/12/23 for F 689 to achieve past noncompliance, but the pattern of the facilities inability to sustain an effective quality assurance program resulted in a citation in F867. The root cause analysis to reduce the risk of future harmful events was conducted on 9/27/23 with the Quality assurance committee members to include the nurse consultant, the director of clinical services and the director of operations with corrective action plan. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: The Quality Assurance Performance Improvement (QAPI) committee held a meeting on 9/12/2023 to review the deficiencies from the May 1, 2023 to May 4, 2023 annual recertification survey, CI survey, and reviewed the citations. On 9/12/2023, Regional Clinical Consultant in-serviced the facility administrator and the Quality Assurance Committee on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying issues and correcting repeat deficiencies. On	

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F 867	Continued From page 16	F 867	9/27/23 the nurse consultant , director of clinical services and the director of operations implemented guidance for performing root cause analysis with Performance improvement projects to ensure regulatory guidance. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 9/12/2023 the administrator completed in-servicing with the QAPI team members that include the Administrator, Director of Nurses, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager, on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying any issues identified including correcting repeat deficiencies. On 9/27/23 the Nurse consultant , the director of clinical services and the director of operations provided education to the QAPI team members on Root cause analysis process to include a way to identify breakdowns in processes and systems that contribute to an event and how to prevent future events. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor compliance utilizing the F867 Quality Assurance Tool weekly x 4 weeks then monthly x 6 months. The tool will monitor facility identified concerns that need to be addressed by the QA Committee. Reports will be presented to the weekly	

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F 867	Continued From page 17	F 867	Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting, indefinitely or until no longer deemed necessary for compliance with the missing laundry process. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. The nurse consultant will review the tool weekly x 4 weeks then monthly x 6 months to ensure root cause analysis and to monitor for any patterns of deficient practice. Date of Compliance: 09/27/23	