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	345419	A. BUILDING _____ B. WING _____	C 02/06/2019

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LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 1/30/19 through 2/1/19 and 2/4/19 through 2/6/19. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tags F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 1/20/19 and was removed on 2/6/19. A Partial extended survey was conducted.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, resident, family, staff, emergency medical services staff, and physician interviews, the facility failed to provide supervision to prevent a fall from bed for 1 of 3 sampled residents (Resident #1) reviewed for accidents. Resident #1 was sent to the hospital for evaluation and treatment of her injuries as a result of the fall and was found to have a fractured vertebra, fractured left arm, a hematoma to left forehead and a contusion to the left lung. Resident #1 passed away eight days	F 689	This Plan of Correction is submitted in compliance with applicable law and regulation. To demonstrate continuing compliance with applicable law, the center has taken or will take the actions set forth in the following allegation of compliance. The following Plan of Correction constitutes the center□s allegation of compliance. All alleged deficiencies have been, or will be completed by the dates indicated.	2/7/19

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

Electronically Signed | 02/26/2019

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F 689	Continued From page 1 after she experienced the fall from bed. Immediate Jeopardy began on 1/20/19 when Resident # 1 fell from bed and was injured while not being supervised by Nursing Assistant (NA) #25. Immediate Jeopardy was removed on 2/6/19 when the facility provided and implemented a credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at the lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of employee education. The findings included: Resident # 1 was admitted to the facility on 8/1/18 with diagnoses of: osteopenia, abnormalities of gait and mobility, muscle weakness, syncope, and a history of cerebrovascular accident. Review of a fall risk assessment dated 11/1/18 revealed Resident # 1 was evaluated to be a high fall risk because she tried to stand, transfer, and walk alone unsafely. The assessment further revealed she was wheelchair bound and required assistance with toileting. Record review of Resident # 1's quarterly minimum data set (MDS) assessment dated for 12/26/18 revealed she was cognitively intact and was not coded for exhibiting any behaviors. She required one staff extensive assistance with bed mobility, dressing, bathing, and personal hygiene, and two staff extensive assistance with transfers. The resident was incontinent of bowel and bladder. Review of Resident # 1's care plan last reviewed on 1/11/19 revealed resident was at risk for falls and required extensive staff assistance with activities of daily living (ADL) Interventions included: make sure resident's call light is within reach and encourage her to use it when she	F 689	F689 How corrective action will be accomplished for those residents found to have been affected by the deficient practice; " The facility failed to prevent a fall from the bed for resident #1 on 1/20/19. This resident is no longer in the facility. How the facility will identify other residents having the potential to be affected by the same deficient practice; " Residents with recent falls were reviewed by the Director of Nursing (DON) on 1/30/19 to determine if there were any other residents that experienced accidents as a result of this same practice. No other issues were found. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur; " The DON and Staff Development Coordinator (SDC) completed one-on-one education to Certified Nursing Assistant (CNA) #25 regarding care during Activities of Daily Living (ADL), safety, and being prepared by having supplies readily available. CNA instructed to ask for assistance if residents exhibit change of status from prior level of functioning. This was initially completed 1/30/19. She was re-educated by the DON on 2/5/19 via telephone.	

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F 689	Continued From page 2 needs assistance with toileting and ADL needs; constant supervision by staff with bathroom use; anticipate and meet resident's needs; fall mats at bedside; bed in low position; and do not leave resident in bathroom unattended. The resident had goals to not have any falls and to maintain current ADL functions. Review of Resident # 1's Kardex last updated on 1/11/19 revealed the resident required one staff assistance with bed mobility and had a low bed, fall mats at bedside, and assist bars to her bed. The Kardex was communication tool used by nursing assistants (NAs) how to care for the residents. Review of a progress note dated 1/20/19 at 1:50 am that was written by Nurse # 10 revealed at 1:35 am Nurse #10 went to Resident #1's room after NA # 25 had yelled for help. Nurse #10 observed Resident # 1 lying on the floor on her left side of her bed with a small pool of blood on the floor near the resident. Resident #1 was observed to have a raised hematoma to the left side of her forehead, and her left shoulder appeared discolored and disfigured. Nurse # 10 left a voicemail for resident's physician and called 911 for emergency medical services (EMS.) EMS arrived at the facility at 1:45 am and transported the resident to the emergency department (ED.) Review of an incident report completed by a revealed on 1/20/19 at 1:35 am a NA yelled for help and the nurse went to Resident #1's room. The resident was observed lying on her left side on the floor beside of her bed with a small pool of blood on the floor. Resident #1 was observed to have a raised hematoma to the left side of her head, and her left shoulder appeared discolored and disfigured. The Resident stated that she fell out of the bed, but she did not know why. The nurse attempted to notify physician and left a	F 689	" The DON completed one-on-one training with nurse #10 via the telephone on 2/5/19 regarding stabilizing a patient and not moving them when there is a suspected head or neck injury. " Remaining nursing staff, which includes nurses and certified nursing assistants, began training on 1/21/2019 by SDC. Staff education consisted of the following components: ADL care and safety, which includes □ reminding them to place care items within reach, which would not require the loss of eye contact with the patient, ensuring the proper height of the bed for ADL care, ask for assistance if residents exhibit change of status from prior level of functioning, and stabilizing the cervical area and not moving residents with suspected head or neck injuries. This was completed on 2/5/19. " Any employee that did not receive the education will be removed from the schedule until education is completed. " All new nursing employees will be educated on ADL care and safety such as: being prepared for ADL care, proper bed height, and not moving a resident with suspected head/neck injury during new hire orientation. " Residents that have a fall will be reviewed by Nursing Administration the next day and any deficiencies noted will be corrected by Unit Manager or designee and new interventions put in place as required. Staff involved will be provided education or corrective action as necessary. " Falls will be reviewed weekly at the	

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F 689	Continued From page 3 voicemail. The resident was sent to the ED for evaluation. The NA told nurse that while she was getting a brief the resident tried to get up out of bed unassisted and she had been unable to stop the resident from rolling herself off the side of the bed. The incident report further revealed that the resident had struck herself on the nightstand and the base of an intravenous (IV) pole when she rolled off the bed. An interview was conducted on 1/31/19 at 1:00PM with NA # 25 who revealed she worked at the facility on a as needed basis. NA # 25 said she had been assigned to care for Residents # 1 and # 2 on the night of 1/20/19 and on prior dates. On the night of 1/20/19 NA # 25 said she had provided incontinence care to Resident # 2 at around 1:00 am, and after she had finished Resident 2's care she had moved over to the other side of the room to provide care for Resident # 1. According to NA # 25, Resident # 1's bed had been in the low position before she started provided care, so she had raised the bed to waist height to provide resident's care. She said the resident's bed was three or four feet off the ground. NA # 25 stated Resident #1 became "fidgety", so she moved the resident to the center of the bed. NA # 25 explained what she meant by "fidgety" was she observed the resident throw her legs over the side of the bed and try to get herself out of bed unassisted. She said that when she had cared for the resident prior to 1/20/19 the resident had not tried to move when she provided care for her. NA # 25 said she then turned to get the Resident # 1's brief that she had placed on a chair prior to providing care for Resident #1. She explained the chair was positioned against the wall that was across from the foot of the resident's bed. When NA # 25 turned back around after a few seconds she said Resident # 1	F 689	Risk Management meeting and any further recommendations from this meeting will be added to the individual residents care plan and Kardex. How the facility plans to monitor its performance to make sure that solutions are sustained; " DON will audit 5 falls from the previous week to ensure interventions and Kardex are completed weekly for four weeks then twice a month for two months and monthly for three months. " The SDC will observe 5 staff a week during care to ensure that staff have all supplies and are following Care plan for four weeks, and then 5 staff every two weeks for two months. " The findings will be reviewed at the quarterly Quality Assurance/Performance Improvement (QAPI) meetings for 4 quarters. Date of compliance is February 5, 2019 The Administrator is responsible for implementing the acceptable plan of correction.	

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was again trying to get up out of bed unassisted and before she could stop her the resident had rolled herself off the left side of the bed striking her head on the nightstand and the bottom of the IV pole before she landed on the floor. She said she saw blood on the floor and yelled out for help. Nurse #10 came into the resident's room and not too long after that NA #26 came into the resident's room. Nurse #10 had supported Resident # 1's head and neck, and then the three of them rolled resident onto her back. She said next all three of them had moved the resident off the floor onto the resident's bed. The resident was in pain Nurse #10 applied a cool compress to a knot on resident's forehead and went to call EMS, and the EMS came and had taken the resident to the ED. She revealed Resident # 1 did not have any fall mats on the floor on either side of her bed on 1/20/19 and could not recall If she observed if the resident had any fall mats prior to the night of the fall. She said she had looked at the resident's Kardex before she had entered the room and said the resident needed one staff extensive assistance with ADLs, her bed in a low position, and fall mats at bedside. NA # 25 said she had received training prior to 1/20/19 concerning what to do if residents had behaviors or were being resistive with care. She said she should have asked another staff member for assistance with the resident's care when she observed the resident trying to throw her legs over the bed and was trying to get up out of bed unassisted instead of just moving her to the center of the bed. NA # 25 further revealed she should not have turned away from the resident to get the brief and should have also brought all of the needed supplies to provide care for the resident before she started. NA #25 denied she had rolled resident off the bed or had been rough

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with her care.
An Interview was conducted with Resident # 2 on 1/30/19 at 1:30 pm who was Resident #1's roommate. Resident # 2's last completed MDS assessment of 12/20/19 revealed she was assessed as being cognitively intact. Resident # 2 said she and Resident # 1 had been roommates for several months. On the night of 1/20/19 at 1:00 am Resident # 2 stated NA # 25 had provided incontinence care to her. Resident # 2 said after NA # 25 had finished providing her care, NA # 25 had removed a brief out Resident # 1's closet and placed it on the end of Resident # 1's bed. She said NA # 25 had partially closed the privacy curtain between her bed and Resident #1's bed. Resident # 2 said she could not see what was happening on Resident # 1's side of the room, but she heard NA # 25 tell Resident # 1 to roll over two times. The next thing Resident # 2 heard was Resident # 1 hit the floor, and then NA # 25 yelled out for help. According to Resident # 2, Nurse # 10 and NA # 26 had come into the room to help Resident # 1. Resident # 2 said she heard the NA # 25 tell other staff that Resident #1 had tried to get up out of bed, she had moved Resident # 1 over to the middle of the bed, and when she had turned away to get a brief Resident # 1 had tried to get up from the bed unassisted and resident had rolled herself off the side of the bed before she could grab her. Resident # 2 also revealed NA # 25 had already placed a brief on the Resident 1's bed before she started providing care for Resident # 1. She said NA # 25 had taken care of both her and Resident # 1 before the night of 1/20/19. She denied that the NA # 25 had been rough with her care, and she denied that she heard NA # 25 being rough with Resident # 1. Resident # 2 also stated that there were no fall mats on the floor beside of Resident # 1's bed

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F 689	Continued From page 6 on 1/20/19. An interview was conducted with Nurse # 10 on 1/30/19 at 1:10 PM revealed she was the nurse assigned to Resident # 1 for 3rd third shift (11pm to 7am) on 1/20/19. At 1:35am NA #25 had yelled out that she needed Nurse #10's help. She went down to Resident # 1's room and observed the resident lying on the floor on her left side with a small pool of blood beside of her. NA #25 was the only staff present in the resident's room. She observed a raised hematoma on resident's left forehead and discoloring and disfigurement to resident's left shoulder. Nurse # 10 stated another NA had entered the room and that she had stabilized the resident's head and neck and that she along with the two NAs had rolled resident onto her back. She said the three of them then moved the resident from off the floor onto her bed. She attempted to call resident's physician but had to leave a voicemail. Resident # 1 was in so much pain according to Nurse #10 she had decided to call 911 and have resident transferred to the ED. She said that NA # 25 had told her that the resident had tried to get up unassisted when she was providing care, so she had moved the resident to the center of the bed. NA had said she had turned around to get a brief off the chair for the resident and the resident had tried to get up out of bed unassisted and she had been unable to keep her from rolling off the side of the bed. An interview was conducted at 1:27 pm on 1/31/19 with NA # 26 who revealed she heard NA # 25 yell out that she needed help at around 1:30 am. NA # 26 said she went into Resident # 1's room and saw the resident laying on the floor on her left side. According to NA # 26, the resident's head was bleeding, she was crying, and	F 689		

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appeared to be in a lot of pain. She said that Nurse # 10 and NA # 26 were already in the room before she went in. NA # 26 revealed that the three of them rolled the resident onto her back and then moved her from the floor to the bed. Nurse # 10 had called EMS and resident was taken to the ED according to NA # 26. NA # 26 revealed NA # 25 had told her the resident had tried to get up out of bed unassisted and had rolled off the bed when she had turned around to get a brief off of a chair. She said she did not recall resident having fall mats on 1/20/19, or prior to that date.
Review of an ED Hospital Summary dated 1/20/19 revealed Resident #1 had reported that she fell off of her bed while being changed by a NA that had been rough with her and shoved her. The ED physician had called the nursing facility. The ED physician stated, "the facility reported that while the resident was being changed she had tried to get up and fell off the bed. The resident fell from a height of 3 to 5 feet. She landed on a hard floor with the point of impact being the head and shoulder. The pain is at a severity of 10/10. The pain is severe." The summary also revealed, "Spinal x-ray results: 8th thoracic vertebra compression fracture, kyphosis, and left arm fracture. Chest x-ray results: no rib fractures, osteopenia, and patchy opacities in both lungs. Computed tomography (CT) scan of head: no fracture or brain bleeds. Lab results: Complete Blood Count (CBC) revealed a white blood count of (WBC) 17.7. The summary went on to reveal Resident #1 had the following clinical impressions listed: fall, contusion of left the lung, closed fracture of the 8th thoracic vertebra, closed displaced fracture of the left surgical neck of the humerus, and an abrasion to left forehead." The resident was discharged to the hospice house on

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1/20/19 per family and resident request.
An interview was conducted on 2/11/19 with the EMS staff that had attended to Resident #1 on 1/20/19. According to the EMS staff person, when he entered the resident's room she was laying on her back in bed. Resident # 1 had a golf ball sized hematoma to her left forehead and her left shoulder was discolored and disfigured. He said he did not hear the resident say what had caused her injuries. The staff had reported to him the resident fell off the bed after she tried to get up unassisted from the bed. The resident had severe pain during her transfer to the ED and he said he had administered the resident a narcotic pain medication through her IV that he had inserted upon his arrival to the facility. He further revealed the resident should not have been moved by the staff.
An interview was conducted on 2/5/19 with the ED physician that had examined Resident # 1 on 1/20/19. The physician revealed Resident # 1 had been seen due to a fall that occurred earlier that day. She said the resident had a golf ball size hematoma to the left side of her head, a compression fracture to a vertebra in the resident's spine, a fractured left shoulder, and discolorations. The physician further revealed Resident # 1 had told her that a NA had been rough with her when she was providing care and the NA had rolled her off the bed onto the floor. She said the resident described the NA. The physician then called the facility and a staff member had told her the resident fell off of a bed that was three to five feet off of the floor when the NA who had been providing care turned to get a brief, the resident tried to get up unassisted, and before the NA could prevent her from falling the resident had rolled off the side of the bed onto the floor. The physician said the resident had severe

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pain. The physician said it had decided by the resident and the resident's responsible party that due to the resident not being a surgical candidate the resident would be discharged to the local hospice house.
An Interview was conducted with Resident # 1's facility physician on 1/31/19 at 1:40 pm. He stated that resident had been receiving hospice services related to her cancer diagnosis. He had been made aware of resident's fall on 1/20/19. He said that the resident weighed 95 pounds and had osteopenia. The interview further revealed due to the resident's poor overall poor medical condition, hospice status, and diagnoses, she had been highly susceptible for continued decline, falls, behaviors, and cognitive loss. The physician said the fall could have caused the resident's death.
An interview conducted with the MDS coordinator on 1/31/19 at 4:20 pm revealed Resident # 1 required one staff extensive hands on at all times assistance with ADLs and was communicated to the staff on the resident's Kardex and care plan.
An interview was conducted with the Director of Nursing on 1/31/19 at 4:45 pm during which she revealed she had been made aware of Resident # 1's fall shortly after it had occurred on 1/20/19. She said Nurse # 10 had advised her that the resident had been trying to get up out of bed unassisted, and NA #25 had moved the resident to the center of the bed, NA # 25 had turned away to get a brief for the resident and when she turned away the resident had tried to get up unassisted and the resident had rolled herself onto the floor before the NA could stop her. She said she had not suspected abuse or neglect by NA #25 and had not reported the incident to the personnel registry. The interview further revealed the resident had a history or falls, had been

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receiving hospice services, needed one staff extensive care with ADL, received bolus tube feedings and pleasure foods, had her bed placed in the low position when she was not receiving care, and had floor mats at bedside when the resident was in bed.
An interview was conducted with the Administrator on 1/31/19 at 4:55 pm. She stated she had been made aware of Resident # 1's fall on 1/20/19 and as a result of the fall on the facility had initiated a PIPs (Project Improvement Program) which had involved staff training on ADLs and safety-such as lowering the bed if they are moving away and taking all needed supplies with them before starting resident care.
An interview was conducted on 2/1/19 at 9:10 am with Resident # 1's responsible party who revealed that the facility had called her on 1/20/19 around 1:40 am to report that the resident had rolled herself out of the bed and the facility was transferring the resident to the ED. She said at the ED the resident had described a NA at the facility that she said had been rough with her and had rolled her off of the bed. She said the resident was not a surgical candidate for the injuries she had received as a result of the fall, and it was decided to send the resident to the hospice house for comfort care. She said the resident had passed away on 1/28/19.
Review of Resident # 1's death certificate dated 1/28/19 revealed resident's cause of death was complications from a fall.
On 2/5/19 at 09:40 am the Administrator was informed of immediate jeopardy.
The facility provided an acceptable Credible Allegation (CA) of Immediate Jeopardy removal on 2/5/19 at 5:45 pm.
The facility provided credible allegation for immediate jeopardy removal as follows:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 02/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 11	F 689		

This allegation of Immediate Jeopardy removal is submitted in compliance with applicable law and regulation. To demonstrate continuing compliance with applicable law, the center has taken or will take the actions set forth in the following allegation of Immediate Jeopardy removal. The following credible allegations constitutes the center's allegation of Immediate Jeopardy removal. All alleged deficiencies have been or will be completed by the dates indicated.
The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited;
Deficient practice - Resident #1 is an alert and oriented resident that required supervision to one person assist for ADL care. While providing care to Resident #1., certified nurse aide (CNA) turned around to grab a brief from a nearby chair. Bed was in a higher position to prevent CNA injury from bending. Resident moved which then caused her to fall to the floor. Mats were listed on the Kardex but are not used during care since they pose a trip hazard to the staff. She sustained the following injuries: left forehead hematoma and left arm fracture. The injuries were obtained when she fell on the nightstand and IV pole base that was at bedside. The nurse and 3 CNAs then stabilized her cervical area and lifted her back to the bed.
Facility Actions
o Vital signs obtained and visual assessment of resident body done by Nurse immediately following incident. Left forehead hematoma with no active bleeding, and discoloration to the left shoulder and upper arm area were noted.
o Resident was taken by EMS to the hospital for further evaluation and treatment and never returned to facility.
The procedure for implementing the acceptable

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F 689	Continued From page 12 plan of correction for the specific deficiency cited; o The Director of Nursing (DON) and Staff Development Coordinator (SDC) completed one-on-one education to NA #25regarding care during ADLs, safety, and being prepared by having supplies readily available. NA # 25 instructed to ask for assistance if residents exhibit change of status from prior level of functioning. o The Director of Nursing (DON) completed one-on-one training with the nurse regarding stabilizing a patient and not moving them when there is a suspected head or neck injury. o Remaining nursing staff, which includes nurses and nursing assistants, began training on January 21, 2019 by SDC. Staff education consisted of the following components: ADL care and safety, which includes - reminding them to place care items within reach, which would not require the loss of eye contact with the patient, ensuring the proper height of the bed for ADL care, and stabilizing the cervical area and not moving residents with suspected head or neck injuries. o Any employee that did not receive the education will be removed from the schedule until education is completed. o All new nursing employees will be educated on ADL care and safety such as: being prepared for ADL care, proper bed height, and not moving a resident with suspected head/neck injury during new hire orientation. o Residents with recent falls were reviewed by the DON to determine if there were any other residents that experienced accidents as a result of this same practice. No other issues were found. The monitoring procedure to ensure that the plan	F 689		

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F 689	Continued From page 13	F 689		

of correction is effective and that specific deficiency cited remains corrected and/or incompliance with the regulatory requirements;

o Residents that have a fall will be reviewed by Nursing Administration the next day and any deficiencies noted will be corrected by Unit Manager or designee and new interventions put in place as required. Staff involved will be provided education or corrective action as necessary.
o Falls will be reviewed weekly at the Risk Management meeting and any further recommendations from this meeting will be added to the individual residents care plan and Kardex. DON will audit falls from previous week to ensure interventions and Kardex are completed.
o The SDC will observe 5 staff a week during care to ensure that staff have all supplies and are following Care plan for four weeks, and then 5 staff every two weeks for two months.
o The findings will be reviewed at the quarterly QAPI meetings for one year (4 quarters).

The Director of Nursing is responsible for implementing the acceptable plan of correction.

The facility's credible allegation of IJ removal was verified on 2/6/19 at 10:08 am. A review of the medical records for a survey sample of residents that had noted falls revealed the residents had been accurately assessed for falls; had care plans that addressed the residents' risk for falls, updated interventions and goals; and the residents' Kardexs had updated fall interventions that were utilized by staff. A review of the in-service training for the nurses and all non-nursing employees were reviewed. The topics covered in the in-services were the areas

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F 689	Continued From page 14 identified in the facility's plan of correction. Interviews were conducted with various staff that included nurses and non-nursing employees. Interviews revealed the staff were knowledgeable of the information provided in the in-services regarding not leaving a bed in high position when a resident is unattended, bring all needed supplied to resident's area before care is started, not moving a resident that has a possible head injury or fracture, the placement of fall mats when a resident who has fall mats as an intervention is in bed, and seeking an additional staff member's assistance when a resident has behaviors.	F 689		