STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345487	A. BUILDING _____ B. WING _____	C 03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY POINT BAY NURSING AND REHABILITATION CENTER	110 MCCOTTER BOULEVARD HAVELOCK, NC 28532

(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 000	INITIAL COMMENTS A complaint investigation survey was conducted onsite on 2/27/24 with additional information received remotely on 2/28/24 and 2/29/24. The surveyor returned to the facility on 3/01/24 to validate the immediate jeopardy removal plans. The removal plans for F689 and F726 were unable to be validated due to insufficient evidence that education had been completed. The surveyor returned to the facility on 3/05/24 and the immediate jeopardy removal plans were validated. Therefore, the exit date was 3/05/24. The following intake was investigated NC00213273. Intake NC00213273 resulted in immediate jeopardy. 2 of the 4 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity J CFR 483.25 at tag F689 at a scope and severity J CFR 483.35 at tag F726 at a scope and severity J The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 2/01/24 and was removed on 2/03/24 for F580 and 3/02/24 for F689 and F726. A partial extended survey was conducted.	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. (i) A facility must immediately inform the resident;	F 580		3/6/24

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

Electronically Signed | 03/18/2024

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F 580	Continued From page 1	F 580		

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)
Admission to a composite distinct part. A facility

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F 580	Continued From page 2 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 review and staff, Nurse Practitioner (NP) and Physician interviews the facility failed to notify the physician immediately when Resident #1 had a fall from the shower bed (a bed utilized for the provision of personal care for residents who are immobile or who have reduced mobility) headfirst to the floor of the shower room on 2/01/24 at approximately 2:50 AM. Resident #1 sustained a small bruise to the back of her head and an abrasion to her lower back area and was at risk for further injury from head trauma due to a history left hemicraniectomy (surgical procedure where a large flap of the skull is removed) and seizures. On 2/01/24 at approximately 10:00 AM the resident had a change in neurological status with nystagmus (repetitive, uncontrolled eye movement) observed. The NP was notified and ordered for the resident to be sent to the Emergency Department (ED) for evaluation. At the hospital on 2/02/24, the resident had a breakthrough seizure. This deficient practice affected 1 of 1 residents reviewed for notification of significant changes. Immediate jeopardy began on 2/01/24 when the facility failed to immediately notify the physician of Resident #1's fall. The immediate jeopardy was removed on 2/03/24 when the facility implemented an acceptable credible allegation of	F 580	Resident #1 continues to reside in the facility and remains in stable condition. Notification of the physician was made the morning of 2/1/24 and orders obtained to continue neurological checks and notify physician of any changes. Nurse Practitioner (NP) evaluated the resident with no new orders given. Neurological checks were completed from 3:00am through 10:00am with no changes noted. At 10:00am, 7 hours post occurrence, during neurological check nurses noted nystagmus (repetitive, uncontrolled eye movement) and notified NP who was in the facility and who evaluated resident. An order was obtained to transfer to the Emergency Department (ED) for evaluation. On 2/1/2024, the Quality Assurance (QA) nurse completed a 100% audit of incident reports from 1/1/2024 to 2/1/2024 to ensure the provider was immediately notified of all incidents including falls with potential head injury. No other areas of concern were identified. On 2/1/2024, the QA nurse initiated an inservice with all nurses regarding Notification of the Physician, with	

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F 580	Continued From page 3 immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. Findings included: Resident #1 was admitted to the facility on 6/04/20 with diagnoses which included non-traumatic brain dysfunction, seizure disorder, and history of a left hemicraniectomy. Resident #1's quarterly Minimum Data Set dated 11/17/23 revealed she was in a chronic vegetative state. Review of Resident #1's fall event report dated 2/01/24 at 2:50 AM completed by Nurse #1 read, in part, that the shower bed hit an uneven area in the floor in the shower room and when the bed jarred the head of the bed folded down and the resident slid to the floor. The immediate action taken read, in part, that a small bruise was noted to the lower back and small reddened bump to the back of the head. The notification section stated that the physician was notified on 2/01/24 at 6:30 AM. An interview with Nurse #1 on 2/27/24 at 10:11 AM revealed that she was on duty and assigned to Resident #1 on 2/01/24 at 2:50 AM when the resident fell from the shower bed to the shower room floor. She observed Resident #1 lying face up on the shower floor. She stated that she assessed the resident and noted an abrasion to her lower back area and a small bruise to the back of her head. She started neurological	F 580	emphasis on how to avoid distractions and delay in notification of the physician including (1) immediately notify the physician of all incidents including falls with a potential head injury (2) if unable to reach the attending, notifying the on-call physician and (3) documentation in the electronic record following notification of the physician. Inservice was completed by 2/2/2024. After 2/2/2024, any nurses that were not inservices by the Staff Development Nurse (SDC) will complete it before working their next scheduled shift. Any newly hired nurses will be educated by the SDC during orientation. The Interdisciplinary team including the Minimum Data Set (MDS) Nurse, Staff Development Nurse, Quality Assurance Nurse, and Director of Nursing will review all incidents 5x/week x4 weeks then 1x/week x4 weeks then monthly x3 months to ensure the physician and/or on-call physician is immediately notified of all incidents to include falls with potential head injury with documentation in the electronic record following the notification. The MDS Nurse, SDC, QA Nurse, and Director of Nursing (DON) will address all concerns identified during the audit to include notification of the physician and/or staff re-training. The Administrator and/or DON will present the findings of the incident audit tools to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 3 months. QAPI Committee will review audits to determine trends and/or issues	

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F 580	Continued From page 4 checks (a neurological check consists of a physical examination to identify signs of disorders affecting your brain, spinal cord, and nervous system) per protocol (every 15 minutes x 4, every 30 minutes x 4, every hour x 4, every 2 hours x 2, and every 4 hours x 2, and every shift x 3 shifts). Nurse #1 stated she had not called the on-call physician until later in the morning as the resident had no neurological changes for the rest of her shift. She indicated she received no new orders when she made the physician notification. A progress note dated 2/01/24 at 10:00 AM by Nurse #2 read in part that the neurological observation for the pupil check noted nystagmus (repetitive, uncontrolled eye movement). An interview with Nurse #2 on 3/04/24 at 9:50 AM revealed that she was on duty and assigned to Resident #1 on 2/01/24 day shift (7am-3pm). She stated that she received a shift report from Nurse #1 that the resident had fallen from the shower bed and had no neurological changes. She stated that she continued the neurological checks per protocol. Nurse #2 stated that Resident #1 had a neurological change of nystagmus at 10:00 AM and she notified the Nurse Practitioner who requested that the resident be sent to the hospital. Review of the hospital discharge summary dated 2/09/24 indicated Computerized Tomography (CT) scans revealed the resident had no acute changes. Discharge was recommended back to the facility. Prior to discharge, Resident #1 was observed with a lateral gaze and she lost the ability to follow commands. She had a breakthrough seizure on 2/02/24 for 2 minutes, Neurology was consulted, and the Levetiracetam	F 580	that may need further interventions and/or the need for additional monitoring.	

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medication was increased to 1500 mg twice a day. Resident #1 was noted with unrelated medical issues while at the hospital. She was discharged back to the facility on 2/9/24.

An interview with the NP on 2/28/24 at 9:34 AM revealed that she was notified of Resident #1's fall the morning of 2/01/24 at 8:30 AM when she went to the facility. She stated that she assessed the resident and requested she be sent to the hospital. She revealed that the physician on call should have been notified immediately and the resident sent to hospital right away for evaluation due to Resident #1 hitting her head during the fall and the resident's history of hemicraniectomy. The NP added that the resident had a history of seizures and was on antiseizure medication. She stated that the resident had not had a seizure at the facility (admission date of 6/4/20). The resident had a seizure at the hospital which she felt could have been related to the fall and hitting her head.

An interview with the Physician on 2/28/24 at 10:00 AM revealed that she believed the on-call physician should have been notified immediately and sent to the hospital after Resident #1's fall due to her head trauma caused by falling off the shower bed. She stated that the resident had a left hemicraniectomy (missing a portion of her skull on the left side of her head) from a brain bleed in 2020. She could not say whether Resident #1's seizure was related to her fall or not. She stated that it was a bad judgement call and the nurse should have been educated on timely notification of the physician if the resident had a fall and hit their head.

An interview with the Administrator on 2/27/24 at

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F 580	Continued From page 6	F 580		

10:54 AM revealed that she believed the on-call physician should have been notified immediately of Resident #1's fall. She stated that the staff had been immediately educated on when to notify the physician.

The Administrator was notified of Immediate Jeopardy on 2/28/24 at 11:15 AM.

The facility provided a corrective action plan that was not acceptable to the State Survey Agency. The plan did not demonstrate a sufficient monitoring plan to ensure compliance was sustained.

The facility provided the following credible allegation of Immediate Jeopardy removal:

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

On 2/1/24 at 02:50 am, Nursing Assistant #1 took Resident #1 to the shower room via the shower bed. The head of the shower bed was in an elevated position, and the foot of the shower bed was not in an elevated position. While entering the shower room, the wheel of the shower bed hit the drain in the floor, causing the bed to become unsteady and begin to tip to the side. The shower bed jarred, and the head of the bed (HOB) support fell. NA #1 prevented the shower bed from completely tipping to the side. However, the resident's body slid off the shower bed onto the floor. NA #1 called for assistance.

The nurse completed a head-to-toe assessment of Resident #1 and noted a hematoma to the back of the head and a bruise on the lower back.

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The resident was assisted up from the floor via mechanical lift onto the shower bed and returned to the room. Neuro checks were completed from 3:00 am to 9:00 am with no negative findings. At 8:05 am, the facility Nurse Practitioner (NP) was updated on the status of the resident with no new orders. At 10:00 am, during a neuro check, the nurse noted nystagmus (repetitive, uncontrolled eye movement) and reported this to the NP. The NP assessed the resident with a new order to send to the emergency room for further evaluation and treatment. While at the hospital, the resident had a 2-minute breakthrough seizure and was treated for seizure-like activity. Additionally, the resident was admitted for a persistent vegetative state, and a small area of cerebral parenchymal hemorrhage chronic in nature, all unrelated to the fall.

All residents who had falls, including those with injury, had the potential to be affected. The Quality Assurance Nurse identified these residents utilizing an incident audit tool on 2/1/24.

On 2/1/24, a root cause analysis was completed by the Administrator and Director of Nursing. The root cause was determined to be that the nurse became distracted and inadvertently failed to notify the on-call provider of the resident's fall per facility protocol.

On 2/1/2024, a 100% audit of incident reports from 1/1/2024 to 2/1/2024 was completed by the Quality Assurance Nurse to ensure the provider was immediately notified of all incidents including falls with a potential head injury. There were no other identified areas of concern.

- Specify the action the entity will take to alter the

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process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

An in-service was initiated on 2/1/24 by the Quality Assurance nurse with all nurses regarding Notification of the Physician, with emphasis on how to avoid distractions and delay in notification of the physician including (1) immediately notifying the physician of all incidents including falls with a potential head injury (2) if unable to reach the attending, notifying the on-call physician and (3) documentation in the electronic record following notification of the physician. In-service was completed by 2/2/24. After 2/2/24, The Staff Development Nurse monitored staff completion and any nurse who had not completed the in-service will complete it before working their next scheduled shift.

Any newly hired nurses will be educated by the Staff Development Nurse during orientation regarding Notification of the Physician with emphasis on how to avoid distractions and delay in notification of the physician including (1) immediately notifying the physician of all incidents including falls with a potential head injury (2) if unable to reach the attending, notifying the on-call physician and (3) documentation in the electronic record following notification of the physician. The Staff Development Nurse was notified of this responsibility by the Administrator on 2/1/24.

Date of Jeopardy Removal 2/3/24.

The credible allegation of immediate jeopardy removal was verified on 3/05/24. Interviews were conducted with a sample of Nurses to verify education was conducted for Nurses regarding

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F 580	Continued From page 9 notification of the physician. Documentation of in-service records was reviewed. In an interview on 3/05/24 at 10:28 AM with the Staff Development Coordinator, she stated that all Nurses had been in-serviced on the policy and procedure to notify the physician. She stated that she was responsible for orienting new nurses on the procedure for notification of the physician. The facility's immediate jeopardy removal date of 2/03/24 was validated.	F 580		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff, Nurse Practitioner (NP), and Physician interviews, the facility failed to follow the manufacturer's instructions for the use of a mobile shower bed (a bed utilized for the provision of personal care for residents who are immobile or who have reduced mobility) and to provide care safely for 1 of 1 resident reviewed for supervision to prevent accidents. On 2/01/24 Nursing Assistant (NA) #1 transported Resident #1 to the shower room via the shower bed without utilizing the locking pins that secured the head and the foot of the bed in place. While transporting the resident to the	F 689	Resident #1 continues to reside in the facility and remains in stable condition. Shower bed was immediately taken out of service and sent to Maintenance Director for evaluation. On 2/1/2024, the Quality Assurance (QA) nurse completed a 100% audit of incident reports from 1/1/2024 to 2/1/2024 to ensure no incident resulted from falls during shower transport by shower bed or chair. No other areas of concern were identified.	3/6/24

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F 689	Continued From page 10 shower room the foot of the shower bed released and dropped toward to the floor. NA #1 did not cease the transport. She continued to push the resident in the shower bed to the shower room. Once arriving in the shower room when the shower bed was wheeled over the drain in the floor, the bed became unsteady, began to tip to the side and the head of the bed released dropping toward the floor resulting in the resident falling off of the shower bed headfirst onto the floor. The resident sustained a small bruise to the back of her head and an abrasion to her lower back area. The resident was transported to the hospital on 2/01/24 at 11:01 AM. At the hospital on 2/02/24, the resident had a breakthrough seizure. Immediate jeopardy began on 2/01/24 when NA #1 failed to provide care safely to Resident #1. The immediate jeopardy was removed on 3/02/24 when the facility provided an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. Findings included: A product website for purchasing of the shower bed utilized by the facility indicated the bed was made of PVC (Polyvinyl chloride) pipe material with a water resistant foam pad across the horizontal surface area of the platform where an individual would lay. It was foldable and mobile. The bed had four casters (wheels that were attached to the bed at the four corners and that were able to lock into position). It was 38.5"	F 689	On 2/1/2024, the Staff Development Coordinator (SDC) completed questionnaires with all alert and oriented residents regarding concerns during shower bed/chair transport. No other areas of concern were identified. On 2/1/2024, the Maintenance Director completed a 100% audit of all shower beds to ensure no other shower bed required locking pins. No other shower beds were identified. The identified shower bed was completely removed from service and removed from the facility. On 2/1/2024, the Maintenance Director completed a 100% audit of all shower beds and shower chairs to ensure no repairs were needed to include locking pins and to ensure safe operation of shower beds and shower chairs. No other areas of concern were identified. On 2/1/2024, the Maintenance Director completed 100% of all shower rooms to ensure no safety hazards existed. No other areas of concern were identified. On 2/1/2024, the Nursing Home Administrator (NHA) decided to not utilize shower equipment that require the use of pins. NHA completed education with supply clerk regarding not ordering shower equipment that require locking pins. An order was placed for new shower beds that do not operate with the use of pins.	

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F 689	Continued From page 11	F 689		

(inches) in height x 32" diameter x 76.5" length. To fold the bed, the head of the bed and the foot of the bed folded down towards the casters with the center portion of the bed remaining in a horizontal plane with the folded length measuring 41.5".

The operating instructions (undated) indicated the purpose of this bed was to transport a person in a horizontal position and to use as a platform for showering. The shower bed folded down at each end for easy storage by unpinning and lifting up on either end until the section disengaged.

Resident #1 was admitted to the facility on 6/04/20 with diagnoses which included non-traumatic brain dysfunction, seizure disorder, and history of a left hemicraniectomy (surgical procedure where a large flap of the skill is removed).

Review of Resident #1's physician's orders revealed an order dated 2/02/23 for Levetiracetam (an antiseizure) 750 milligrams twice a day for seizures.

Resident #1's quarterly Minimum Data Set assessment dated 11/17/23 revealed she was in a chronic vegetative state and was dependent on staff for activities of daily living. She was not prescribed an anticoagulant.

Resident #1's care plan last revised 5/24/23 revealed a focus area for activities of daily living with an intervention for total dependence for bathing. There was also an intervention to keep the head of the bed elevated.

Review of Resident #1's fall event report dated

On 2/2/24, the NHA completed an inservice with the maintenance director regarding notifying the NHA of any equipment that needs frequent attention/repairs and monitoring of shower beds/chairs weekly.

On 2/1/2024, the SDC initiated education with all nurses and nursing assistants regarding safety hazards and operational procedures when transporting residents in shower beds/chairs and completed return demonstrations. The inservice emphasized 1) inspecting equipment for function and missing parts before transport; 2) immediately reporting to maintenance staff and/or supervisor safety hazards to prevent the risk of falls; 3) ensuring the resident is properly positioned in the shower bed/chair; 4) not using the shower bed/chair if equipment is not fully functional with all parts; and 5) if repairs are needed, red tag the shower transport device and place outside maintenance office for repairs. Inservice was completed on 2/2/2024. Any nurse or nursing assistance who did not complete the inservice with SDC will be inserviced prior to their next scheduled shift. Newly hired nurses and nursing assistants will be educated by the SDC with return demonstration obtained during orientation.

On 3/1/24, the NHA re-inserviced the SDC on the responsibility to include both shower chairs and beds with the education of all newly hired staff.

On 3/1/24, the SDC initiated an inservice

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F 689	Continued From page 12 2/01/24 at 2:50 AM completed by Nurse #1 read, in part, that the shower bed hit an uneven area in the floor and when the bed jarred the head of the bed folded down and the resident slid to the floor. The immediate action taken read, in part, that a small bruise was noted to the lower back and small reddened bump to the back of the head. An interview with NA #1 on 2/27/24 at 3:15 PM revealed that she regularly provided care for Resident #1 and had given her showers previously using the shower bed. She stated she and NA #2 had transferred Resident #1 from her bed to the shower bed via the mechanical lift. Then NA #1 stated she transported Resident #1 down the hallway toward the shower room. There were side rails on each side of the shower bed that were able to be locked in place with locking pins. She stated the side rails were in an upright and locked position (with the locking pins in place) when she transported Resident #1 down the hallway. The head of the shower bed was elevated, and the foot was not elevated. She stated that the resident care guide intervention was to keep the head of the bed elevated at all times, so she kept the head of the shower bed elevated as well. Part of the way down the hallway, the foot section of the shower bed (a portion that was capable of folding down toward the casters), released which caused it to be in a downward position toward the ground while the center of the bed remained on the horizontal plane. She did not know why this happened. She stated that no part of the resident was off the shower bed and she did not believe the resident was in danger of failing off of the bed so she continued pushing the shower bed towards the shower room. NA #1 stated that after she entered the shower room, the head of the shower bed (a	F 689	with all nurses and nursing assistants regarding safety hazards and operational procedures when transporting resident in shower chairs. The inservice emphasized 1) inspecting equipment for function and missing parts before transport; 2) immediately reporting to maintenance staff and/or supervisor safety hazards to prevent the risk of falls; 3) ensuring the resident is properly positioned in the shower bed/chair; 4) not using the shower bed/chair if equipment is not fully functional with all parts; and 5) if repairs are needed, red tag the shower transport device and place outside maintenance office for repairs. Inservice was completed by 3/2/24. The SDC monitored staff completion of the inservice and ensured any nurse or nursing assistant who had not completed the inservice will complete it before working their next scheduled shift. The Director of Nursing (DON) provided oversight of staff education to validate staff knowledge and understanding of the education provided. The Maintenance Director will audit the shower rooms and shower beds/chairs for any safety hazards weekly x4 weeks then monthly x3 months to ensure no repairs are needed in shower rooms and/or on shower equipment. The NHA will review audits weekly x4 weeks then monthly x3 months to ensure all concerns are addressed. The Administrator and/or Maintenance Director will present the findings of audit to the Quality Assurance Performance Improvement (QAPI) Committee monthly	

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F 689	Continued From page 13 portion of the bed that was capable of folding down toward the casters) released and fell toward the ground. The resident slid off the shower bed headfirst into the floor. The resident was lying face up flat on the shower room floor. NA #1 stated she went to the shower room door and called for help. The nurse (Nurse #1) came to assess the resident. After the resident was assessed, they used the mechanical lift to put the resident on the shower bed and transport her to her room. She stated that she was unaware there were locking pins for the head and foot of the shower bed. (These locking pins for the folding mechanism were separate from the locking pins utilized for the side rail securement). She stated she had not been trained on what the manufacturer's instructions were. NA #1 stated the training she had received for the shower bed was from another NA about the locking pins which held the side rails in an upright, locked and secured position on each side. An interview with Nurse #1 on 2/27/24 at 10:11 AM revealed that she was on duty and assigned to Resident #1 on 2/01/24 at 2:50 AM when the resident fell from the shower bed to the shower room floor. She stated that NA #1 had called out and she responded. She observed Resident #1 lying face up flat on the shower room floor. She stated that she observed the head of the shower bed had folded down. She stated that she assessed the resident and noted an abrasion to her lower back area and a small bruise to the back of her head. Nurse #1 stated that they used the mechanical lift to transfer Resident #1 to the shower bed and transported her back to her room. She started neurological checks (a neurological check consists of a physical examination to identify signs of disorders	F 689	for 3 months. QAPI Committee will review audits to determine trends and/or issues that may need further interventions and/or the need for additional monitoring.	

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affecting you brain, spinal cord, and nervous system) per protocol (every 15 minutes x 4, every 30 minutes x 4, every hour x 4, every 2 hours x 2, and every 4 hours x 2, and every shift x 3 shifts). Nurse #1 stated that the resident had no neurological changes for the rest of her shift, and she called the on-call physician the next morning. She indicated she received no new orders when she made the physician notification.

A progress note dated 2/01/24 at 10:00 AM by Nurse #2 read in part that the neurological observation for the pupil check noted nystagmus (repetitive, uncontrolled eye movement).

An interview with Nurse #2 on 3/04/24 at 9:50 AM revealed that she was on duty and assigned to Resident #1 on 2/01/24 day shift (7am-3pm). She stated that she received a shift report from Nurse #1 that the resident had fallen from the shower bed and had no neurological changes. She stated that she continued the neurological checks per protocol. Nurse #2 stated that Resident #1 had neurological change of nystagmus at 10:00 AM and she notified the Nurse Practitioner who requested that the resident be sent to the hospital.

Review of the hospital discharge summary dated 2/09/24 indicated Computerized Tomography (CT) scans revealed the resident had no acute changes. Discharge was recommended back to the facility. Prior to discharge, Resident #1 was observed with a lateral gaze and she lost the ability to follow commands. She had a breakthrough seizure on 2/02/24 for 2 minutes, Neurology was consulted, and the Levetiracetam medication was increased to 1500 mg twice a day. Resident #1 was noted with unrelated

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medical issues while at the hospital. She was discharged back to the facility on 2/9/24.

An interview on 2/27/24 at 1:38 PM with the Maintenance Director revealed the facility had one shower bed and he did not have a procedure in place to regularly check the shower bed for mechanical safety. He stated that he was aware of the locking pins which were used to transition the bed from a folded position by securing the head and foot of the shower bed in a horizontal position. He stated there were also locking pins on the side rails of the shower bed to hold them in an upright position. He stated that he usually checked the shower bed weekly to ensure all the locking pins (the side rail pins and the pins that secured the head and the foot of the shower bed preventing them from folding down) were in place because the pins "went missing sometimes" and he had to replace them. He also stated that he was out of the facility the week before Resident #1 fell and when he was out there was only emergency maintenance coverage. The Maintenance Director stated that when he checked the bed after returning to work on 2/01/24, the locking pins for the head and foot of the bed were missing. He stated that shower bed had been discarded after the accident and was no longer in the facility and the new shower bed did not have locking pins on the bottom.

An interview with the Nurse Practitioner (NP) on 2/28/24 at 8:15 AM revealed that she was notified of Resident #1's fall. She stated that she assessed the resident and requested that she be sent to the hospital. She also stated that since the resident had hit her head, she should have been transported to the hospital right away for evaluation because of the resident's history of the

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hemicraniectomy. The NP stated that the resident had a history of seizures and was on antiseizure medication. She also stated that the resident had not had a seizure at the facility (admission date of 6/4/20). The resident had a seizure at the hospital which she felt could have been related to the fall and hitting her head.

An interview with the Physician on 2/28/24 at 10:00 AM revealed that she believed that Resident #1 should have been sent to the hospital immediately after her fall due to her head trauma caused by falling off the shower bed. She stated that the resident had a left hemicraniectomy (missing a portion of her skull on the left side of her head) from a brain bleed in 2020. She could not say whether Resident #1's seizure was related to her fall or not. She stated that she did not know if the resident's fall had caused any negative consequences as the resident was in a chronic vegetative state.

An interview with the Administrator on 2/27/24 at 10:54 AM revealed that she believed the cause of Resident #1's fall from the shower bed was caused by the shower bed failure due to the missing locking pins on the head and foot of the bed and the lack of staff education to check the pins were in place. She stated that the shower bed had been removed from use immediately. She indicated they did not have a system in place for training the staff on the shower bed.

The Administrator was notified of immediate jeopardy on 2/28/24 at 11:15 AM.

The facility provided a credible allegation of immediate jeopardy removal and the State Survey Agency returned to the facility on 3/01/24

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to validate. The immediate jeopardy removal plan could not be validated as the facility failed to have sufficient evidence that education was completed for staff. Multiple staff working had not received education. The facility was asked to provide a revised credible allegation of immediate jeopardy removal.

The facility provided the following revised credible allegation of immediate jeopardy removal:

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

On 2/1/24 at 02:50 am, Nursing Assistant #1 took Resident #1 to the shower room via the shower bed. The head of the shower bed was in an elevated position, and the foot of the shower bed was not in an elevated position. While entering the shower room, the wheel of the shower bed hit the drain in the floor, causing the bed to become unsteady and begin to tip to the side. The shower bed jarred, and the head of the bed (HOB) support fell. NA #1 prevented the shower bed from completely tipping to the side. However, the resident's body slid off the shower bed onto the floor. NA #1 called for assistance.

The nurse completed a head-to-toe assessment of Resident #1 and noted a hematoma to the back of the head and a bruise on the lower back. The resident was assisted up from the floor via mechanical lift onto the shower bed and returned to the room. Neuro checks were completed from 3:00 am to 9:00 am with no negative findings. At 8:05 am, the facility Nurse Practitioner (NP) was notified of the status of the resident with no new orders. At 10:00 am, during a neuro check, the

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nurse noted nystagmus (repetitive, uncontrolled eye movement) and reported this to the NP. The NP assessed the resident with a new order to send to the emergency room for further evaluation and treatment. While at the hospital, the resident had a 2-minute breakthrough seizure and was treated for seizure-like activity. Additionally, the resident was admitted for a persistent vegetative state, and a small area of cerebral parenchymal hemorrhage chronic in nature, all unrelated to the fall.

All residents who are transported via shower beds have the potential to be affected. The Director of Nursing identified these residents utilizing a census sheet on 2/2/24.

On 2/1/24, a root cause analysis was completed by the Administrator and Director of Nursing. The root cause of the fall was that the footrest was not in the up position, and the locking pins were not in place per the manufacturer's specifications.

On 2/1/2024, a 100% audit of incident reports from 1/1/2024 to 2/1/2024 was completed by the Quality Assurance Nurse (QA) to ensure no incident resulted from falls during shower transport by gurney or chair. There were no other identified areas of concern.

On 2/1/24, a 100% audit was completed by the Maintenance Director to ensure that no other shower beds required locking pins. There were no other beds identified. The identified shower bed was immediately removed from service by the Maintenance Director.

On 2/1/2024, questionnaires were initiated by the Staff Development Nurse with alert/oriented

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residents regarding concerns during shower chairs/bed transport. The questionnaires were completed on 2/1/24. There were no identified areas of concern.

- 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:

On 2/1/2024, a 100% audit of all shower beds/chairs was completed by the Maintenance Director to ensure no needed repairs were required including locking pins and to ensure safe operations. There were no other identified areas of concern.

On 2/1/2024, a 100% audit of all shower rooms was completed by the Maintenance Director to ensure no safety hazards. There were no other identified concerns.

On 2/1/24, the Administrator decided to not utilize the shower bed/chairs with pins. An in-service was completed by the Administrator on 2/1/24 with the supply clerk regarding not ordering any shower equipment requiring locking pins.

An in-service was completed on 2/2/24 by the Administrator with the maintenance director regarding notifying the Administrator of any equipment that needs frequent attention/repairs and monitoring of shower beds/chairs weekly.

An in-service was initiated on 2/1/2024 by the Staff Development Nurse with all nurses and nursing assistants regarding safety hazards and operational procedures when transporting residents in shower beds. This in-service

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emphasized (1) inspecting equipment for function and missing parts before transport, (2) immediately reporting to maintenance staff and/or supervisor safety hazards to prevent the risk of falls, (3) ensuring the resident is properly positioned in the shower bed, (4) not using the shower bed if equipment is not fully functional with all parts and (5) if repairs are needed, red tag the shower transport device and place outside maintenance office for repairs. In-service was completed by 2/2/2024. The Staff Development Nurse monitored staff completion of the in-service and ensured any nurse or nurse aide who had not completed the in-service will complete it before working their next scheduled shift.

An in-service was initiated on 3/1/2024 by the Staff Development Nurse with all nurses and nursing assistants regarding safety hazards and operational procedures when transporting residents in shower chairs. This in-service emphasized (1) inspecting equipment for function and missing parts before transport, (2) immediately reporting to maintenance staff and/or supervisor safety hazards to prevent the risk of falls, (3) ensuring the resident is properly positioned in the shower chair, (4) not using the shower chair if equipment is not fully functional with all parts and (5) if repairs are needed, red tag the shower transport device and place outside maintenance office for repairs. In-service was completed by 3/1/2024. The Staff Development Nurse monitored staff completion of the in-service and ensured any nurse or nurse aide who had not completed the in-service will complete it before working their next scheduled shift.

The Director of Nursing will provide oversight of staff education to validate staff knowledge and

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understanding of the education provided.

Any newly hired nurses and nurse assistants will be educated by the Staff Development Nurse during orientation regarding safe operational procedures during shower chair/bed transport. The Staff Development Nurse was notified of this responsibility by the Administrator on 2/1/24. On 3/1/24, the Staff Development Nurse was instructed by the Administrator on the responsibility to include both shower chairs and beds with the education of all newly hired staff.

Date of Immediate Jeopardy Removal: 3/2/24

The credible allegation of immediate jeopardy removal was verified on 3/05/24. Interviews were conducted with a sample of Nursing Assistants and Nurses to verify education was conducted for Nurses and NAs regarding shower bed/chair safety. Documentation of in-service records was reviewed.

In an interview on 3/05/24 at 9:08 AM with the Maintenance Director, he stated that he had received education on the process that was put in place to monitor the shower beds/chairs weekly for safety.

In an interview on 3/05/24 at 10:28 AM with the Staff Development Coordinator, she stated that all Nurses and Nursing Assistants had been in-serviced on the shower bed/chair for safety. She stated that she was responsible for orienting new nurses and nursing assistants on the safe operational procedure during shower bed/chair transport and use.

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F 689	Continued From page 22 An observation of the shower room revealed the current shower bed had no locking pins on the bottom of the bed. The shower chairs were observed and appeared to be in good condition. Three shower chairs were observed to be located on the maintenance hall with out of order tags attached to them. The facility's immediate jeopardy removal date of 3/2/24 was validated.	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff	F 693	Resident #1 continues to reside in the	3/6/24

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F 693	Continued From page 23 interviews the facility failed to 1) follow procedure for gastrostomy tube (g-tube) care by Nurse #2 pushing water with the plunger through the syringe into the g-tube and 2) failed to store a tube feeding syringe with the plunger separated from the barrel. This was for 1 of 1 resident reviewed for enteral feeding management (Resident #1). Findings included: Resident #1 was admitted to the facility on 6/04/20 with diagnoses which included cerebrovascular accident and Diabetes Mellitus. Resident #1's quarterly Minimum Data Set dated 11/17/23 revealed she was dependent on staff for activities of daily living. An observation on 2/27/24 at 11:38 AM revealed that Nurse #2 injected 30 cubic centimeters (cc) into Resident #1's g-tube using the plunger instead of allowing the water to flow in the syringe by gravity through the g-tube to prevent discomfort in the abdomen and potential damage to the g-tube. Nurse #2 then placed the syringe with the plunger inside the barrel in the storage bag. An interview on 2/27/24 at 11:47 AM with Nurse #2 revealed that she had been taught to push the water into the g-tube instead of allowing it to flow in by gravity. She also stated that she had been taught to store the syringe barrel and plunger separately in the bag but had not done so due to nervousness. An interview on 2/27/24 at 11:54 AM with the Director of Nursing (DON) revealed that she did	F 693	facility and remains in stable condition with no ill affects from 30cc of water being pushed through the g-tube syringe by using the plunger. On 2/27/24, the Director of Nursing educated the Nurse #1 immediately regarding administering medication/flushes via g-tube by gravity flow and on storing the feeding tube syringe/plunger with plunger removed from the syringe. On 2/27/2024, the Quality Assurance (QA) nurse completed a 100% audit of all residents who receive nutrition/medication via g-tube to ensure the tube feeding syringe was not being stored with the plunger inside the syringe. No other areas of concern were identified. On 2/27/2024, the Staff Development Coordinator (SDC) initiated an inservice with all nurses regarding 1) providing medications/flushes through the g-tube via gravity flow as not to potentially cause abdominal discomfort or damage to the tube and 2) to store feeding tube syringe/plunger with plunger removed from the syringe. Inservice was completed on 2/28/2024. Any nurses who did not complete inservice with SDC will be inserviced prior to their next scheduled shift. Newly hired nurses will be educated by the SDC during orientation. The QA nurse/SDC will complete 5 observations a week x4 weeks then 10 observations x1 month to observe nurses	

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F 693	Continued From page 24 not know why Nurse #2 pushed the water into the g-tube with the plunger instead of allowing it to flow by gravity or why she had stored the syringe plunger and barrel together.	F 693	1) providing medications/flushes through the g-tube via gravity flow and 2) storing feeding tube with plunger removed from the syringe. The Director of Nursing (DON) will review audits weekly x2 weeks. The DON will present the findings of audits to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 1 month. QAPI Committee will review audits to determine trends and/or issues that may need further interventions and/or the need for additional monitoring	
F 726 SS=J	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and	F 726		3/6/24

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F 726	Continued From page 25 implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, Nurse Practitioner (NP), and Physician interviews the facility failed to train Nursing Assistants (NAs) and verify competency for the safe operation of a foldable shower bed (a bed utilized for the provision of personal care for residents who are immobile or who have reduced mobility) for 1 of 1 NA (NA #1) reviewed. NA #1 was unaware that the shower bed required locking pins to be inserted to secure the head of the bed and the foot of bed to prevent the shower bed from folding. On 2/01/24 NA #1 transported Resident #1 to the shower room via the shower bed without utilizing the locking pins. While transporting the resident to the shower room the foot of the shower bed released and dropped toward to the floor. She continued to push the resident in the shower bed to the shower room. Once arriving in the shower room the shower bed was wheeled over the drain in the floor, the bed became unsteady, began to tip to the side and the head of the bed released dropping toward the floor resulting in the resident falling off of the shower bed headfirst onto the floor. The resident sustained a small bruise to the back of her head and an abrasion to her lower back area. The resident was transported to the hospital on 2/01/24 at 11:01 AM. At the hospital on 2/02/24,	F 726	Resident #1 continues to reside in the facility and remains in stable condition. On 2/1/2024, the Quality Assurance (QA) nurse initiated questionnaires with all nursing staff regarding observations of any concerns during residents shower bed/chair transports. Questionnaires were completed by 2/2/2024. After 2/2/24, any nurse or nurse aide who did not complete the questionnaire will complete a questionnaire before working their next scheduled shift. On 2/1/24, the Staff Development Coordinator (SDC) initiated return demonstrations of shower chair/bed transport with all nurses and nursing assistants. The purpose of the return demonstration is to ensure staff demonstrate a successful knowledge of safe operational procedures during shower bed/chair transport. For any identified concerns during the return demonstration, staff will be immediately retrained and only allowed to operate shower transport equipment once they pass the return demonstration. The return	

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F 726	Continued From page 26 the resident had a breakthrough seizure. Immediate jeopardy began on 2/01/24 when the failure to train and verify competency of NAs to safely operate a shower bed resulted in Resident #1 falling from the shower bed to the floor headfirst. The immediate jeopardy was removed on 3/02/24 when the facility provided an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. Findings included: This tag is cross-referenced to: F689: Based on record review, observation, staff, nurse practitioner, and physician interviews, the facility failed to follow the manufacturer's instructions for the use of a mobile shower bed (a bed utilized for the provision of personal care for residents who are immobile or who have reduced mobility) and to provide care safely for 1 of 1 resident reviewed for supervision to prevent accidents. On 2/01/24 Nursing Assistant (NA) #1 transported Resident #1 to the shower room via the shower bed without utilizing the locking pins that secured the head and the foot of the bed in place. While transporting the resident to the shower room the foot of the shower bed released and dropped toward to the floor. NA #1 did not cease the transport. She continued to push the resident in the shower bed to the shower room. Once arriving in the shower room when the	F 726	demonstrations were completed by 2/2/2024. After 2/2/24, any nurse or nurse aide who has not completed the return demonstration with the SDC will complete it before working their next scheduled shift. Any newly hired nurses and nurse assistants will be educated by SDC during orientation regarding safe operational procedures during shower chair/bed transport with the completion of a return demonstration before using the equipment. On 3/1/24, the SDC initiated return demonstration of shower chair transport with all nurses and nursing assistants. The purpose of the return demonstration is to ensure staff demonstrate a successful knowledge of safe operational procedures during shower chair transport. For any identified concerns during the return demonstration, staff will be immediately retrained and only allowed to operate shower transport equipment once they pass the return demonstration. The return demonstrations were completed by 3/1/24. After 3/1/24, any nurse or nurse aide who has not completed the return demonstration with the SDC will complete it before working their next scheduled shift. All newly hired nurses and nursing assistants will be educated by the SDC during orientation regarding safe operational procedures during shower chair/bed transport with the completion of return demonstration prior to using the equipment. The Director of Nursing (DON) will provide oversight of the education and return demonstrations of all	

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F 726	Continued From page 27 shower bed was wheeled over the drain in the floor, the bed became unsteady, began to tip to the side and the head of the bed released dropping toward the floor resulting in the resident falling off of the shower bed headfirst onto the floor. The resident sustained a small bruise to the back of her head and an abrasion to her lower back area. The resident was transported to the hospital on 2/01/24 at 11:01 AM. At the hospital on 2/02/24, the resident had a breakthrough seizure. An interview on 2/27/24 at 1:13 PM with the Staff Development Coordinator (SDC) revealed that she had been SDC for about one year and had not provided training for the safe operation of the shower bed for nursing assistants or nurses. She stated that the skills checklists do not include training for shower beds. The Administrator was notified of Immediate Jeopardy on 2/28/24 at 11:15 AM. The facility provided a credible allegation of immediate jeopardy removal and the State Survey Agency returned to the facility on 3/01/24 to validate. The immediate jeopardy removal plan could not be validated as the facility failed to have sufficient evidence that education was completed for staff. Multiple staff working had not received education. The facility was asked to provide a revised credible allegation of immediate jeopardy removal. The facility provided the following revised credible allegation of immediate jeopardy removal: - Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as	F 726	nurses and nursing assistants to validate staff knowledge and understanding of the education received. The SDC/QA nurse will complete 10 observations of nursing staff performing safety checks on shower bed/chair and safely transporting via shower equipment weekly x4 weeks then monthly x3 months. The Director of Nursing (DON) and/or the Nursing Home Administrator (NHA) review observation audits weekly x4 weeks then monthly x3 months. The DON and/or NHA will audit all newly hired nurses and nursing assistants training education weekly x4 weeks then monthly x3 months to ensure staff are trained during orientation regarding safe operational procedures of shower beds/chairs and have provided return demonstrations. The DON and/or NHA will present the findings of the staff observations and training record audits to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 3 months. QAPI Committee will review audits/observations to determine trends and/or issues that may need further interventions and the need for additional monitoring	

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a result of the noncompliance;
On 2/1/24 at 02:50 am, Nursing Assistant #1 took Resident #1 to the shower room via the shower bed. The head of the shower bed was in an elevated position, and the foot of the shower bed was not in an elevated position. While entering the shower room, the wheel of the shower bed hit the drain in the floor, causing the bed to become unsteady and begin to tip to the side. The shower bed jarred, and the head of the bed (HOB) support fell. NA #1 prevented the shower bed from completely tipping to the side. However, the resident's body slid off the shower bed onto the floor. NA #1 called for assistance.

The nurse completed a head-to-toe assessment of Resident #1 and noted a hematoma to the back of the head and a bruise on the lower back. The resident was assisted up from the floor via mechanical lift onto the shower bed and returned to the room. Neuro checks were completed from 3:00 am to 9:00 am with no negative findings. At 8:05 am, the facility Nurse Practitioner (NP) was notified of the status of the resident with no new orders. At 10:00 am, during a neuro check, the nurse noted nystagmus (repetitive, uncontrolled eye movement) and reported this to the NP. The NP assessed the resident with a new order to send to the emergency room for further evaluation and treatment. While at the hospital, the resident had a 2-minute breakthrough seizure and was treated for seizure-like activity. Additionally, the resident was admitted for a persistent vegetative state, and a small area of cerebral parenchymal hemorrhage chronic in nature, all unrelated to the fall.

All residents who are transported via shower beds have the potential to be affected. The

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Director of Nursing identified these residents utilizing a census sheet on 2/2/24.

On 2/1/24, a root cause analysis was completed by the Administrator and Director of Nursing. The root cause of the fall was that the nursing assistant transported the resident to the shower room without being properly educated on the safe operation procedures for using the shower bed with locking pins prior to using it.

- 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

On 2/1/2024, questionnaires were initiated by the Quality Assurance Nurse (QA) with all nursing staff regarding observations of any concerns during residents' shower bed/chair transports. Questionnaires were completed by 2/2/2024. After 2/2/24, the Staff Development Nurse monitored staff completion and any nurse or nurse aide who has not completed the questionnaire will complete these before working their next scheduled shift.

On 2/1/24, the Staff Development Nurse initiated return demonstrations of shower bed transport with all nurses and nursing assistants. The purpose of the return demonstration is to ensure staff demonstrate a successful knowledge of safe operational procedures during shower bed transport. For any identified concerns during the return demonstration, staff will be immediately retrained and only allowed to operate shower transport equipment once they pass the return demonstration. The return demonstrations were completed by 2/2/2024. After 2/2/24, the Staff

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Development Nurse monitored staff completion and any nurse or nurse aide who has not completed the return demonstration will complete it before working their next scheduled shift.

On 3/1/24, the Staff Development Nurse initiated return demonstrations of shower chair transport with all nurses and nursing assistants. The purpose of the return demonstration is to ensure staff demonstrate a successful knowledge of safe operational procedures during shower chair transport. For any identified concerns during the return demonstration, staff will be immediately retrained and only allowed to operate shower transport equipment once they pass the return demonstration. The return demonstrations were completed by 3/1/2024. After 3/1/24, the Staff Development Nurse monitored staff completion and any nurse or nurse aide who has not completed the return demonstration will complete it before working their next scheduled shift.

The Director of Nursing will provide oversight of the education and return demonstrations of all staff to validate staff knowledge and understanding of education.

Any newly hired nurses and nurse assistants will be educated by the Staff Development Nurse during orientation regarding safe operational procedures during shower chair/bed transport with the completion of a return demonstration before using the equipment. The Staff Development Nurse was notified of this responsibility by the Administrator on 2/1/24. On 3/1/24, the Staff Development Nurse was instructed by the Administrator on the responsibility to include return demonstrations of both the shower chair and shower bed with the

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F 726	Continued From page 31 education of all newly hired staff. Immediate Jeopardy Removal Date: 3/2/24 The credible allegation of immediate jeopardy removal was verified on 3/05/24. Interviews were conducted with a sample of Nursing Assistants and Nurses to verify education was conducted for Nurses and NAs regarding shower bed/chair safety. Documentation of in-service records was reviewed. In an interview on 3/05/24 at 10:28 AM with the Staff Development Coordinator, she stated that all Nurses and Nursing Assistants had been in-serviced on the shower bed/chair for safety. She stated that she was responsible for orienting new nurses and nursing assistants on the safe operational procedure during shower bed/chair transport and use. The facility's immediate jeopardy removal date of 3/02/24 was validated.	F 726		
F 867 SS=D	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	F 867		3/6/24

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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.

§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

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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 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

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F 867	Continued From page 34 collection and analysis described in paragraphs (c) and (d) of this section. §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, observation, nurse practitioner, physician, and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee put into place following the recertification and complaint investigation survey of 4/20/23. This was for the deficiency in the area of Free of Accident hazards/Supervision/Devices (F689) that was subsequently recited on the current complaint investigation survey of 3/05/24. The continued failure of the facility during 2 federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included:	F 867	On 2/28/2023, The Facility Consultant initiated an audit of previous citations and action plans to include F689 Free of Accident Hazards/Supervision/Devices to ensure the QAPI committee has maintained and monitored interventions that were put into place. Action plans were revised and updated and presented to the QAPI Committee by QA Nurse for any concerns identified. The Facility Consultant will address all concerns identified during the audit to include but not limited to the education of staff. Audit was completed by 3/1/2024. On 3/1/2024, the Facility Consultant completed an inservice with the Administrator, Director of Nursing (DON)	

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	345487	A. BUILDING _____ B. WING _____	C 03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY POINT BAY NURSING AND REHABILITATION CENTER	110 MCCOTTER BOULEVARD HAVELOCK, NC 28532

(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 867	Continued From page 35 This tag is cross-referenced to: F689: Based on record review, observation, staff, nurse practitioner, and physician interviews, the facility failed to follow the manufacturer's instructions for the use of a mobile shower bed (a bed utilized for the provision of personal care for residents who are immobile or who have reduced mobility) and to provide care safely for 1 of 1 resident reviewed for supervision to prevent accidents. On 2/01/24 Nursing Assistant (NA) #1 transported Resident #1 to the shower room via the shower bed without utilizing the locking pins that secured the head and the foot of the bed in place. While transporting the resident to the shower room the foot of the shower bed released and dropped toward to the floor. NA #1 did not cease the transport. She continued to push the resident in the shower bed to the shower room. Once arriving in the shower room when the shower bed was wheeled over the drain in the floor, the bed became unsteady, began to tip to the side and the head of the bed released dropping toward the floor resulting in the resident falling off of the shower bed headfirst onto the floor. The resident sustained a small bruise to the back of her head and an abrasion to her lower back area. The resident was transported to the hospital on 2/01/24 at 11:01 AM. At the hospital on 2/02/24, the resident had a breakthrough seizure. During the recertification and complaint investigation survey of 4/20/23, the facility was cited for failure to provide a safe transfer by mechanical lift for a dependent resident. The facility also failed to prevent a cognitively impaired resident with known exit seeking behaviors from exiting the facility unsupervised.	F 867	and Quality Assurance (QA) Nurse regarding the Quality Assurance (QA) process to include implementation of Action Plans, Monitoring Tools and length of time for monitoring, the evaluation of the QA process, and modification and correction if needed to prevent the reoccurrence of deficient practice to include professional standards. Inservice also included identifying issues that warrant development and establishing a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA process. All newly hired Administrator, DON, and QA nurse will be educated during orientation regarding the QA Process. All data collected for identified areas of concerns to include F689 Free of Accident Hazards/Supervision/ Devices will be taken to the Quality Assurance Performance Improvement (QAPI) committee for review monthly x3 months then Quarterly x3 quarters by the Quality Assurance Nurse. The QAPI committee will review the data and determine if the plans of correction are being followed, if changes in plans of action are required to improve outcomes, if further staff education is needed, and/or if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by the QA Nurse. The Facility Nurse Consultant will review the QA meeting minutes monthly x3	

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F 867	Continued From page 36 An interview with the Administrator on 3/05/24 at 8:10 AM revealed that she believed that 1 month of monitoring was not sufficient to ensure the changes were sustained. She stated that moving forward the QAA committee will monitor longer than one month and evaluate whether the changes were sustained.	F 867	months then quarterly x3 quarters to ensure the QA committee has maintained and monitored interventions that were put into place for all current citations to include F689 Free of Accident Hazards/Supervision/Devices to ensure the QA committee has maintained and monitored interventions that were put into place. The Facility Consultant will immediately retrain the Administrator, DON and QA nurse for any identified areas of concern. The results of the Monthly Quality Assurance meeting minutes will be presented by the Quality Assurance Nurse to the QAPI Committee monthly x3 months then quarterly x3 quarters for review and the identification of trends, development of action plans as indicated, an/or to determine the need and/or frequency of continued monitoring	