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F 000	INITIAL COMMENTS A complaint survey was conducted on 6/19/24 through 6/20/24. Additional informationn was obtained remotely on 7/1/24. Therefore, the exit date was changed to 7/1/24. Event ID# J6OE11. The following intakes were investigated NC00217606, NC00218265, NC00217732, NC00214791. 1 of the 6 complaint allegations resulted in deficiency. Past non-compliance 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 reviews, Physician, staff and Resident interviews, the facility failed to provide a safe transfer when Nurse Aide (NA) #7 failed to utilize a mechanical lift when transferring Resident #2. She was transferred to hospital and diagnosed with a fractured femur. Resident #2 expressed the knee felt like it had been "bashed" and it was painful. This was for 1 of 3 residents reviewed for falls (Resident #2).	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 07/24/2024

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The findings included:

Resident #2 was admitted to the facility on 2/24/18 with diagnoses which included coronary artery disease, heart failure, end-stage renal disease and osteoporosis.

A review of the care plan that was revised on 9/20/23 revealed Resident #2 required full mechanical lift equipped with the green sling for all transfers with 2 staff during transfers.

A review of a quarterly Minimum Data Set (MDS) dated 2/24/24 revealed Resident #2 was cognitively intact and was dependent with transfers from bed to the chair.

Review of an incident report initiated dated 5/27/24 revealed Resident #2 was transferred with Nurse Aide #7 when Resident # 2 expressed discomfort in her left leg at the knee area and was lowered to the floor, by the Nurse Aide #7. Nurse #3 was notified, and Resident #2 was transported to hospital by Emergency Services.

Review of the hospital Emergency Department Physician note dated 5/26/24 revealed left knee pain after a fall that morning. The results of the X-ray revealed total knee joint replacement with intact hardware. No evidence of acute fracture or dislocation.

Record review of the medication order and administration record (MAR) for May 2024 revealed Resident #2 received Tramadol 50 MG (milligrams) by mouth every 6 hours for pain. On 5/27/2024 she received a dose at 6:00AM for a pain level of seven with effective relief. A dose of

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50MG was administered at 12:00 PM and 6:00 PM with a pain level of zero. On 5/28/27 at 12:00PM and 6:00AM doses were administered, for a pain level of zero. Resident #2 was out of the facility on 5/28/24 at 12:00PM. She returned to the facility, and she had a pain level of seven and was administered a dose of Tramadol 50 MG by mouth at 6:00PM, which was effective.

Review of hospital history and physical dated 5/29/24 revealed a CT scan (computed tomography scan was diagnostic imagining that used an x-ray and computers to view cross sections of the anatomy to identify injury) identified a fracture in the distal lateral left femoral metaphysis (a weight -bearing part of the lower end of the femur, or the thighbone, that forms the top of the knee joint). Resident #2 was not a candidate for surgery and was discharged back to the facility with a brace on her knee.

An interview via telephone on 6/19/24 at 2:29 PM Agency Nurse Aide #7 (NA) revealed this was the first time she had worked in this facility. She had finished Resident #2's morning bath, Resident #2 then asked to sit in the recliner. NA #7 stated she wanted to get help, but she felt pressured to move Resident #2 to the chair. Resident #2 stated that she could stand. She had Resident # 2 put her arms around her neck and stood her up. Resident #2 complained of knee pain and stated to sit her on the floor. Another NA came into the room and was asked by NA #7 to assist with moving Resident #2. The NA expressed that she would go get the nurse and did not assist with moving the resident. Resident #2 was sent to the hospital. NA #7 stated afterwards NA# 5 told her that Resident #7 used a mechanical lift for transfer. She indicated that being rushed was why

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she did not use a mechanical lift or ask for help.

An interview was conducted on 6/20/24 at 10:24 AM with Resident #2. She stated that NA #7 had finished her bath and she wanted to sit in the recliner. She told NA #7 to get help. NA #7 stated she didn't see anyone in the hall. Resident #2 stated she again told NA #7 to get the nurse to help. NA #7 looked out the door and stated she didn't see anyone. NA #7 moved the recliner from the bathroom to beside the bed and stood her up. When she stood up her knee hurt like someone had 'bashed' it. NA #7 put her on the floor and her knee 'hit' the floor and the pain was terrible. The nurse came into the room and called 911.

Interview with Nurse #3 on 6/20/24 at 11:38 AM revealed when she walked into Resident #2's room Resident #2 was sitting on the floor next to the bed, she stated that she knew Nurse Aide #7 was new and she told her she needed the mechanical lift and told her to get the nurse. NA #7 stated she did not have help. Nurse #3 stated NA #7 did not say why she did not use the mechanical lift.

An interview with Nurse Aide #5 on 6/20/24 at 11:42 AM revealed Nurse Aide #7 came out into the hall and asked for assistance, and when she entered the room, Resident #2 was on the floor. Nurse Aide #7 asked for help to get Resident #7 up off the floor. Nurse Aide #5 returned with Nurse #3, who called Emergency Services.

An interview with the facility Physician on 6/20/24 at 3:37 PM revealed after Resident #2 fell on 5/26/24 the hospital documentation revealed no injury to the knee. The pain was addressed with medication. Resident #2 continued to complain of

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knee pain the evening of 5/27/24 during a visit. Another x-ray with a mobile x-ray provider was ordered. The morning of 5/28/24 Resident #2 went to a scheduled appointment. Resident #2 returned to the facility with complaints of knee pain and was sent to a different hospital before the mobile x-ray was obtained. The CT scan identified a fracture. Resident #2 was not a surgical candidate, and a knee brace was continued. The Physician indicated that the facility provided appropriate care. The physician did state the fracture was a result of the fall on 5/26/24.

The facility provided the following Corrective Action Plan with a completion date of 6/3/24.

The facility identified concerns regarding Resident #2's fall caused by the lack of orientation education of Nurse Aide #7 that was required of all new agency staff.

1. Corrective action for resident(s) affected by the alleged deficient practice:

On 5/26/24 Resident #2 was immediately assessed by Nurse #3. The Medical Director and Patient Representative was notified, and orders were obtained to send Resident #2 to hospital for further evaluation. After hospital discharge 6/3/24 Resident #2 returned to the facility and remained in a knee brace and continued with pain medication ordered as needed.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice.

On 5/28/24 the Director of Nursing and

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Administrator identified residents that were potentially impacted by this practice by completing interviews with resident with BIMS of 13 or greater to identify any concerns of unreported falls or concerns with method used for transferring. This was completed on 5/28/2024. The results included: No identified concerns.

The Unit Manager completed body audits for residents with BIMS 12 or less to identify any concerns of post fall injuries and indications of any further falls or incidents that did not have a corresponding incident report. This was completed on 5/28/24. The results included: No identified concerns.

On 5/28/24 all residents were assessed for falls by the Director of Nursing, Assistant Director of Nursing or the MDS Coordinator. Then care plans were reviewed to ensure accuracy, task initiated and Kardex accuracy. This was completed on 5/29/2024. The results included: 15/70 residents noted with additional required interventions. On 5/28/2024 the facility Interdisciplinary team implemented corrective action for those residents which includes updated care plan and Kardex.

On 5/28/24 the Director of Nursing reviewed incident reports for the last 14 days to ensure that no other adverse events occurred due to inaccurate transfer status and that the MD and family were notified. This was completed on 5/28/2024. The results included: 0/9 residents were identified as having no concerns.

On 5/28/2024 the Director of Nursing and Staff Development Coordinator assessed all residents who sustained a fall in the past 14 days for

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adequate pain control and potential injuries. This was completed on 5/28/2024. The results included there were no identified concerns.
On 5/28/24 the Director of Nursing and Staff Development Coordinator reviewed resident progress notes for the past 14 days to ensure that incident reports were completed for fall events. This was completed on 5/28/2024. The results included: There were no identified concerns. On 5/28/24 the Director of Nursing and Interdisciplinary team determined no implemented corrective action were needed for those residents which includes completion of incident report, notification to Medical Director/Patient Representative and assessment for any change in condition.

3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:
On 5/28/24, the Staff development Coordinator began in servicing all full time, part time and prn Registered Nurses, Licensed practical Nurse, Nurse Aides and medication aide staff (including agency) on Transfer safety and Fall prevention and post fall process. This training will include all current staff including the agency. This training included:
- Importance of checking Kardex prior to any Resident Transfer
- How to check the Kardex
- Importance of following Kardex to ensure resident safety.
- Reporting adverse events
- What are the common causes of falls?
-Identifying Falls Risk
- General Falls Prevention Strategies
- What should I do if I see a resident fall or see a resident on the floor?
- Nursing immediate actions

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F 689	Continued From page 7 - Post Fall Documentation and Ongoing Assessment - Completing the incident report On 5/30/2024 Education was added for: - Handling resident behaviors - The Director of Nursing will ensure that any of the above-mentioned staff who does not complete the in-service training by 5/30/2024 will not be allowed to work until the training is completed. 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. 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 Director of Nursing will monitor by observation audits the transfer safety, and audits of fall prevention and Agency Orientation process weekly for 2 weeks and monthly for 3 or until resolved. Reports will be presented to the weekly Quality Assurance committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored, and an ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum data set Coordinator, Therapy, Health Information management, and the Dietary Manager. All items listed on this self-imposed action plan were complete and implemented on 5/28/24with	F 689		

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F 689	Continued From page 8 ongoing monitoring to ensure compliance. This includes the action plan and any potential citation associated with this action plan should be considered past noncompliance as of 6/3/24. The corrective action plan was validated on 6/20/24 and concluded the facility implemented an acceptable corrective action plan. Interviews conducted with staff revealed the facility provided education and training on patient transfers and the utilization of lifts. The ongoing monitoring audits were validated as completed on 6/3/24. The facility's corrective action plan's completion date was verified as 6/3/24.	F 689		
F 726 SS=G	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		7/2/24

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F 726	Continued From page 9 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 Physician, staff, resident interviews and record review the facility failed to ensure 1 of 4 agency Nurse Aides (NAs) interviewed were oriented on the first day of assignment to the facility kiosk system, Kardex and residents' transfer method. NA #7 did not use a mechanical lift with assistance to transfer Resident #2 to her recliner. Resident #2 was transferred to the hospital and diagnosed with a fractured femur. This was for 1 of 3 residents reviewed for falls (Resident #2). Findings included: This tag was cross referenced to F 689: Based on record reviews, Physician, staff and Resident interviews, the facility failed to provide a safe transfer when Nurse Aide (NA) #7 failed to utilize a mechanical lift when transferring Resident #2. She was transferred to hospital and diagnosed with a fractured femur. Resident #2 expressed the knee felt like it had been "bashed" and it was painful. This was for 1 of 3 residents reviewed for falls (Resident #2). An interview via telephone on 6/19/24 at 2:29 PM Agency Nurse Aide (NA) #7 revealed 5/26/24 was	F 726	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. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: F726 the facility failed to ensure 1 of 4 agency Nurse Aides (NAs) interviewed were oriented on the first day of assignment to the facility kiosk system, Kardex and residents' transfer method 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident was immediately assessed by nurse SC. Medical Director and Patient Representative was notified and orders were obtained to send resident to hospital for further evaluation.	

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F 726	Continued From page 10 the first time she had worked in this facility. NA #7 stated afterwards another NA# 5 told her that Resident #7 used a mechanical lift for transfer. She indicated she had no competency training prior to starting her assignment. An interview with the Scheduler on 6/20/24 at 9:15 AM revealed she did not have an orientation competency packet for NA #7. The Scheduler stated she had not prepared an orientation competency packet for the nursing staff to provide orientation training to NA #7 because she came in to replace another agency staff that called out. When an agency staff worked for the first time on a weekend or after hours, the charge nurse signed off with the agency staff on the orientation packets. The Scheduler confirmed Agency Nurse #3 was the charge nurse on 5/26/24. Interview with Agency Nurse #3 on 6/20/24 at 11:38 AM revealed she was the charge nurse on 5/26/24. On the weekends, a new agency staff had a packet at the nursing station, and she helped agency staff members to complete the orientation packet. The orientation packet included instructions on how to use the kiosk system (used to provide patient care information and view transfer information). NA #7 did not have an orientation packet as she was called in to cover a shift. During an interview on 6/20/24 at 4:44 PM the Assistamt Director of Nursing (ADON) indicated she had not come into the facility to complete an orientation packet with NA #7. The charge nurse in the facility was tasked with orientation. The ADON indicated NA #7 contacted the IT (information technology) department to get	F 726	2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 6/3/2024 the Nursing Scheduler under the direction of the Director of Nursing audited the past 7 days of agency staff that have worked to ensure Agency orientation was completed. This was completed on 6/3/24. The results included 10 of 21 agency staff have not received orientation. On 6/3/24 the Director of Nursing implemented corrective action to include completion of orientation packets with all agency staff currently on the working schedule as of 6.3.24. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 6/3/24 the Nurse Consultant educated the Director of Nursing, Staff development Coordinator, Administrator, and scheduler on the Agency Orientation Process. The Administrator will ensure that any of the above identified staff who does not complete the in-service training by 6/3/2024 will not be allowed to work until the training is completed. On 6/3/24, the education provided was the expectation to ensure all agency staff will be oriented to the facility and their duties before the start of their first shift. The Registered Nurse in facility or the designated-on call licensed Nurse will be present prior to start of assigned shift for new agency member to ensure completion of orientation checklist prior to the start of their first shift. The Nurse management team and Staff scheduler will review schedules daily to	

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F 726	Continued From page 11 access to the medical record and time clock. An interview on 6/20/24 at 8:45 AM with the Director of Nursing revealed when staff reported to work for the first time an orientation packet was reviewed and signed off by the agency staff and the Scheduler prior to the staff member working the floor. On weekends the charge nurse reviewed the packets with the agency staff before they began work. There was no orientation packet available for NA #7 on 5/26/24. An interview with the Administrator on 6/19/24 at 3:00 PM revealed all agency staff were trained with an orientation packet before work. The facility identified that Nurse Aide #7 did not get the orientation packet and was not trained by the Scheduler or the nursing staff. The Administrator explained there was no orientation packet available for NA #7 on 5/26/24, and it was a weekend. The procedure for training agency staff was put into place after this accident.	F 726	identify any new agency staff requiring orientation. 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 Director of Nursing will monitor the Agency Orientation process weekly for 2 weeks and monthly for 3 months or until resolved. Reports will be presented to the Quality Assurance committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum data set Coordinator, Therapy, Health Information management, and the Dietary Manager. The Director of Nursing Services and/or designee will verify on the next working business day that all orientation packets are completed to its entirety and logged. Date of Compliance: 7/2/24	