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	345261	A. BUILDING _____ B. WING _____	C 06/29/2020

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F 000	INITIAL COMMENTS An unannounced complaint investigation was conducted on 06/25/20 through 06/29/20. There were 11 allegations investigated and all were unsubstantiated. Event ID XHYP11.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, Nurse Practitioner, Medical Director, and Radiologist interviews the facility failed to provide supervision to prevent accidents by leaving a resident unassisted on the toilet while summoning assistance which resulted in a resident being lowered to the floor. Once the resident was lowered to the floor the facility failed to assess the resident and subsequently failed to notify the medical provider. The resident sustained an acute fracture of the tibia and fibula. This affected 1 of 3 residents (Resident #1) investigated for providing care according to professional standards. The findings included: Resident #1 was admitted to the facility on 07/20/12 with diagnoses that included dementia, Alzheimer's disease, polyosteoarthritis, and	F 689	Alleghany Center provides this Plan of Correction without admitting or denying the validity or existence of the alleged deficiencies. The Plan of Correction is prepared and executed solely because it is required by federal and state law. 1. Resident #1 returned to the facility on 5/8/20 and remains in the center. Resident #1 is currently being promptly assessed upon any changes in status and has any pain needs addressed and met timely. Resident #1 was assessed for current ROM ability and pain level on 7/15/20 by Director of Nursing and Nurse Practitioner with no concerns noted. 2. All residents experiencing falls have the potential to be affected by this deficient practice. A 100% audit of all current	7/22/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/20/2020

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F 689	Continued From page 1 age-related osteoporosis. Review of Resident #1's quarterly Minimum Data Set (MDS) dated 02/18/2020 indicated Resident #1 was moderately impaired for daily decision making and required total assistance of 2 staff members with transfers and toileting. The MDS further indicated that Resident #1 had one fall with injury (except major) since the previous assessment. Review of a care plan last updated on 03/18/20 read in part, Resident #1 was at risk for falls related to impaired mobility, unsteady gait, pain, osteoporosis, dementia, non-complaint with calling for assistance of staff for transfers, history of falls, and demanding behavior with history of placing self in the floor. The goal read, Resident #1 has had a change in wheelchair due to brakes and brakes stopped being faulty. The interventions included: continue to remind resident to call for assistance, encourage and remind resident to lock wheelchair brakes prior to transfer, encourage resident to use bathroom light prior to attempting to transfer to toilet, encourage resident to use grab bar in bathroom if she is going to transfer herself to toilet unassisted, and offer and assist with commode as requested/needed. Review of a late entry Change in Condition created on 05/03/20 read in part: on 05/02/20 at 3:40 PM a change in condition had been noted. The symptoms included: fall on 05/02/20 in the afternoon. Change reported to primary care clinician, order obtained, and name of family/healthcare agent notified were all blank. The change in condition indicated that no changes were noted, and no pain was reported.	F 689	residents with falls in the last 60 days was completed by the Director of Nursing, Assistant Director of Nursing and Unit Manager to ensure all residents with falls have been assessed per protocol and appropriately medicated for any pain if applicable status post fall, with physician notification as indicated. Interventions were reviewed, to include Resident #1, to ensure appropriate with care plans reviewed and updated as needed. This audit will be completed by 7/22/20. 3. Licensed staff will be educated on the Fall Policy to include the fall definition, proper assessment including neuro checks (as needed) and vital signs, adequate supervision, timely MD/RP notification and documentation of same due to the change in condition. Training was conducted by the nursing leadership team with full time, part time, prn and agency staff beginning 6/25/20 and will be completed by 7/22/20. Non-nursing staff will be educated by 7/22/20 on immediate notification of the nurse and/or DON upon a resident fall, witnessed or unwitnessed, in the event they are the first staff member on the scene to include not leaving the resident unattended. Training will include all full time, part time, prn and agency staff and will be completed by 7/22/20. 4. All falls, with or without injury, will be reviewed by the clinical team 5 days per week during the Clinical Meeting to ensure the appropriate procedure post fall was carried out including adequate supervision, assessment and notification,	

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F 689	Continued From page 2 The summary read, Nurse Aide (NA) reported resident lowered to floor in bathroom. The change in condition was signed by Nurse #1. Review of the on-call log (which was used to document phone calls made to the on-call Medical Director or Nurse Practitioner) indicated Nurse Practitioner (NP) #2 had been on call 5/02/20 and 5/03/20. A call had been placed on 5/02/20 at 7 PM (unrelated to Resident #1.) and another on 5/03/20 at 1:34 AM by Nurse #3 related to Resident #1. An interview was conducted with NA #1 on 06/25/20 at 2:06 PM. NA #1 stated that on 05/02/20 she was caring for Resident #1 and was familiar with her care. At approximately 3:00 PM Resident #1's call light came on and she responded to find Resident #1 in the bathroom on the commode. NA #1 stated she was not sure how Resident #1 got on the commode but stated she assumed her partner on the unit that day NA #3, placed her on the commode. She instructed Resident #1 to sit still while she went to find some help in getting her off the commode because Resident #1 usually required 2 person assistance with transfers with the use of a gait belt. NA #1 added Resident #1 had a history of being impatient and not waiting on staff to assist her. NA #1 stated she went to the doorway and could not find any other staff, so she returned to the bathroom and Resident #1 was standing between the toilet and sink. Resident #1 reached out for her and said she was going to fall. NA #1 stated she did what she was trained to do. NA #1 stated that Resident #1's wheelchair was sitting outside the door out of her reach, so she pulled Resident #1 to her own thigh and slid her down her leg to the floor as gently as possible. She indicated she	F 689	as well as to monitor for appropriate treatment of pain post falls where applicable. These investigations will be completed by the DON, ADON and Unit Manager to ensure placed interventions and documentation of same on the Care Plan. Any corrective action needed will be completed during review and all findings will be recorded on the monitoring tool. Any fall with injury over the weekend will be called to the DON or Nurse in Charge for immediate review at that time. The results of these reviews will be brought before the Quality Assurance and Performance Improvement (QAPI) Committee meeting Weekly x 4, then monthly x 4, with the QAPI Committee responsible for ongoing review thereafter once determination of compliance has been achieved.	

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sat Resident #1 on the floor on her buttocks with her feet straight out in front of her. Once Resident #1 was on the floor NA #1 again went to the door to find some help and saw Nurse #1 coming down the hallway. She summoned her to Resident #1's room. NA #1 stated that she and Nurse #1 got on each side of Resident #1 and lifted her off the floor and stood her up so they could clean her bottom. While Resident #1 was standing with her pants down she and Nurse #1 visually checked Resident #1 and asked her if she was ok and she replied "yes" she was fine. Once they had her cleaned up, they placed her back in the wheelchair. NA #1 stated that Resident #1 did not voice any complaints and was not showing any non-verbal signs of pain or discomfort.

An interview with Nurse #1 was conducted on 06/25/20 at 12:13 PM. Nurse #1 stated that on 05/02/20 (she could not recall the time) she was walking down the hall and saw NA #1 in the hall summoning her to Resident #1's room. Nurse #1 stated she went into Resident #1's bathroom and observed Resident #1 sitting on the floor on her bottom with her legs out in front of her. She stated that they lifted Resident #1 off the floor by grabbing Resident #1 under her arms and stood her up. Nurse #1 stated that once Resident #1 was standing up with their assistance she "looked at her legs and her arms and did not see anything" and they placed Resident #1 in her wheelchair. Nurse #1 again confirmed that it was a visual check and no range of motion was completed and stated she could not answer if Resident #1 was able to bear weight because she and NA #1 had a hold of Resident #1. Nurse #1 stated that she did not recall any inward rotation of the leg or foot and observed no bruising. She

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added that Resident #1 also had no indication of pain. Nurse #1 stated that shortly after the incident Resident #1 did complain of pain in her right leg and she gave her some Tylenol and that was effective. Nurse #1 stated she did not consider this a fall because NA #1 "said she sat her in the floor." She further stated she does not recall obtaining vital signs. Nurse #1 added that if someone was lowered to the floor then it was considered a fall, but NA #1 stated she lowered Resident #1 to the floor, so she initially did not consider this a fall. Nurse #1 stated that it was her responsibility to determine if Resident #1 had any injury but NA #1 "kept saying she did not fall she was lowered to the floor." Nurse #1 confirmed that for the remainder of her shift, she did no further assessment, inspection, range of motion, or vital signs of Resident #1. Nurse #1 stated that she did not call the Medical Director (MD) because she was lowered to the floor, she did not consider this a fall at the time. She also confirmed that she did not notify the MD when Resident #1 began complaining of pain in her right leg after being lowered to the floor.

An interview was conducted with NA #2 on 06/25/20 at 11:26 AM. NA #2 confirmed she was the night shift staff that cared for Resident #1 on 05/02/20-05/03/20. NA #2 stated that during report NA #3 reported that Resident #1 had fallen in the bathroom earlier in the day. NA #2 stated they rounded with Resident #1 at approximately 6:50 PM and during that round they provided incontinent care and she complained of her right leg hurting and she reported that to Nurse #2 and Nurse #3 but she did not notice any visible injuries to her leg. NA #2 stated that she again rounded at 10:00 PM to again provide incontinent care and Resident #1 was still complaining of

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right leg pain but she stated she did not notice anything wrong with the leg but again reported it to the nurse who she believed gave Resident #1 some Tylenol. NA #2 stated at 1:00 AM when they rounded with Resident #1 and pulled the covers back the knee was swollen, and the leg was turned inwards and was badly bruised and had a blister. NA #2 stated she immediately went and got Nurse #2 and Nurse #3 and they came to Resident #1's room.

An interview was attempted with NA #3 on 06/25/20 at 2:36 PM and was unsuccessful.

An interview was conducted with Nurse #3 on 06/25/20 at 3:05 PM. Nurse #3 stated that the first time he encountered Resident #1 on 05/02/20 was when he took her medications at 8:30 PM. He stated she was resting in bed and did not have any complaints at the time, and he did not perform any assessment at that time. Nurse #3 stated that Nurse #1 had reported Resident #1 was lowered to the floor earlier in the day and had no injury. Sometime after midnight NA #2 reported that Resident #1 was guarding her right leg and would not let them move her. Nurse #3 stated he went to the room and as soon as he touched her leg she cried out in pain, the leg was shorter than the left leg and was rotated inwards. Nurse #3 stated he knew that it was broken or dislocated. He stated he notified the on-call provider and obtained an order for x-ray. When he called the x-ray company they could not come until later in the morning, so he called the on-call provider back and obtained an order to go ahead and send Resident #1 to the local emergency room (ER). Nurse #3 stated Resident #1 was discharged to the ER on 05/03/20 at 3:15 AM. He stated that he was unsure if Nurse #1

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notified the medical provider but stated there was no change in condition note completed and no 72-hour monitoring (which was standard procedure after a fall) initiated until he completed them.

An interview was conducted with Nurse #2 on 06/25/20 at 2:29 PM. Nurse #2 stated she was in training with Nurse #3 on night shift on 05/02/20-05/03/20. She stated that sometime after midnight NA #2 came to her and stated that Resident #1 did not want to be moved and was hurting really bad. Nurse #2 stated that she went to Resident #1's room and her right leg was red, swollen, and had a blister. Nurse #2 stated she really did not complain of pain unless they were moving her. She stated since she was in training Nurse #3 did the majority of the paperwork, but she did assess the leg for a pulse and was able to find one.

Review of the Medication Administration Record (MAR) 05/01/20 through 05/31/20 revealed that Resident #1 received Tylenol 650 milligrams (mg) by mouth at 3:15 PM on 05/02/20 for pain reported as a 4 on a pain scale and was effective. The MAR also revealed that Resident #1 received Tramadol (pain medication) 50 mg by mouth twice a day at 8:00 AM and 8:00 PM.

An x-ray report from the local ER read: Right Tibia (shin bone)/Fibula (lower leg bone): obtained 05/03/2020 at 4:25 AM read in part, Acute tibial (shin bone) fracture and acute fibula (lower leg bone) fracture, and osteopenia (low bone mass).

Resident #1 was readmitted to the facility on 05/08/20 after surgical repair of her acute tibial

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and fibular neck fracture.

An observation of Resident #1 was made on 06/25/20 at 10:35 AM. Resident #1 was up in her wheelchair dressed in pants and a sweater and had on slippers. She was leaning to the left side of her wheelchair and was propelling herself in short distances.

An observation and interview were conducted with Resident #1 on 06/25/20 at 3:46 PM. Resident #1 was up in her wheelchair in her room sucking on a sucker. Resident #1 stated she did not recall falling and breaking her leg. When asked if her leg hurt, she pointed to her right knee area. Resident #1 stated she took a pill for her pain and that it helped ease the pain most of the time. Resident #1 was asked if she recently had surgery on her right leg and she replied, "did I?" Resident #1 had no recollection of the fall, fracture or subsequent surgery.

An interview was conducted with the Director of Nursing (DON) on 06/25/20 at 5:05 PM. The DON stated she started with the company on 05/18/20. The DON stated that when an incident occurred whether it be a fall, or a resident being lowered to the floor the staff were expected to immediately let the nurse know. The nurse was expected to immediately conduct a head to toe assessment and from that assessment determine what the next action was. They should obtain a set of vital signs and initiate neurological checks if needed. They need to determine if the resident needs to go the ER or if they can be treated in the facility. The DON stated that anytime a resident went from a higher plane to a lower plan that was considered a fall whether it was assisted or unassisted. The DON stated that she expected

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the Nurse to complete a head to toe assessment including range of motion moving the arms/legs and a set of vital signs despite what the NA told them. In addition, the DON stated the MD should be notified as soon as possible following the incident. If the resident began complaining of pain, she would expect another assessment to be completed and the MD provider to be notified of the new onset of complaints.

An interview was conducted with the MD on 06/26/20 at 12:43 PM. The MD stated that he was aware of the fall and fracture with Resident #1 via the on-call system. The MD stated that it would be very coincidental to have a fracture after a fall or being lowered to the floor coupled with osteopenia. He stated he was not able to discern if the fracture occurred at the time of the incident or if it was spontaneous, but it would be very coincidental if it occurred spontaneously after having a fall. The MD stated that after any type of incident whether it be a fall or being lowered to the floor, he expected the nursing staff to conduct a complete head to toe assessment including range of motion and a set of vital signs and subsequently notify the medical provider. He further stated that if a resident began complaining of pain after the incident, he would expect another assessment to be completed and the medical provider to again be notified.

An interview was conducted with NP #2 on 06/26/20 at 2:11 PM. NP #2 confirmed that she was on call the weekend of 05/02/20 -05/03/20. She stated that she received a call in the early hours of 05/03/20 reporting that Resident #1 was having pain and swelling to her leg after being lowered to the floor. An x-ray was ordered but when the x-ray company could not come for an

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extended period of the time a decision was made to send Resident #1 to the local ER for evaluation. NP #2 stated she did not recall the specific details about the call at 7:00 PM from the facility but stated the call on 05/03/20 in the early morning hours was the first time she had been notified about Resident #1 falling or her complaints of pain.

An interview was conducted with the Radiologist on 06/29/20 at 10:01 AM. The Radiologist confirmed he read Resident #1's x-ray report at the local ER. He stated that her tibial plateau fracture was most likely a result of her recent trauma. The type of fracture that Resident #1 sustained does not typically occur spontaneously as a result of osteopenia. The fractures seen on the x-ray report are going to be the result of some type of trauma 99% of the time. The Radiologist stated that Resident #1 was certainly at risk for other types of fracture due to her osteopenia but there was some type of trauma to "bust her tibia in this way" in my professional opinion.