STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345523	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ramseur Rehabilitation and Healthcare Center	**7166 JORDON ROAD , RAMSEUR, North Carolina, 27316**

(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
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 7/28/25 through 8/1/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1D190C-H1.	E0000		08/16/2025
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 7/28/25 through 7/31/25. Event ID# 1D190C-H1. The following intakes were investigated: 874730,874737, 874740, 874739, 874738, 874732, and 874728 2 of the 22 complaint allegations resulted in deficiency.	F0000		08/16/2025
F0580 SS = G	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; 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	F0580	"Past Noncompliance - no plan of correction required"	08/02/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0580 SS = G	Continued from page 1 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 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 and Physician interviews, the facility failed to notify the Physician when a STAT (immediately or urgently) x-ray was not completed as ordered for a resident that had right hip pain after a fall on 2/22/25. The order for the x-ray was called to the mobile x-ray provider the evening of 2/22/25. The nurse assigned to the resident on 2/23/25 contacted the mobile x-ray provider to follow up about the STAT x-ray order around 5:00 PM but did not notify the Physician the STAT x-ray had not been completed. Another nurse contacted the mobile x-ray provider on 2/24/25 and the x-ray was completed that afternoon and noted Resident #90 had a displaced right femoral neck fracture (a break in the upper part of the femur [thigh bone],near the hip joint, where broken bone fragments have moved out of their normal alignment). The lack of	F0580		

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F0580 SS = G	Continued from page 2 notification resulted in a delay of an evaluation at the hospital for stabilization or surgery for the fracture until 2/24/25. The deficient practice occurred for 1 of 4 residents reviewed for notification of changes (Resident #90). Findings included: Resident #90 was admitted to the facility on 01/17/25 with diagnoses that included dementia, hypertension and protein calorie malnutrition. Resident #90's admission Minimum Data Set (MDS) dated revealed he had cognitive impairment. A review of Resident #90's fall report dated 02/22/25 read in part, Resident was ambulating unassisted and lost his balance and fell landing on their right side, range of motion completed and movement of extremities without difficulty. The report read further Resident complained of (c/o) right hip pain. A review of Nurse #1's progress note dated 02/22/25 read in part, "Nurse Practitioner (NP) notified at 10:24pm. Received new order for x-ray 2 view right hip STAT x-ray order through mobile company at 10:30pm." On 07/30/25 at 1:39 pm an interview was conducted with Nurse #1 (worked 7p-7a on 02/22/25) and she indicated Resident #90 had a fall on 02/22/25 that was witnessed. She indicated, Resident complained by moaning of right hip pain, however he was able to move all extremities without difficulty, and when she called the NP, she received an order to do a STAT x-ray of right hip. Nurse #1 stated, "I did report off to oncoming nurse of fall, pain in his hip, and not getting the x-ray, and called the x-ray company with the order." Nurse #1 indicated the portable/mobile x-ray company did not come during her shift. A review of Nurse #2's progress noted dated 02/23/25 read in part, "Resident status post (S/P) fall with no injures, c/o right hip area pain, awaiting on portable x-ray for 2 view x-rays of right hip area, in bed resting with eyes closed, respirations even with no distress noted, continue to monitor." An interview was conducted with Nurse #2 (worked 7a-7p shift on 02/23/25) on 07/29/25 at 3:28 pm. Nurse #2 indicated the 3rd shift nurse had called the portable/mobile x-ray company on the night of 02/22/25. She indicated she had contacted the portable/mobile company for the x-ray on 02/23/24 around 5 pm because they had not arrived and the representative that she	F0580		

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F0580 SS = G	Continued from page 3 spoke with stated the dispatcher would call her back to give the time they would arrive to perform the x-ray. Nurse #2 reported she was not aware the order for the x-ray was STAT and did not receive a return call from the portable/mobile x-ray company. Nurse #2 indicated she did not notify the Physician/NP that the STAT order had not been performed as she was waiting for a return call from the dispatcher from the portable/mobile company. A review of Nurse #3's progress note dated 02/24/25 read in part. "Resident has been in bed this am resting, and staff went to get him out of bed (OOB) he grimaced with pain. The writer spoke with portable/mobile about stat x-ray, and they stated it depends on quality and severity of STAT x-ray, and they will continue to reschedule. She informed me of estimated time of arrival (ETA) time today is between 1-3 pm. Resident was administered acetaminophen for pain and discomfort. Staff will continue to monitor." A review of the radiology results report dated 02/24/25 revealed findings as follows: fracture of the right femoral neck (right hip bone) with displacement of the distal fragment. Femoral head appropriately positioned Conclusion: acute, displaced right femoral neck fracture as noted. On 07/30/25 at 1:07 pm an interview was conducted with Nurse #3 (worked 02/24/25 7a-7p shift) and she indicated Resident #90's x-ray had not been performed and she called the portable/mobile x-ray company to see why it had not been done. She stated the x-ray representative she spoke with indicated they would be out that day to perform the x-ray. Nurse #3 indicated the portable/mobile x-ray company arrived around 2:30 pm and performed the x-ray and it was revealed Resident had a fracture to his right hip. She stated she called and informed the Nurse Practitioner and received orders to send Resident out to the hospital due to the x-ray results. Nurse #3 stated she also informed the Residents' responsible party of x-ray results and the order to send him to the hospital. An interview was conducted with a Representative from the portable/mobile x-ray company on 07/31/25 at 9:54 am and she indicated the turn around time for a STAT x-ray was 4 to 6 hours from the time the order was received and the x-ray technician was on site. The Representative indicated a x-ray technician was unable to get in the door of facility early in the morning on 02/23/25 due to it being locked and no one answered the phone when the x-ray technician called the facility. She indicated they implemented a protocol to use back	F0580		

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F0580 SS = G	Continued from page 4 up numbers to reach facility staff if unable to get into the facility. An interview was conducted with the Director of Nursing (DON) on 07/20/25 at 1:26 pm and she indicated on 02/24/25 she was informed Resident #90 had a fall on 02/22/25 and had orders for an x-ray to be performed due to right hip pain. She stated she was informed by Nurse #3 the x-ray had not been performed, and they would be coming out that day to do the x-ray. The DON indicated the NP was in the facility and evaluated the Resident and according to the NP the Resident wasn't in any distress at the present time and did not present with any pain when she evaluated him and that it would be ok to wait for the portable/mobile x-ray to come. She stated the protocol now was anybody that had a fall with pain would be sent to the hospital. The DON also stated she called the portable/mobile company and spoke with the director, and a plan was implemented going forward. An interview was conducted with the Physician on 07/3/25 at 9:01 am and he indicated the NP evaluated Resident #90 on 02/24/25 and he was not experiencing pain at that time. The Physician indicated the staff provided the appropriate care for the Resident. He stated, "He had chronic diseases, osteoporosis, which is a bone disease that could cause problem with fractures". The physician indicated communication would have been good as far as the x-ray not being performed STAT. He stated, "in my opinion it was no delay in care, I was ok with the care the staff provided." The facility provided the following corrective action plan: 1. Adress how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 2/24/2025 facility identified that a Stat X-Ray for Resident #90 was not completed, and the facility failed to notify the physician/nurse practitioner of delay in X-Ray services. The facility failed to notify the MD/NP of delay in X-Ray services until 2/24/2025. Resident #90 discharged from the facility on 2/24/25. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with falls have the potential to be affected. Per policy all residents that fall require MD/NP notification:	F0580		

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F0580 SS = G	Continued from page 5 On 2/24/2025 all nursing staff, including Certified Nursing Assistants and Licensed Nurses that had been scheduled on 2/22/2025 from 7pm-7am were interviewed, by the Director of Nursing, concerning any changes in condition for residents during the shift needing provider notifications or updates of previously identified changes of condition to the provider. No concerns beyond Resident #1 were identified. On 2/24/2025 the Director of Nursing reviewed the 24-hour reports/Progress notes for the last 30 days for all current residents with falls to ensure the physician/nurse practitioner were notified of all falls and notified of any delay in obtaining X Rays. No concerns were identified. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 2/24/2025 the Director of Nursing educated the Licensed Nurses, including agency Licensed Nurses on falls management program, process change for stat x-ray orders, including sending residents to the Emergency Department if needing a stat x-ray/change in condition/pain after a fall, notification of physician/nurse practitioner for any falls, delay in treatment/services from outside vendors. This education was completed on 2/25/2025. Any nursing staff that were not educated will receive this education prior to their next shift, from the Director of Nursing. This education will be added to the facility orientation program for licensed nurses, including new agency staff and will be the responsibility of the Director of Nursing/Assistant Director of Nursing or Nurse Manager. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Quality assurance performance improvement (QAPI) committee met on 02/25/2025 to determine need for monitoring. Beginning 2/26/2025 The Director of Nursing/Designee will review the 24-hour report 5 times a week, including all 7 days of the week, for 12 weeks to ensure provider notification of changes in condition and ensure the provider receives updates if diagnostic/laboratory testing had not been obtained per order. Beginning 3/1/2025 on the weekends, the charge nurse was assigned to contact the Director of Nursing or	F0580		

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F0580 SS = G	Continued from page 6 On-call nursing manager that includes the unit manager, Assistant Director of Nursing and Wound Care Nurse in addition to notifying the provider of any delays in X-Ray Services, diagnostic or laboratory testing. Beginning 2/28/2025, the Director of Nursing, Administrator, Nurse Practitioner and Medical Director will have weekly meetings to ensure that the providers have been updated timely. Alleged date of compliance: 2/26/25. An onsite validation of the facility's Corrective Action Plan was completed on 7/31/25. Reviewed education dated 2/24/25 through 2/25/25 of Licensed Nurses on falls management program, process change for stat x-ray orders, including sending residents to the emergency department if needing a stat x-ray/change in condition/pain after a fall, notification of physician/nurse practitioner for any falls, delay in treatment/services from outside vendors. Reviewed Inservice sign-in sheets with staff signage with dates of 2/24/25 through 2/25/25 and staff were found to be trained. Reviewed audit sheets for weeks 1-12 with dates 2/24/25 through 5/16/25 and no concerns were identified. Resident #90 was discharged to hospital on 2/22/25. Reviewed notification for 3 sampled residents and no concerns were identified. Staff interviewed were able to verbalize education training provided in reference to residents with process change for stat x-ray orders, including sending residents to the emergency department if needing a stat x-ray/change in condition/pain after a fall, notification of physician/nurse practitioner for any falls, delay in treatment/services from outside vendors. The corrective action plan's compliance date of 2/26/25 was validated.	F0580		
F0641 SS = B	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F0641	The preparation and/or execution of this plan of correction does not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. This plan is submitted as evidence of our compliance. F641: Accuracy of Assessments Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:	08/02/2025

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F0641 SS = B	Continued from page 7 §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to accurately code Minimum Data Set (MDS) assessments for 2 of 23 residents reviewed for MDS accuracy (Resident #8 and Resident #14). The findings included: a. Resident #8 was admitted to the facility 11/2/2024 with diagnoses including schizoaffective disorder, bipolar type. Review of the physician orders for Resident #8 included an order dated 12/31/24 Haloperidol (an antipsychotic medication) 100 milligrams (mg) to be administered intramuscularly (injection into the muscle) one time per month. Review of the medication administration record revealed Resident #8 received Haloperidol in June and July 2025. The quarterly MDS assessment dated 7/24/25 documented Resident #8 did not take antipsychotic medications.	F0641	Continued from page 7 The identified MDS assessments for resident #8 Antipsychotic medication coding was corrected by the MDS Coordinator and resubmitted on 7/30/25. The identified MDS assessments for resident #14 insulin medication coding was corrected by the MDS Coordinator and resubmitted on 7/30/25. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. A whole house audit was conducted by the Regional Clinical Director of Reimbursement and MDS coordinator for all resident's last ARD on 7/31/25. The audit identified ten assessments that were corrected and transmitted 8/1/25. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The facility MDS team were educated by the Regional Director of Clinical Reimbursement on the RAI manual for accuracy of coding related to insulin and antipsychotic medications on 7/30/25. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Regional Director of Clinical Reimbursement/designee will audit 10 Minimum Data Set (MDS) weekly assessments for 12 weeks to ensure accuracy of coding for insulin and antipsychotic medications. The Regional Director of Clinical Reimbursement or designee will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits. The Administrator will be responsible for this plan of correction. Indicate dates when corrective action will be completed: 8/1/25 Date of Compliance 8/2/25	

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F0641 SS = B	Continued from page 8 b. Resident #14 was admitted to the facility 10/30/24 with diagnoses including obesity. Review of the physician orders for Resident #14 included an order dated 3/14/25 for semaglutide (a medication used to facilitate weight loss) weekly subcutaneously (into the fatty tissue). This order was modified on 6/9/25 to administer 1 mg every Monday for weight loss. Review of the medication administration record revealed Resident #14 received the semaglutide injection every Monday in June and July 2025 as ordered. The quarterly MDS dated 7/24/25 documented Resident #14 received 1 injection of insulin in the 7-day look-back period. Review of the physician orders for Resident #14 revealed no orders for insulin. The MDS coordinator (MDS Nurse #1) was interviewed on 7/30/25 at 2:29 PM. MDS Nurse #1 reviewed the assessments for Resident #8 and Resident #14 and agreed that Resident #8 should have been coded for antipsychotic medications, and Resident #14 should not have been coded for insulin. MDS Nurse #1 reported that MDS Nurse #2 had completed those assessments for Resident #8 and Resident #14. An attempt was made to interview MDS Nurse #2, but no response was received from voice messages or text messages sent. The Administrator was interviewed on 7/30/25 at 2:40 PM and she reported she did not know why the MDS for Resident #8 and Resident #14 were coded incorrectly, and she expected all MDS assessments to be accurate.	F0641		
F0684 SS = G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F0684	The preparation and/or execution of this plan of correction does not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. This plan is submitted as evidence of our compliance. F684 Quality of Care Address how corrective action will be accomplished for	08/16/2025

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F0684 SS = G	Continued from page 9 This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and staff and Physician interviews, the facility failed to provide immediate medical evaluation and treatment when Resident #90 fell and complained of right hip pain on 2/22/25. Nurse #1 notified the Nurse Practitioner and received an order for a STAT (immediately or urgently) of the right hip on 2/22/25. The x-ray was not completed until 2/24/25 and the results revealed a displaced right femoral neck fracture (a break in the upper part of the femur [thigh bone], near the hip joint, where the broken bone fragments have moved out of their normal alignment). In addition, nurses failed to document thorough ongoing assessments of the resident's condition and staff continued to turn and reposition the resident in the bed which was painful for the resident. Resident #90 was sent to the hospital for an evaluation on 2/24/25 and x-rays confirmed the displaced right femoral neck fracture. Initially the Orthopedic surgeon considered operating on Resident #90 but then further evaluating determined Resident #90 was a very high risk for surgery and would not do well postoperatively due to his significantly worsening dementia, severe protein calorie malnutrition, and already having frequent falls. After having long conversation with the family member hospice was consulted and Resident #90 was transferred to hospice services from the hospital on 2/27/25. The deficient practice occurred for 1 of 4 residents reviewed for falls (Resident #90). Findings included: Resident #90 was admitted to the facility on 01/17/25 with diagnoses that included dementia, hypertension and protein calorie malnutrition. Resident #90's admission Minimum Data Set (MDS) dated revealed he had severe cognitive impairment and needed partial/moderate assistance with eating, substantial/maximum assistance with toileting hygiene assistance, shower/bath, personal hygiene, substantial/maximum assistance to dependent assistance with transfers, dependent with walking, and supervision/touching assistance with bed mobility. A review of Resident #90's care plan last revised 02/20/25 revealed Resident was at risk for falls. The goal was Resident would be free from falls and free of minor injuries. The Interventions read in part, Resident would be kept in areas of observation while awake, anticipate and meet the Resident's needs, prompt	F0684	Continued from page 9 those residents found to have been affected by the deficient practice: Resident #90 was discharged to the hospital on 2/24/25 and did not return to the facility. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents with falls have the potential to be affected. On 8/15/2025 all residents with a BIMs score (Brief Interview for Mental Status) below 13 had a skin assessment completed by Licensed Nurses to include the identification of pain. No concerns were identified. On 8/15/2025 all residents with a BIMs score (Brief Interview for Mental Status) 13 and greater were interviewed concerning abuse and neglect in addition to pain by the Director of Nursing. No concerns were identified. On 8/15/2025 the Director of Nursing reviewed all current residents with orders for Mobile X-Ray for the last 30 days to ensure completion in a timely manner per physician orders. No concerns were identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 8/15/2025 the Director of Nursing educated the Licensed Nurses, including agency Licensed Nurses on falls management program, process change for stat x-ray orders, including sending residents to the Emergency Department if needing a stat x-ray/change in condition/pain after a fall, notification of physician/nurse practitioner for any falls, notifying the Director of Nursing for any/all resident falls. This education was completed on 8/15/2025. Any nursing staff that were not educated will receive this education prior to their next shift, from the Director of Nursing. This education will be added to the facility orientation program for licensed nurses, including new agency staff. On 8/15/2025 the Director of Nursing educated the Licensed Nurses and Certified Nursing Assistants, including agency on turning and repositioning residents who are in pain. If a resident is noted to be in pain when bed mobility is being performed, the Certified Nursing Assistant will need to immediately notify the	

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F0684 SS = G	Continued from page 10 response to requests for assistance, nonskid strips to be applied to left side of bed on floor, keep bed in lowest position, staff to offer toileting assistance during periods of restlessness, offer toileting prior to meals and bedtime, ensure proper footwear (nonskid socks/shoes) in place while awake, anti-rollbacks to wheelchair, bariatric bed with bolster, dycem (non-slip material) to wheelchair, provide diversional activities during periods of restlessness. A review of Resident #90's fall report dated 02/22/25 read in part, Resident was ambulating unassisted and lost his balance and fell landing on their right side, range of motion completed and movement of extremities without difficulty. The report read further residents complained of (c/o) right hip pain. A review of Nurse #1's progress note dated 02/22/25 at 10:40 pm read in part, "Resident noted on the floor laying on his right side at 10:00pm. Fall was witnessed. Resident was noted ambulating unassisted and lost his balance and fell landing on his right side. The Resident did not hit his head. The Resident assisted off the floor x 2 staff. Resident c/o right hip pain. Temperature 97.3, respiration 18, blood pressure 144/94, pulse 60, oxygen saturation 94% on room air. Resident assisted to bed x 2 staff. As needed (PRN) acetaminophen administered 325 milligrams (mg) x 2 tablets administered for pain. Nurse Practitioner notified at 10:24pm. Received new order for X-ray 2 view right hip STAT. X-ray order through mobile company at 10:30 pm. Resident responsible party notified at 10:35 pm. No signs or symptoms (s/s) of acute distress noted. Will continue to monitor. Call light within reach." A review of Nurse #1's progress note dated 02/23/2025 at 4:58 am read in part, "Resident status post (s/p) witnessed fall. No pain or discomfort. No apparent injuries noted. Able to move all extremities without any difficulty. Will continue to monitor." On 07/30/25 at 1:39 pm an interview was conducted with Nurse #1 (worked 7:00 pm to 7:00 am on 02/22/25) and she indicated Resident #90 had a fall on 02/22/25 that was witnessed. She indicated, Resident complained by moaning of right hip pain, however he was able to move all extremities without difficulty, and she administered acetaminophen as ordered for the pain in right hip after the fall. Nurse #1 indicated she called the NP and received an order to do a STAT x-ray of right hip. Nurse #1 stated, "I did report off to oncoming nurse of fall, pain in his hip, and not getting the x-ray, and called the x-ray company with	F0684	Continued from page 10 Licensed Nurse for additional instruction and assessment. The Licensed Nurse will contact the Director of Nursing and Provider for additional recommendations. This education was completed on 8/15/2025. Any nursing staff that were not educated will receive this education prior to their next shift, from the Director of Nursing. This education will be added to the facility orientation program for licensed nurses and Certified Nursing Assistants including new agency staff. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing/Designee will review all orders for mobile x-rays during clinical meetings 5 times a week for 12 weeks to ensure x-rays are completed in a timely manner per physician orders. The Director of Nursing/Designee will review all falls during clinical meetings 5 times a week for 12 weeks to ensure staff address pain, bed mobility needs with pain and timely evaluation of falls with pain. The Director of Nursing/Designee will be responsible for reporting the results of these audits to the Quality Assurance Performance Improvement Committee monthly x 3 months. The Quality Assurance Performance Improvement Committee will make recommendations based on the findings of these audits. The Director of Nursing will be responsible for this plan of correction. Indicate dates when corrective action will be completed: 8/15/25 Date of Compliance 8/16/25	

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F0684 SS = G	Continued from page 11 the order." Nurse #1 indicated the portable/mobile x-ray company did not come during her shift. Unable to contact Nursing Assistant #3 (NA) (worked 02/22/25 7p-7a). A review of the electronic medication administration record (EMAR) revealed Resident #90 received acetaminophen tablet 325 mg 2 tablets by mouth for s/s of pain/discomfort to right hip/leg on 2/23/2025 at 8:10 am. A review of Nurse #2's progress noted dated 02/23/25 at 10:13 am read in part, "Resident status post (s/p) fall with no injuries, c/o right hip area pain, awaiting on portable x-ray for 2 view x-rays of right hip area, in bed resting with eyes closed, respirations even with no distress noted, continue to monitor." A review of the EMAR revealed Resident #90 received acetaminophen tablet 325 mg 2 tablets by mouth for mild pain: s/s of pain to right hip/leg on 02/23/25 at 5:30 pm. An interview was conducted with Nursing Assistant #1 (NA) (worked 02/23/25 7a-7pm) on 07/30/25 at 10:16 am. She indicated she provided activities of daily living (ADL) care with Nurse #2 on Resident #90 and he exhibited "some" pain during movement. She indicated Resident stayed in bed and rested quietly during the shift. An interview was conducted with Nurse #2 (worked 7:00 am to 7:00 pm shift on 02/23/25) on 07/29/25 at 3:28 pm. She indicated Resident #90 exhibited pain only when he was moved in bed and she administered pain medication as ordered. She stated he was able to move his extremities and there was no bruising, rotation or shortening of right leg. Nurse #2 indicated the 3rd shift nurse had called the x-ray company on the night of 02/22/25. She indicated she had contacted the portable/mobile company for the x-ray around 5:00 pm because they had not arrived and the representative that she spoke with stated the dispatcher would call her back to give time they would arrive to perform the x-ray. Nurse #2 stated she was not aware that the order for the x-ray was STAT. Nurse #2 indicated Resident did not get out of bed during the shift. A review of the EMAR revealed Resident #90 received acetaminophen tablet 325 mg by mouth for mild pain on 02/24/25 at 6:38 am. A review of Nurse #3's progress note dated 02/24/25 at	F0684		

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F0684 SS = G	Continued from page 12 1:17 pm read in part, “Resident has been in bed this am resting, and staff went to get him out of bed (OOB) he grimaced with pain. The writer spoke with portable/mobile about stat x-ray, and they stated it depends on quality and severity of STAT x-ray, and they will continue to reschedule. She informed me of estimated time of arrival (ETA) time today is between 1:00 and 3:00 pm. Resident was administered acetaminophen for pain and discomfort. Staff will continue to monitor.” A review of the EMAR revealed Resident #90 received acetaminophen tablet 325 mg 2 tablets by mouth for mild pain noted for grimacing upon movement on 02/24/25 at 1:24 pm. An interview was conducted with NA #2 (worked 7:00 am to 7:00 pm on 02/24/25) on 07/30/25 at 10:42 am. She indicated she as assigned to Resident #90 on 2/24/25 and when she provided ADL care to the resident he exhibited pain in his right leg when she would turned him. NA # indicated Resident would moan when turned and repositioned. She indicated she did not attempt to get the Resident out of bed because they were waiting for the x-ray company to come to x-ray his right leg due to the fall on 02/22/25. On 07/30/25 at 1:07 pm an interview was conducted with Nurse #3 (worked 02/24/25 on the 7:00 am to 7:00 pm shift) and she indicated she had assessed Resident # 90, and he did not appear to be in pain except during movement of his right leg. She stated Resident #90’s x-ray had not been performed and she called the portable/mobile x-ray company to see why it had not been done. She stated the x-ray representative she spoke with indicated they would be out to perform the x-ray that day between 1:00 and 3:00 pm. Nurse #3 indicated the portable/mobile x-ray company arrived around 2:30 pm and performed the x-ray and it was revealed Resident had a fracture of his right hip. She stated she called and informed the Nurse Practitioner and received orders to send Resident out to the hospital due to the x-ray results. Nurse #3 stated she also informed the Residents’ responsible party of x-ray results and the order to send him to the hospital. Nurse #3 indicated Resident did not get out of bed during the shift until he transferred to the hospital. A review of the Nurse Practitioner note dated 02/24/25 read in part, "Resident seen for recent fall with injury. He was saw ambulating in the hallway when he fell and landed on his right side. He did not hit his heard. x-ray of the right hip was ordered 02/22/25. Comorbidities: hypertension (HTN), dementia, physical	F0684		

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F0684 SS = G	Continued from page 13 deconditioning. Resident was sitting comfortably in no acute distress. Due to impaired cognition, resident is unreliable historian; information obtained through chart review and discussion of clinical staff. No complaints of pain or discomfort. No chest pain, shortness of breath, palpitations, cough. No other cardiopulmonary, gastrointestinal (GI), genitourinary (GU) signs or symptoms. Normal appetite, sleep, bowel and bladder functions. Musculoskeletal: no joint deformity, swelling, redness, pain, muscle weakness. Unable to contact Nurse Practitioner due to family medical leave. A review of the radiology results report dated 02/24/25 revealed findings as follows: fracture of the right femoral neck (right hip bone) with displacement of the distal fragment. Femoral head appropriately positioned. Conclusion: acute, displaced right femoral neck fracture as noted. A review of the emergency department (ED) report dated 02/24/25 read in part, “Patient sent from rehabilitation facility with concerns for a broken hip. Patient slipped and fell landing on the right side, 2 days ago, since then he has not been bearing weight. Today the facility x-rayed and claimed the hip is broken. Patient has advanced dementia and provides no history.” Further review of ED report read in part, “Exam of extremities: internal rotation of the right hip with noted deformity in the right foot, leg shortened on right side, calves are non-tender to palpation.” A review of hospital history and physical dated 02/24/25 read in part, “Physical exam of musculoskeletal (muscles, bones, tendons, ligaments, joints, and cartilage): right hip painful to movement.” Further review of hospital report read in part, “Assessment and Plan (A/P): closed acute right hip fracture (a bone break with skin intact) from mechanical fall. Orthopedic surgery consulted, initially Orthopedic was thinking of operating on patient but then further evaluating the case it was felt patient is very high risk for surgery and will not do well postoperatively due to his significantly worsening dementia, severe protein calorie malnutrition, already having frequent falls. After having long conversation with family member hospice consulted.” An interview was conducted with a Representative from the portable/mobile x-ray company on 07/31/25 at 9:54 am and she indicated the turn around time for a STAT	F0684		

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F0684 SS = G	Continued from page 14 x-ray was 4 to 6 hours from the time the order was received and the x-ray technician was on site. The Representative indicated a x-ray technician was unable to get in the door of facility early in the morning on 02/23/25 due to it being locked and no one answered the phone when the x-ray technician called the facility. She indicated they implemented a protocol to use back up numbers to reach facility staff if unable to get into the facility. An interview was conducted with the Director of Nursing (DON) on 7/31/25 at 1:26 pm and she indicated on 02/24/25 she was informed Resident #90 had a fall on 02/22/25 and had orders for a x-ray to be performed due to right hip pain. She stated she was informed by Nurse #3 the x-ray had not been performed, and they would be coming out on that day to do the x-ray. The DON indicated the NP was in the facility and evaluated the Resident and according to the NP the Resident wasn't in any distress at the present time and did not present with any pain when she evaluated him and that it would be ok to wait for the portable/mobile x-ray to come. She stated the protocol now was anybody that had a fall with pain would be sent to the hospital. The DON also stated she called the portable/mobile company and spoke with the director, and a plan was implemented going forward. An interview was conducted with the Physician on 07/31/25 at 9:01 am and he indicated the NP evaluated Resident #90 on 02/24/25 and he was not experiencing pain at that time. The Physician indicated the staff provided the appropriate care for the Resident. He stated, "He had chronic diseases, osteoporosis, which is a bone disease that could cause problem with fractures". He stated, "communication would have been good as far as the x-ray not being performed STAT." The Physician also stated, "in my opinion it was no delay in care, I was ok with the care the staff provided." The facility provided a corrective action plan that was not approved due to not including audits or monitoring.	F0684		