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	345092	A. BUILDING _____ B. WING _____	C 11/22/2024

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F 000	INITIAL COMMENTS The survey team entered the facility on 10/16/24 to conduct a complaint survey and exited on 10/17/24. The survey team returned to the facility on 11/22/24 to validate a corrective action plan and exited on 11/22/24. Therefore, the exit date was changed to 11/22/24. The following intake was investigated NC00222600. 1 of the 4 complaint allegation did result in deficiency. The 2567 was amended on 11/27/24 to reflect a change as result of IDR.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to safely assist a resident with incontinence care causing injury to 1 of 3 residents (Resident #1) reviewed for accidents. Resident #1 received care by Nurse Aide (NA) #1 and fell from her bed to the floor and sustained a closed fracture of the right hip. The findings included: Resident #1 was admitted on 08/24/24 with	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 11/29/2024

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diagnoses which included dementia, malnutrition, and osteoporosis.

Review of Resident #1's significant change Minimum Data Set (MDS) dated 09/10/24 revealed Resident #1 was severely cognitively impaired and required extensive assistance with two people assist for bed mobility. The MDS further revealed Resident #1 was not coded for any upper or lower extremity impairment.

Review of Resident #1's vital sign's dated 9/10/24 revealed Resident #1 weighed 97.3 pounds (lbs.).

Review of Resident #1's care plan revised on 09/18/24 revealed the resident had an activities of daily living (ADL) self-care performance deficit due to dementia. Resident #1 required extensive to total assistance with ADLs. Interventions included Resident #1 required staff participation to reposition and turn in bed and was a two person assist for ADLs.

Resident #1's care guide (undated) revealed the resident required staff participation to reposition and turn in bed and was a two person assist for ADLs.

A progress note dated 09/29/24 completed by Nurse #1 revealed Nurse Aide (NA) #1 had provided care and Resident #1 rolled off the bed onto the floor. The note further revealed Resident #1 was assessed and had a small skin tear to the left shoulder. According to the note, as needed pain medication was administered, responsible party was notified, on call provider was notified, and the hospice nurse was also notified and indicated they would assess the resident to determine if Resident #1 needed to seek

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emergency care.

A progress note dated 09/29/24 completed by Nurse #2 revealed Resident #1 was positive for a right femur fracture and was ordered to send the resident to the emergency room.

Resident #1's order dated 09/29/24 revealed to start morphine sulfate concentrate 10 mg (milligram) every 6 hours for pain for 24 hours and hold if blood pressure is lower than 85.

Review of hospital admission note dated 09/29/24 revealed Resident #1 was admitted to the hospital for a fall at the facility and obtained a closed fracture of the right hip. It was decided Resident #1 to receive orthopedic care management and not receive surgery. Resident #1 was discharged from the hospital and was discharged to another facility on 09/30/24.

A phone interview conducted with NA #1 on 10/16/24 at 3:15 PM revealed she consistently cared for Resident #1 and was normally a one person assist for bed mobility due to being so small. NA #1 further revealed it was around 6:00 AM and she was giving incontinence care to Resident #1 alone and had the resident sit up in bed. NA #1 indicated the resident was sitting up in bed but it was wet, so she decided to do a linen change and while removing a sheet the Resident rolled over to her side and fell off the bed to the left and landed on her right side. NA #1 stated it happened so fast that she was unable to catch her. NA #1 revealed she immediately yelled for staff and Nurse #1 entered the room and assessed the Resident. NA #1 stated Nurse #1 and she assisted Resident #1 back into bed. NA #1 indicated Resident #1 did not make facial

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expression or noises that she was in pain. NA #1 revealed once the Resident was in bed it was shift change and she left around 7:00 AM. It was further revealed to NA #1 by the Director of Nursing (DON) going forward that Resident #1 needed a second person for bed mobility assistance.

A phone interview conducted with Nurse #1 on 10/16/24 at 1:50 PM revealed on 09/29/24 at the end of 3rd shift she heard NA#1 yell out for assistance. Nurse #1 further revealed she went to Resident #1's room and found the resident laying on her right side on the left side of the bed. Nurse #1 indicated she assessed Resident #1 and found a small skin tear towards her right back shoulder with no other injuries. Nurse #1 indicated Resident #1 complained of pain in her feet but did not show any other signs of pain when assessed. Nurse #1 stated they transferred Resident #1 back into bed with a bed sheet and notified the hospice on call. Nurse #1 revealed she believed Resident #1 was a one person assist due to being so small. Nurse #1 stated NA #1 disclosed to her that she was giving incontinence care, and the resident fell off the bed when the NA turned her to dry her. Nurse #1 revealed she updated Nurse #2 at shift change and left her shift with the hospice staff coming to assess the resident.

An interview conducted with Nurse #2 on 10/16/24 at 12:10 PM revealed she worked first shift 09/29/24 at 7:00 AM and Nurse #2 disclosed Resident #1 had a fall from her bed and that hospice was on the way to assess the resident as well. Nurse #2 further revealed when hospice arrived Resident #1 had experienced pain in her right hip, and it was ordered for Resident #1 to

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have a x-ray completed. Nurse #2 stated a mobile x-ray was obtained and results showed a possible right femur fracture. Nurse #2 stated she notified the family and hospice and sent Resident #1 to the emergency room (ER).

A phone interview conducted with Hospice Director of Patient Services on 10/16/24 at 2:20 PM revealed on 09/29/24 hospice staff received a call Resident #1 had fallen from her bed and went out to the facility around 8:40 AM. It was further revealed hospice nurse assessed Resident #1 and observed bruising on right hip and was very tender to the touch. The Hospice Director of Patient Services stated orders were obtained for mobile x-rays to be completed which resulted in a right femur fracture. It was revealed Resident #1 was admitted to hospice on 09/04/24.

A phone interview conducted with the Nurse Practitioner (NP) on 10/17/24 at 9:40 AM revealed Resident #1's health had declined mentally and physically. The NP further revealed Resident #1 was small and recalled her being a one person assist. The NP stated after the incident on 09/29/24 the facility spoke to her about the incident. The NP revealed Resident #1 had osteoporosis and was fragile due to decline of health.

An interview conducted with the DON dated 10/17/24 at 10:20 AM the DON stated Resident #1 was not alert and oriented and laid on an air mattress. The DON further revealed she expected staff to follow resident care guides and keep residents safe when giving care. The DON indicated in-service was completed the next day with nursing staff.
An interview conducted with the Administrator on

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10/17/24 at 11:00 AM the Administrator revealed Resident #1 was coded and documented to be a two person assist and she expected for nursing staff to follow that.

The administrator provided the following Corrective Action Plan.

· Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
On 9/28/2024 Resident #1 rolled off of the bed and on to the floor while Certified Nursing Assistant (CNA) #1 was turning the resident on her side to provide care. Resident #1 was assessed by the nurse and had a small skin tear to the left shoulder. Nurse administered pain medication, responsible party was notified, on call provider was notified, and the hospice nurse was also notified and indicated they would assess to determine if Resident #1 needed to seek emergency care. Mobile x-ray of Resident #1 right hip and pelvis were obtained at the facility revealing an intertrochanteric fracture of the right femur. Resident #1 was sent to the emergency department for further evaluation and treatment of an intertrochanteric fracture of the right femur. Hospital x-rays confirmed right femur fracture. Resident discharged to a hospice house from hospital on 09/30/2024.

· Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
Residents care planned for maximum assistance of 2 people with activities of daily living (ADL) have been identified as having the potential to be affected by the deficient practice. The Director of Nursing (DON) and Unit Managers completed an

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audit of current residents with a care plan of maximum assistance of 2 people with ADLs, and 35 residents were identified to have the potential to be affected by the deficient practice by requiring maximum assistance of 2 people with ADLs. An audit was conducted 10/01/2024 to verify by observation that residents were provided the correct assistance with ADL care and bed mobility. No other residents were found to be affected as ADL care was provided by maximum assistance of 2 people for the 35 residents identified. Residents were interviewed while observations were completed, and none had concerns regarding with ADL care or assistance. DON, Assistant Director of Nursing (ADON), and Unit Managers will complete an assessment of residents upon admission, quarterly, and any change in condition will be re-assessed for any change required during ADL care assistance. Assessment will ensure if any changes are identified, care plan will be updated and referral to therapy if necessary.

· Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
Root cause analysis revealed Resident #1 was care planned for maximum assistance of 2 people however CNA #1 was providing care alone. Education was completed on 9/29/2024 with CNA #1 and on 10/01/2024 with current CNA staff by the Staff Development Coordinator (SDC). Certified Nursing Assistants (CNA) were educated on ADL care and bed mobility for residents that require maximum assistance of 2 people for safety. CNAs and newly hired CNAs or agency CNAs that did not receive the education will receive education prior to his/her next scheduled shift.

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· Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and
Quality assurance performance improvement (QAPI) committee met on 09/30/2024 and reviewed residents with ADL care that require maximum assistance and bed mobility. Plan for improvement was accepted by the committee. Results of audits and education will be presented by DON or ADON at QAPI committee for three months. Observational rounds during ADL care and ADL care plans were reviewed by administrative nurses to identify the amount of assistance required for residents on 10/01/2024. Administrative nurses will audit through observation 10 residents per week for twelve weeks to verify that ADL and bed mobility with maximum assist residents is completed correctly.

The facility was in compliance effective 10/02/2024.

An onsite validation of the facility's Corrective Action Plan was complated on 11/22/24. A review of the Bed Mobility Audit dated 10/1/24 revealed the audt was completed and there were no concerns. Reviewed education dated 10/1/24: Nursing Assistants (NAs) were to check the residents Kardex prior to providing care to ensure the correct amount of assistance is being provided. If a resident was care planned for maximum assistance of 2 people then 2 people must be present while providing Activity of Daily Living (ADL) care/bed mobility. Reviewed Inservice sign-in sheets with staff signage with dates of 9/30/24 & 10/1/24 and NAs were found to be trained. Reviewed bed mobility audit sheets dated 10/4/24, 10/8/24, 10/15/24, 10/25/24,

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F 689	Continued From page 8 11/1/24, 11/4/24, 11/11/24, and 11/19/24. No concerns were identified. Resident #1 discharged to hospital on 9/29/24. Reviewed falls for 2 residents and no concerns were identified. Staff interviewed and they were able to verbalize education training provided in reference to providing care to ensure the correct amount of assistance needed for ADL care/ bed mobility. The facility was validated as being back into compliance as of 10/2/24.	F 689		