STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345215	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Trace Nursing and Rehabilitation Center	250 Lovers Lane , Washington, North Carolina, 27889

(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
F0000	INITIAL COMMENTS The survey team entered the facility 7/14/25 to conduct a complaint investigation survey. The survey was conducted on site 7/14/25 through 7/15/25 with additional information received offsite on 7/16/25 through 7/17/25. Therefore, the exit date was 7/18/25. The following intake was investigated: 844220. Intake 844220 resulted in immediate jeopardy. 1 of the 2 complaint allegations resulted in deficiency. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity J. The tag F689 constituted Substandard Quality of Care. Non-compliance and immediate jeopardy began on 6/30/25. Immediate jeopardy was removed on 7/7/25 and the facility came back in compliance effective 7/7/25. A partial extended survey was conducted.	F0000		
F0689 SS = SQC-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 observations, record reviews, and resident, staff, and Medical Director (MD) interviews, the	F0689	"Past Noncompliance - no plan of correction required"	

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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F0689 SS = SQC-J	Continued from page 1 facility failed to provide care in a safe manner. On 6/30/25 Resident #2 rolled off her bed during incontinence care and landed on the floor. Resident #2 sustained a right forearm skin tear and complained of “severe” pain and was sent to the Emergency Department (ED) for evaluation. The Resident was diagnosed with a closed fracture (the broken bone does not penetrate the skin) at the distal end (just above the knee joint) of the left femur (thighbone) and closed fracture at the distal end of the right femur. In the ED, Resident #2 required intravenous (IV) fentanyl (an opioid drug used to treat severe pain) for pain. The Resident was discharged back to the facility the same day with an immobilizer on her right knee and orders to follow up with orthopedic surgery. Following the incident Resident #2 required oxycodone for pain management with pain levels rated up to a 9 (on a scale of 0 to 10 with 10 being the worst possible pain). On 7/14/25, a new order was entered for methocarbamol (muscle relaxer) for fracture induced muscle spasms. Prior to the incident Resident #2 was getting out of bed daily and attending activities. The Resident stated during interview that she missed attending group activities. This was for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #2). The findings included: Resident #2 was admitted to the facility on 5/12/25 with diagnoses that included age related osteoporosis, restless leg syndrome, chronic pain and osteoarthritis. Review of a physician’s order dated 5/12/2025 revealed an order for Acetaminophen 325 milligram (mg) tablet – Give 2 tablets every 4 hours as needed for general discomfort. A care plan dated 5/13/25 and revealed a focus of Risk for falls characterized by multiple risk factors related to pain and osteoarthritis. The goal was for Resident #2 not to sustain serious injury through the review date. The interventions included: Substantial/maximal assistance with 1 person assistance for bed mobility and toileting hygiene. A care plan initiated 5/13/25 revealed a focus of chronic pain related to osteoporosis, restless leg syndrome. The goal was for Resident #2 to report satisfactory pain control.	F0689		

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F0689 SS = SQC-J	Continued from page 2 A care plan dated 5/13/25 revealed a focus of osteoporosis/osteoarthritis: At risk for fractures. The goal was for Resident #2 to remain free from fractures through the next review date. The admission Minimum Data Set (MDS) Assessment dated 5/19/25 revealed Resident #2 was cognitively intact and had no behaviors. She had no impairment of her upper or lower extremities and used a wheelchair for mobility. Resident #2 requires substantial maximal assistance with 1 staff physical assistance for rolling left and right. She was always incontinent of bowel and bladder. Resident #2 was coded as on a scheduled pain medication regiment within the past five days. Resident #2 denied pain during the pain assessment. Resident #2's activity assessment found it somewhat important to do things with a group and she enjoyed participating in religious services or practices. Review of a physician's order dated 6/5/2025 with an end date of 7/5/25 revealed an order for Acetaminophen 325 mg tablet – Give 2 tablets two times a day for acute toe pain. The investigational summary written by the Administrator dated 6/30/25 revealed Nurse Aide (NA) #1 entered Resident #2's room to provide incontinent care. NA #1 was standing on the resident's left side. NA #1 grasped the draw sheet and pulled Resident #2 towards her. NA #1 told Resident #2 to grab the bed rail to turn over. NA #1 was straightening the draw sheet to get ready to place the brief beneath Resident #2. NA #1 indicated Resident #2 grabbed the bed rail with her left hand and rolled over to her right side. NA #1 stated she noticed Resident #2 had crossed her leg over the edge of the bed and continued to roll onto the floor. NA #1 reported she attempted to catch Resident #2 by grabbing her arm but was unsuccessful. Resident #2 landed on her left side on the floor on her left side with her legs slightly bent at the knees and Resident #2 was propping her upper body up with the left arm. Resident #2 complained of pain in her legs. Resident #2 was sent to the emergency department where x-rays and CT (computed topography) scans revealed she had severe osteopenia and diagnoses of fracture to the right and left distal femurs. A nursing progress note dated 6/30/25 and written by Nurse #1 revealed NA#1 stated she was assisting Resident #2 with incontinence care when resident turned	F0689		

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F0689 SS = SQC-J	Continued from page 3 to grab bedside rail and resident's legs began to swing off the bed and resident fell off the bed onto the floor. NA #1 came out of Resident #2's room and called a code green. (Code used by the facility to indicate an emergency). Nurse #1 entered Resident #2's room and on visual assessment observed the resident lying on the floor on her left side and holding her upper body up with her left elbow. Resident #2 complained of severe left hip and left ankle pain. Nurse #1 noted a skin tear to Resident #2's right forearm and applied a dressing. 911 was called due to a resident's complaint of severe pain and Resident #2 was transported to the hospital emergency department for evaluation and treatment. During an interview with NA #1 on 7/14/25 at 4:30 PM she revealed she was familiar with Resident #2 and had taken care of her multiple times. NA #1 stated on 6/30/25 during the night shift, she walked into Resident #2's room and announced herself and explained that she was there to provide incontinent care. NA #1 stated she was standing on Resident #2's left side and used the draw sheet to pull the resident closer to her. NA #1 stated she instructed Resident #2 to grab the bed rails. NA #1 stated Resident #2 grabbed the bed rail with her left hand and pulled herself over. NA#1 stated Resident #2's legs continued to roll. NA #1 stated she tried to catch Resident #2 but was unsuccessful. NA#1 stated Resident #2 was still holding on to the bed rail when she landed on the floor. NA#1 stated Resident #2 complained of pain in her legs and ankle. NA #1 stated Resident #2 required one-person physical assistance for turning before she fell. Multiple attempts to interview Nurse #1 who was assigned to Resident #2 at the time of the fall on 6/30/25 were unsuccessful. A review of the Hospital Emergency Department (ED) note dated 6/30/25 revealed Resident #2 had pain in her left ankle and diffusely through her right leg. The ED assessment further revealed Resident #2 was tender over the upper and lower left leg. The discharge summary dated 6/30/25 indicated Resident #2 was seen in the emergency department after the fall and found to have a closed fracture at the distal end of the left femur and closed fracture of the distal end of the right femurs and skin tear to right forearm without complications. Resident #2 was evaluated by an	F0689		

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F0689 SS = SQC-J	Continued from page 4 Orthopedic surgeon and no surgical interventions were recommended. Resident #2 required intravenous (IV) Fentanyl for pain at the hospital. Resident #2 was placed on non-weight bearing status and prescribed a short course of Oxycodone (an opioid pain medication). Resident #2 was discharged back to the facility with an immobilizer on her right knee and she was to follow up with orthopedic surgery. A nursing progress note written by Nurse #3 dated 6/30/25 at 4:48 PM revealed Resident #2 returned to the facility with an immobilizer intact to her right lower extremity. Review of a physician's order dated 6/30/2025 revealed an order for Oxycodone HCl 5 MG (milligram) oral tablet- Give 5 mg by mouth every 6 hours as needed for moderate pain until 07/03/2025. Review of a physician's order dated 7/2/25 revealed an order for Oxycodone HCl 5 MG oral tablet- Give 5 mg by mouth every 6 hours as needed for moderate pain until 7/5/2025. Review of Resident #2's Medication Administration Record from 6/30/25 to 7/5/25 revealed the following: -On 6/30/25 at 5:35 PM Resident #2 rated her pain at 7/10 and received Acetaminophen 650 mg. Medication effective. -On 6/30/25 at 9:00 PM Resident #2 rated her pain at 5/10 and received scheduled Acetaminophen 650mg. Medication effective. -On 7/1/25 at 7:30 AM Resident #2 rated her pain at 3/10 and received Oxycodone 5mg. Medication effective. -On 7/1/25 at 9:00 AM Resident #2 rated her pain at 3/10 and received scheduled Acetaminophen 650 mg. Medication effective. -On 7/1/25 at 9:00 PM Resident #2 rated her pain at 0/10 and received scheduled Acetaminophen 650 mg. Medication effective. -On 7/2/25 at 9:00 AM Resident #2 rated her pain at 4/10 and received scheduled Acetaminophen 650 mg. Medication effective.	F0689		

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F0689 SS = SQC-J	Continued from page 5 -On 7/2/25 at 2:21 PM Resident #2 rated her pain at 7/10 and received Oxycodone 5mg. Medication effective. -On 7/2/25 at 9:00 PM Resident #2 rated her pain at 5/10 and received scheduled Acetaminophen 650 mg. Medication effective. -On 7/2/25 at 11:05 PM Resident #2 rated her pain at 9/10 and received Oxycodone 5mg. Medication effective. -On 7/3/25 at 9:00 AM Resident #2 rated her pain at 5/10 and received scheduled Acetaminophen 650 mg. Medication effective. -On 7/3/25 at 9:00 PM Resident #2 rated her pain at 5/10 and received scheduled Acetaminophen 650 mg. Medication effective. On 7/4/25 at 12:07 AM Resident #2 rated her pain at 8/10 and received Oxycodone 5mg. Medication effective. -On 7/4/25 at 9:00 AM Resident #2 rated her pain at 3/10 and received scheduled Acetaminophen 650 mg. Medication effective. -On 7/4/25 at 9:00 PM Resident #2 rated her pain at 1/10 and received scheduled Acetaminophen 650 mg. Medication effective. -On 7/5/25 at 9:00 AM Resident #2 rated her pain at 4/10 and received scheduled Acetaminophen 650 mg. Medication effective. A review of the Orthopedic Surgery follow-up visit note dated 7/7/25 revealed Resident #2 was seen in the office and rated her pain as 4 out of 10 at its worst level. Resident #2 indicated she had been taking Acetaminophen for pain. She described her pain as on and off achy pain that increased with motion of the knees. Resident #2 also reported she had increased pain with transfers. Orthopedic surgery recommended resident continue with the immobilizer to right knee and recommended an immobilizer for left knee to keep the knees in extension and prevent motion that was painful. The significant Change Minimum Data Set (MDS) Assessment dated 7/11/25 revealed Resident #2 was cognitively intact. Resident #2 had bilateral lower extremity impairment with a diagnosis of fracture. She was assessed as having pain frequently that interfered with her sleeping at night and interfered with performance of daily activities. She described her pain as 10 on a scale of 1 through 10. Resident #2 was coded	F0689		

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F0689 SS = SQC-J	Continued from page 6 as having limitations to her daily activities. A physician's progress note dated 7/14/25 revealed Resident #2 was seen for pain control and new onset of muscle spasms related to the bilateral femur fractures. Review of a physician's order dated 7/14/25 revealed an order for Oxycodone HCl 5 MG oral tablet- Give 1 tablet by mouth every 8 hours for bilateral distal femur fracture. Review of a physician's order dated 7/14/25 revealed an order for Methocarbamol (a muscle relaxant) 500 MG Oral Tablet - Give 1 tablet by mouth every 8 hours for fracture induced muscle spasms. An observation of incontinence care conducted on 7/14/25 at 12:55 PM revealed Resident #2 required the assistance of 2 staff for turning and repositioning. Resident #2 was positioned in the middle of the bed after care was rendered. During an interview with Resident #2 on 7/14/25 at 1:30 PM she revealed on 6/30/25 she was awakened in the middle of the night when NA #1 came to assist her with incontinence care. Resident #2 stated NA #1 was standing on the left side of the bed and she was instructed to turn over. Resident #2 stated when she went to roll over to the right, she continued to roll and ended up on the floor. Resident #2 stated the fall happened so fast that before she knew it, she was on the floor. Resident #2 stated she was holding on to the rails when she slid down. Resident #2 stated her left ankle was hurting and her right ankle was bent in an awkward position. Resident #2 stated she was transferred to the hospital emergency department and told both of her lower thigh bones were broken. Resident #2 stated she was now taking strong pain medication for pain to her lower thighs. Resident #2 also stated she had recently received a new medication for spasm to her thigh muscles. Resident #2 stated she had not been taking medication for pain prior to the fall. Resident #2 further stated she missed getting up to the chair daily and going out to activities. Resident #2 stated she had not begun working with therapy yet and movement was very painful. During an interview with Nurse #2 on 7/15/25 at 11:14	F0689		

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F0689 SS = SQC-J	Continued from page 7 AM. Nurse #2 stated she was familiar with Resident #2 and worked with her over the past couple of months. Nurse #2 stated she had been made aware of Resident #2's fall. Nurse #2 reported Resident #2 required only one person assistance for turning in bed prior to the fall. She indicated Resident #2 now required two-person physical assistance for turning and positioning in bed. Nurse #2 stated Resident #2 was not receiving any pain medication prior to the fall. Nurse #2 further stated Resident #2 did get up daily to the chair and participated in group activities prior to the fall but had not been to group activities since the fall due to her non weight bearing status. During an interview with Nurse Aide #2 on 7/15/25 at 11:22 AM she stated Resident #2 was able to assist with turning herself in bed using the handrails prior to the fall on 6/30/25. Nurse Aide #2 stated the resident required 1 staff for assistance with incontinent care before the fall. NA #2 stated she had worked with Resident #2 on multiple occasions and indicated Resident #2 had been participating in activities prior to the fall. NA #2 stated Resident #2 was currently on non-weight bearing status and complained of pain with movement. During an interview with the Medical Director on 7/15/25 at 11:40 AM he stated he was made aware Resident #2 had fallen from the bed and had fractures on her right and left lower femur. The Medical Director stated he felt that Resident #2's fractures were caused by fragility due to her diagnosis of severe osteoporosis. The Medical Director stated he did not feel there was anything the facility could have done differently to prevent the fall. During an interview with the Activities Director on 7/15/25 at 1:30 PM she stated Resident #2 got up to the reclining chair in her room daily and participated in group activities prior to going out to the hospital this last time. The Activity Director stated Resident #2 experienced a lot of pain with movement, so she had not been attending out of room activities. The Activity Director stated Resident #2 had been doing self-directed activities in her room. During an interview with the Director of Nursing on 7/18/25 at 9:02 AM she stated that residents were to be assessed by the nurse after a fall and the physician notified. The DON stated the nurse would follow the	F0689		

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F0689 SS = SQC-J	Continued from page 8	F0689		

Continued from page 8

orders given by the physician. The DON further stated she was not the DON at the facility when Resident #2 fell. She stated that all resident falls should be investigated, and interventions put into place. The DON stated she expected all care provided to residents would be conducted in a safe manner and immediate education was provided.

During an interview with the Administrator on 7/18/25 at 9:05 AM she stated the DON should be contacted when a resident falls and emergency medical services were notified if there was something acute going on. An investigation including statements was initiated and root cause analysis completed. Education was conducted with staff and interventions were put in place.

The Administrator was notified of immediate jeopardy on 7/15/25 at 3:03 PM.

The facility provided the following corrective action plan with a completion date of 7/7/25.

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

Resident #2 is alert and oriented with a brief interview mental status (BIM) score of 15/15, indicating the resident is cognitively intact. Diagnoses include osteoporosis, high blood pressure, depression, restless leg syndrome, chronic pain, hypothyroidism and coronary artery disease. On 6/30/25 at approximately 3:00 am Nursing Assistant (NA) #1 entered Resident #2's room to provide incontinent care. NA #1 turned on the light and woke the resident up. Resident #2 was lying on her back in the center of the bed with the head of bed slightly elevated. NA #1 gathered supplies and then lowered the head of the bed to a flat position. NA #1 was standing on the resident's left side. NA #1 grasped the draw sheet and pulled the resident towards the left side. NA #1 then instructed Resident #2 to grasp the bed rail to turn over. Resident #2 grasped the bed rail with her left hand and rolled over to the right side. NA #1 observed Resident #2 continue to roll off the side of the bed. NA #1 attempted to stop the roll by grasping the resident by the arm but was unsuccessful. Resident #2 landed on the left side on the floor still holding on to the bed rail with her legs slightly bent at the knees and the upper body propped up with her left arm. NA #1 immediately notified the nurse. At approximately 3:17 am, the nurse entered the room and assessed the resident. Resident #2 complained of pain to her left

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F0689 SS = SQC-J	Continued from page 9 ankle and bilateral lower extremities. A skin tear was noted to resident's right forearm. The nurse applied a dressing to the skin tear. The nurse notified emergency medical services (EMS). Resident #2’s resident representative was notified of the fall. At approximately 3:29 am, EMS arrived, and Resident #2 was transferred to the emergency room for further evaluation and treatment. At approximately 3:44 am, the provider was made aware by the nurse of Resident #2’s emergency transfer. At approximately 4:48 pm Resident #2 returned to the facility with a new diagnosis of bilateral femur fractures and a new order for pain medication every six hours as needed. An immobilizer was present to the right lower extremity. An appointment with orthopedics was scheduled for 7/7/25. At approximately 5:00 pm, the Director of Nursing interviewed Resident #2 upon return to the facility. Resident #2 stated as she rolled herself over, she just kept going, “it happened so fast”. On 6/30/25, the Administrator completed a root cause analysis for Resident #2’s fall from bed. During the investigation it was determined that Resident #2 grasped the bed rail as instructed by NA #1 and independently rolled over in a forward motion away from NA #1 to assist in care. This forward motion positioned the resident out of the center of the bed and further toward the right side of the bed causing the resident to fall. As a result, the facility identified the root cause of the incident to be, ensuring appropriate safety measure are in place to support the resident while self-positioning during care. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 6/30/25, the Director of Nursing (DON), Unit Managers, Assistant Director of Nursing (ADON) and/or Staff Development Coordinator initiated an audit, through observation, of all residents positioning in bed. This audit was to identify any resident who was not positioned in the center of bed and away from the edge of bed during care. There were no additional areas of concern. The audit was completed by 7/6/25. On 6/30/25, the Social Workers (SW) initiated resident questionnaires with all alert and oriented residents with BIMs of 13 or higher regarding turning and	F0689		

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F0689 SS = SQC-J	Continued from page 10 positioning in bed during care. This questionnaire was to identify any concerns related to turning and positioning during care. There were no additional concerns. The questionnaire was completed by 7/6/25. On 6/30/25, the Director of Nursing (DON), Unit Managers, Assistant Director of Nursing (ADON) and/or Staff Development Coordinator Initiated staff questions with all nurses, nursing assistants to include NA #1 and therapy staff related to turning and repositioning. The audit is to identify any safety concerns during care to include turning and positioning. The Director of Nursing (DON), Unit Managers, Assistant Director of Nursing (ADON) and/or Staff Development Coordinator addressed all areas of concern identified during the audit to include therapy referrals when indicated and initiate interventions for resident safety. The questionnaires were completed by 7/6/25. The Director of Nursing monitored the completion of staff questionnaires. After 7/6/25, any nurse, nursing assistant or therapy staff who have not completed the questionnaire will complete it upon the next scheduled work shift. On 6/30/25, the Director of Nursing (DON) completed an audit of all falls for the past 30 days. This audit is to identify any incidents related to safety concerns during care to include turning and positioning in bed. There were no identified areas of concern. The audit was completed by 6/30/25. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 6/30/25, the Director of Nursing (DON), Unit Managers, Assistant Director of Nursing (ADON) and/or Staff Development Coordinator initiated an in-service, in person, with all nurses, nursing assistants to include NA #1, agency staff and therapy staff regarding (1) Turning and Positioning During Care with emphasis on checking the care guide and providing care according to care plan/care guide for safety, technique for turning and positioning resident when providing care to include pulling the resident toward the side nearest staff prior to turning, positioning resident back in the center of the bed following care after turning and positioning to prevent falls/injury and (2) Safe Handling with emphasis on checking/following care guide when providing care even after a fall to include transfer method. The in-service included a return demonstration to validate staff knowledge and understanding of the education to include technique for turning and positioning and ensuring resident safety	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345215	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Trace Nursing and Rehabilitation Center	**250 Lovers Lane , Washington, North Carolina, 27889**

(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
F0689 SS = SQC-J	Continued from page 11 during care and how to check care guide on iPad. In-service with return demonstration was completed by 7/6/25. The Director of Nursing monitored the completion of the in-service and return demonstrations. After 7/6/25 any nurse, nursing assistant or therapy staff that has not received the in-service/return demonstration will complete it prior to the next scheduled work shift. All newly hired nurses, nursing assistants, agency staff and therapy staff will be in-serviced by the Staff Development Coordinator (SDC) during orientation regarding turning and positioning during care. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. On 6/30/25, the decision was made by the Administrator to monitor the plan for ensuring safety during care to include turning and positioning and presented to the Quality Assurance Performance Improvement (QAPI) committee to include the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, Staff Development Coordinator, Medical Records, Social Worker, and Minimum Data Set Nurse on 6/30/25. On 6/30/25, the decision was made by the Administrator for the Director of Nursing (DON), Unit Managers, Assistant Director of Nursing (ADON) and/or Staff Development Coordinator to complete 10 Resident Care Audits-Turning and Positioning/Safe Handling, through observation, weekly x 4 weeks then monthly x 1 month utilizing the Resident Care Audits-Turning and Positioning tool. This audit will be completed during various shifts and various days including weekends. This audit is to ensure staff review care guides prior to providing care, use proper technique for turning and positioning during care and residents are positioned in the center of the bed during care. The Director of Nursing (DON), Unit Managers, Assistant Director of Nursing (ADON) and/or Staff Development Coordinator will address all concerns identified during the audit to include repositioning the resident and re-education of the staff. The Director of Nursing (DON) will review Turning and Positioning/Safe Handling audit tools weekly x 4 weeks then monthly x 1 month to ensure all areas of concern are addressed. The Director of Nursing (DON), Unit Managers, Assistant Director of Nursing (ADON) and/or Staff Development Coordinator were made aware of this responsibility by the Administrator on 6/30/25. The Administrator or Director of Nursing will present the findings of the Turning and Positioning/Safe	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345215**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/18/2025**

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F0689 SS = SQC-J	Continued from page 12 Handling audit tools to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months to review and to determine trends and/or issues that may need further interventions and the need for additional monitoring. Alleged IJ removal date: 7/7/25 The corrective action plan was verified on 7/15/25 as evidenced by staff interviews. Staff education was initiated on 6/30/25 regarding (1)Turning and Positioning during Care with emphasis on checking care guide and providing care according to care plan guide for safety, techniques for turning, positioning resident back in center of bed following care after turning and positioning to prevent falls/injury (2) Safe Handling with emphasis on checking and following care guide when providing care even after a fall to include transfer method. All staff interviewed (nurses, nursing assistants and therapy staff) stated they had been educated to check the care guide to review techniques for turning and positioning residents, resident transfers, as well as positioning residents in the center of the bed following care to prevent falls. Staff return demonstrations on checking the care guide and technique for turning and repositioning residents during care were initiated on 6/30/25. Observations of residents during incontinence care revealed correct turning and positioning techniques and positioning of the resident in the center of the bed after care. Audit reports of resident falls for the past 30 days were reviewed. Audits of care plans for turning and positioning in bed, and staff and resident questionnaires were reviewed and completed 7/6/25. Quality Assurance Resident Care Audits to ensure staff reviewed care guide prior to providing care, proper technique for turning and positioning during care and positioning of residents in the center of the bed following care for the dates of 7/8/25 and 7/9/25 were reviewed. The facility's IJ removal date and corrective action plan compliance date of 7/7/25 was validated.	F0689		