STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

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E 000	Initial Comments An unannounced onsite recertification and complaint investigation was conducted on 2/14/22 through 2/18/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# LG2K11.	E 000		
F 000	INITIAL COMMENTS An unannounced onsite recertification and complaint investigation was conducted on 2/14/22 through 2/18/22. Two complaint allegations were investigated and they not substantiated. Immediate Jeopardy was identified at: CFR 483.25 at tag F 684 at a scope and severity J. CFR 483.25 at tag F 689 at a scope and severity J. The tags F 684 and F 689 constituted Substandard Quality of Care. Immediate Jeopardy began on 10/31/21 and was removed on 2/17/22. An extended survey was conducted.	F 000		
F 684 SS=J	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. This REQUIREMENT is not met as evidenced	F 684		3/11/22

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

Electronically Signed 03/11/2022

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F 684	Continued From page 1 by: Based on record review and staff interviews, the facility failed to have a nurse assess Resident #19 after the resident fell from the bed to the floor. Resident #19 was on life support and connected to a ventilator. Before reporting the fall to a nurse, staff transferred Resident #19 from the floor to the bed, then from the bed to a shower stretcher, provided a shower and then transferred the resident from the shower stretcher to her bed. Nurse #1 was made aware of the fall after Resident #19 had been transferred three times and showered. Nurse #1 performed a head-to-toe assessment and determined that Resident #19 had abrasions to her abdomen and right arm. Resident #19 was sent to the emergency room and was determined to have acute right tibia and fibula fractures. This deficient practice affected 1 of 1 resident reviewed for falls (Resident #19). The immediate jeopardy began on 10/31/21 when Resident #19 who was on a ventilator for life support and received an anticoagulant fell from her bed and was transferred three times before a nurse was notified and assessed the resident. The immediate jeopardy was removed on 02/17/22 when the facility provided and implemented a credible allegation of immediate jeopardy removal. The facility remained out of compliance at a lower scope and severity of a D (an isolated situation with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education was in place and monitoring systems put into place were effective. Findings included:	F 684	Valley Nursing Center acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance. Valley Nursing Center's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Valley Nursing Center reserves the right to refute any of the stated deficiencies on this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or administrative or legal proceedings. # 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Nurse Aide (NA) #1 requested help from Respiratory Therapist/Nurse Aide #2 and they placed a pad under Resident # 19□s buttocks, lifted and transferred her back to the bed. Respiratory Therapist/Nurse Aide #2 ensured that the resident□s airway was patent, ventilator circuit and tracheostomy tube were connected, and patient was being ventilated appropriately before leaving the room. Nurse Aide #1 and Nurse Aide #3 then transferred	

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F 684	Continued From page 2 Resident #19 was admitted to the facility on 6/29/15 with diagnoses that included a persistent vegetative state with chronic ventilator usage and severe osteoporosis. A physician's order dated 8/1/19 indicated Resident #1 was to receive Xarelto (an anticoagulant- blood thinner) 20mg (milligram) daily at bedtime. A quarterly Minimum Data Set (MDS) assessment dated 09/10/21 indicated Resident #19 had a urinary catheter, special respiratory treatments including oxygen therapy, suctioning, tracheostomy care and ventilator and received an anticoagulant. A review of a document written by Nurse Aide (NA) #1 dated 10/31/21 read, in part, "while I was changing [Resident #19], she started coughing and bouncing. I couldn't catch her before she rolled off the bed. [Respiratory Therapist (RT)/NA #2] and I put a bed pad under her and lifted her back into bed. We then took her to the bath." This document did not provide any details after Resident #19 was taken to the shower. Three attempts were made to contact NA #1 were unsuccessful. A review of a document written by RT/NA #2 dated 10/31/21 read, in part, "walking past resident's room. C.N.A (NA#1) asked for assistance getting resident in bed. Assisted C.N.A. in getting into bed. Resident covered in BM (bowel movement). C.N.A took resident to shower. " An additional typed witness statement signed by	F 684	Resident #19 to the shower bed and took her to the shower room and Nurse Aide #1 completed a shower because she had a large amount of bowel on her. Respiratory Therapist/NA#2 notified Nurse # 1 after resident #19 had been transferred back to the bed. Nurse #1 performed a head to toe assessment of Resident #19 after she was made aware of the fall. Nurse #1 noticed that the resident had an abrasion to her abdomen and her right forearm and that her right leg was positioned differently and was very flexible at the top near her knee. Then at approximately 6:45am Nurse #2 came on shift and he and Nurse #1 assessed the resident together. The Physician on call was notified at 6:59am and gave new orders for an X-ray of right leg. Nurse #2 stated that during the assessment and thereafter, Resident #19 remained at her baseline, no facial grimacing, or nonverbal signs of pain were observed. Nurse #2 immobilized the resident□s leg while awaiting the x-ray report. X-ray report received indicating fractures of right tibia and fibula. Nurse #2 reported the X-ray results to the Physician and the order was received for Resident #19 to be sent to the CVMC Emergency Room. EMS arrived at approximately 6:00pm on 10/31/2021 to transport. Resident returned to this facility at 00:15 on 11/1/21. The facility Nurse Practitioner assessed and evaluated this resident on the morning of 11/1/21. On 11/1/2021 the DON suspended NA#1 while an incident investigation was conducted. NA#1 was subsequently	

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F 684	Continued From page 3 RT/NA #2 on 10/31/21 read, in part, "Resident #19 was sitting on the floor/leaned up against bed in between the bed and the wall air conditioner. Resident #19 was covered in BM; BM was all over the floor and Resident #19's fully inflated catheter was lying on the floor under Resident #19. NA #1 stated he just needed help getting Resident #19 back in the bed. RT/NA #2 believed NA #1 had already reported to the nurse and NA #1 just needed help to transfer Resident #19 back to bed. After Resident #19 returned from the shower, NA #1 commented to RT/NA #2 and NA #3 that the catheter needed to be replaced. RT/NA #2 wrote after this conversation, he alerted the nurse about what he had observed and notified her that the catheter needed to be replaced. At that time, he learned she was unaware of the fall. An interview with RT/NA #2 on 02/15/22 at 3:53 PM revealed he did not notify the nurse that Resident #19 was on the floor prior to assisting NA #1 to move her from the floor to bed. RT/NA #2 stated that he assumed NA #1 had already reported the fall to Nurse #1 but stated he told her about it on his way back to his unit. He stated it was five to ten minutes after he had assisted NA #1 to transfer Resident #19 back to the bed. There were no written statements written by NA #3 provided by the facility. An interview with NA #3 on 02/16/22 at 7:15 PM revealed she was familiar with Resident #19 and was working on the 500 Hall on the night of 10/31/21. NA #3 indicated she was approached and asked for assistance by NA #1 when he was enroute to retrieve a shower stretcher for Resident #19 after she had a large BM and	F 684	terminated from employment on 11/3/2021 due to not immediately notifying the nurse of the fall and for moving the resident prior to her being assessed by the Nurse. # 2 - Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Beginning on 11/1/2021, the DON began reviewing and monitoring all fall incidents. All fall incidents are monitored to ensure immediate nurse notification and assessment before the resident was moved. As of 3/11/22 all falls incidents have been in compliance with timely nurse notification and assessment prior to the resident being moved. # 3 - Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 11/1/21 the DON provided in-service training for all Certified Nursing Assistants on immediately notifying a Nurse upon observation of any resident experiencing a fall and that the nurse is to assess the resident before the resident is moved. On 11/1/21 the DON began reviewing all falls that occur to determine if a nurse was notified immediately of the fall and the nurse performed an assessment prior to the resident being moved. All fall incidents have been in compliance with requirement of immediate nurse notification and nurse assessment of the	

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needed to be bathed. NA #3 said RT/NA #2 performed tracheostomy care and ensured Resident #19 was properly attached to the ventilator before he left the room to alert the nurse and let her know the catheter needed to be replaced. NA #3 stated she did not know that Nurse #1 was not made aware of the fall immediately by NA #1 and did not alert Nurse #1 herself.

An incident report dated 10/31/21 at 5:50 AM written by Nurse #1 read, in part, "I assessed resident for injuries and noted abrasions on right forearm and left lower abdomen. Also, right lower leg swelling just below the knee and some discoloration noted. I was not informed of fall until after she was back in bed and taken to shower and put in bed again. C.N.A. (NA#1) said he was changing her, and she rolled off bed into floor."

A nurses' note written by Nurse #1 on 10/31/21 at 7:00 AM indicated Resident #19 had noted swelling to her right lower extremity.

An interview with Nurse #1 on 2/15/21 at 1:42PM revealed she cared for Resident #19 on the night of 10/30/21 (7:00 PM to 7:00 AM). Nurse #1 indicated she was made aware that Resident #19 had fallen earlier in her shift while Resident #19 was being provided incontinence care by NA #1. Nurse #1 recalled RT/NA #2 making her aware Resident #19's catheter needed to be replaced, but as she recalled she thought NA #1 told her about the fall when she went to the room about the catheter. Nurse #1 explained NA #1 reported that Resident #19 began coughing and jerking after she was rolled on her side during incontinence care. Resident #19 came out of bed because NA #1 was unable to catch her before

resident.
On 2/16/22, the DON implemented facility wide in-service training for all staff (dietary, housekeeping, activities, maintenance, Social Workers, Therapy staff, office staff, Licensed nursing staff and Certified Nursing Assistance including all agency staff on the Fall Protocol that includes:
Notifying a Licensed Nurse immediately before moving the resident.
Before the resident is moved, the Licensed Nurse shall perform an assessment of the resident to determine if any injury has occurred. If no obvious injury is present, the resident should be assisted back to the bed, chair, or wheelchair using the appropriate transfer device.
The Director of Nursing informed Nursing Supervisors of their responsibility to continue this education / re-education on all shifts for all staff.
The Director of Nursing and / or her designee will track which staff has been educated by comparing educational roster to the employee work schedule.
Any Staff not working on 2/16/22 are required to receive this education on their next scheduled workday. Staff will not be allowed to work until this education is completed.
New educational material has been added to the New Hire Orientation packet, new CNA clinical competencies, and the facility information that is provided to Nursing Agency staff.

4 - Indicate how the facility plans to

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F 684	Continued From page 5 she came off the bed and landed on the floor. Nurse #1 found Resident #19 bathed and back in bed when she arrived at the room to assess her. She had abrasions to her abdomen and right forearm as well as swelling in her right lower extremity. Nurse #1 described Resident #19's right lower extremity to be "more flexible and different." Nurse #1 stated she did not notify the provider at the time of her assessment but passed the abnormalities along to the oncoming day shift nurse (Nurse #2). Nurse #1 indicated she was busy finishing her shift duties and planned to notify the provider at the end of her shift because she did not assess Resident #19 to have sustained major injuries. A physician's order written by Nurse #2 and dated 10/31/21 at 6:59 AM indicated Resident #19 was to have an anterior/posterior (AP) and lateral x-ray of the right lower extremity. An interview with Nurse #2 on 2/15/21 at 4:45 PM revealed he arrived to work on 10/31/21 at approximately 6:45 AM. He stated Nurse #1 reported to him that Resident #19 had fallen out of the bed earlier on the shift and the staff had not reported the fall to her until after she was placed back in the bed. Nurse #2 explained that he and Nurse #1 went to Resident #19's room to assess her. He stated that her right leg was positioned "differently" and was very "flexible" at the top, near her knee, which was abnormal for Resident #19. Nurse #2 stated that during the assessment and thereafter Resident #19 remained at her baseline with no visible facial grimacing or nonverbal signs of pain that he could recall. He stated that he returned to the nurse's station and notified the physician and obtained new orders. He said later in the shift the portable x-rays were	F 684	monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. The Director of Nursing and/or her designee will continue to monitor all fall incident reports to determine if a nurse was notified immediately of the fall and the nurse performed an assessment prior to the resident being moved. The Nurse who completes the incident report will be interviewed to assure that they were immediately notified of the incident and that the resident was assessed prior to being moved. The fall incident monitoring with staff interviews will be recorded on a newly implemented audit sheet titled "Fall Incident Monitoring". This monitoring tool was implemented 3/1/22 and will be completed after each resident fall incident for a minimum of six (6) months. The results of these audits will be reported monthly to the Quality Assurance Performance Improvement committee by the Director of Nursing. The results will be reviewed and discussed. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance with immediate nurse notification and assessment of the resident prior to moving after a fall incident.	

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obtained and resulted in fractures to her tibia and fibula on her right side.

A review of x-ray reports from both the contracted in -house company and the hospital dated 10/31/21 confirmed acute fractures to the right tibia and fibula.

According to an Emergency Room (ER) report dated 10/31/21, Resident #19 was transported to the ER after a traumatic injury of the right lower leg. Per the report, it was unable to determine if Resident #19 fell during incontinence care or if she was dropped during a transfer from the bed to the shower stretcher. Resident #19 was splinted because she was not a surgical candidate and ordered to be non-weight bearing and subsequently discharged back to the facility on 11/1/21.

During an interview with the Director of Nursing (DON) on 2/15/22 at 5:00 PM, additional documentation titled "Fall Investigation-Resident #19-10/31/21 5:50 AM" signed by the DON on 11/2/21 was provided which indicated "in an abundance of caution and concern for our resident safety, all facility nurses and NAs were reeducated on positioning a resident in lateral position." The DON reported that following any fall in the facility, when a resident was found to be on the floor, a staff member should immediately notify a nurse prior to moving a resident. She also explained she determined Resident #19 had received a shower before assessed for injury by Nurse #1. The DON stated she did not think NA #1 did anything wrong related to the fall but was an accident.

An interview with the DON, Assistant

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Administrator, and Administrator on 2/16/22 at 12:00 PM revealed each expected all staff to notify the nurse if a resident had a fall and a nurse should assess the resident for injury before the resident is moved to ensure safety.

An interview with the Physician on 2/17/22 at 2:01 PM revealed he expected to be contacted with all changes in conditions to include a fall. The Physician stated he thought this occurrence was an accident.

The Administrator was notified of the Immediate Jeopardy on 2/16/22 at 12:11 PM.

The facility provided the following IJ removal plan.

o Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome because of the noncompliance.
Resident # 19 slid off the bed to the floor during incontinent care at approximately 5:50a. Nurse Aide (NA) #1 requested help from Respiratory Therapist/Nurse Aide #2 and they placed a pad under the resident's buttocks, lifted and transferred her back to the bed. Respiratory Therapist/NA#2 ensured that the resident's airway was patent, ventilator circuit and tracheostomy tube were connected, and patient was being ventilated appropriately before leaving the room. Nurse Aide #1 and Nurse Aide #3 then transferred Resident #19 to the shower stretcher and took her to the shower room and Nurse Aide #1 completed a shower because she had a large amount of bowel on her. Respiratory Therapist/NA#2 notified Nurse # 1 after resident #19 had been transferred back to the bed. Nurse #1 performed a head-to-toe assessment of Resident #19 after she was made aware of the

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fall. Nurse #1 noticed that the resident had an abrasion to her abdomen and her right forearm and that her right leg was positioned "differently" and was very "flexible" at the top near her knee. Then at approximately 6:45am Nurse #2 came on shift and he and Nurse #1 assessed the resident together. The Physician on call was notified at 6:59am and gave new orders for an X-ray of right leg. Nurse #2 stated that during the assessment and thereafter, Resident #19 remained at her baseline, no facial grimacing, or nonverbal signs of pain were observed. Nurse #2 immobilized the resident's leg while awaiting the x-ray report. X-ray report received indicating fractures of right tibia and fibula. Nurse #2 reported the X-ray results to the Physician and the order was received for Resident #19 to be sent to the CVMC Emergency Room. EMS arrived at approximately 6:00pm on 10/31/2021 to transport. Resident returned to this facility at 00:15 on 11/1/21. The facility Nurse Practitioner assessed and evaluated this resident on the morning of 11/1/21. On 11/1/2021 the DON suspended NA#1 while an incident investigation was conducted. NA#1 was subsequently terminated from employment on 11/3/2021 due to not immediately notifying the nurse of the fall and for moving the resident prior to her being assessed by the Nurse.

To identify any other resident who may have been affected; beginning on 11/21/2021, the DON began reviewing and monitoring all fall incidents. All fall incidents are monitored to ensure immediate nurse notification and assessment before the resident was moved. As of 2/16/22 all falls incidents have been in compliance with nurse notification and assessment.

-Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and

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when the action will be complete
On 11/01/21 the DON provided in-service training for all Certified Nursing Assistants on immediately notifying a Nurse upon observation of any resident experiencing a fall and that the nurse is to assess the resident before the resident is moved.
On 11/1/21 the DON began reviewing all falls that occur to determine if a nurse was notified immediately of the fall and the nurse performed an assessment prior to the resident being moved. All fall incidents have been in compliance with requirement of immediate nurse notification and nurse assessment of the resident.
On 2/16/22, the DON implemented facility wide in-service training for all staff (dietary, housekeeping, activities, maintenance, Social Workers, Therapy staff, office staff, Licensed nursing staff and Certified Nursing Assistance including all agency staff on the Fall Protocol that includes:
" Notifying a Licensed Nurse immediately before moving the resident.
" Before the resident is moved, the Licensed Nurse shall perform an assessment of the resident to determine if any injury has occurred. If no obvious injury is present, the resident should be assisted back to the bed, chair, or wheelchair using the appropriate transfer device.
" The Director of Nursing informed Nursing Supervisors of their responsibility to continue this education / re-education on all shifts for all staff.
" The Director of Nursing and / or her designee will track which staff has been educated by comparing educational roster to the employee work schedule.
" Any Staff not working on 2/16/22 are required to receive this education on their next scheduled workday. Staff will not be allowed to work until

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F 684	Continued From page 10 this education is completed. " New educational material has been added to the New Hire Orientation packet, new CNA clinical check off list, and the facility information that is provided to Nursing Agency staff. Alleged IJ removal date: 2/17/22 A credible allegation validation for quality of care was conducted in the facility on 02/17/22. Record review included Resident #19's Kardex and care plan. Notable revisions were as follows: Resident #19's transfer status has been updated to 2-person draw sheet on both the Kardex and care plan which are available to all nursing staff. The in-service training records reflected all staff to include nursing, housekeeping, maintenance, dietary, activities, and administrative staff were in serviced on notification of a nurse with any changes in a resident's condition to include a fall and staff were not to move a resident without a nurses' assessment and direction to do so. The facility's IJ removal date of 2/17/22 was validated.	F 684		
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:	F 689		3/11/22

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F 689	Continued From page 11 Based on record review and staff interview, the facility failed to provide incontinence care according to an established plan to Resident #19 who was on a ventilator and in a persistent vegetative state. Nurse Aide #1 (NA #1) lost control of Resident #19 when he was in the process of providing incontinent care to Resident #19 who began to cough and bounce on the air mattress. NA #1 was unable to prevent Resident #19 from falling out of bed. NA#1 did not immediately report to a nurse. Prior to a nursing assessment to check for injury, nurse aides transferred Resident #19 three times, from the floor to the bed, from the bed to the shower stretcher and then from the shower stretcher to her bed. These transfers were performed by two staff without the use of the mechanical lift. This deficient practice affected 1 of 1 resident reviewed for falls (Resident #19). Resident #19 was sent to the emergency room and diagnosed with acute right tibia and fibula fractures. The immediate jeopardy began on 10/31/21 when Resident #19 fell from her bed during incontinence care and sustained acute fractures. The immediate jeopardy was removed on 02/17/22 when the facility provided and implemented a credible allegation of immediate jeopardy removal. The facility remained out of compliance at a lower scope and severity of a D (an isolated situation with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education was in place and monitoring systems put into place were effective. Findings included: Resident #19 was admitted to the facility on	F 689	# 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Transfer status for Resident #19 was evaluated by the Physical Therapist Doctor of Physical Therapy for patient safety and mobility 2/17/2022. Therapist determined resident is dependent on functional mobility and would benefit utilizing a draw sheet for lateral transfers with total assistance from 2+ staff. Kardex and Care Plan was updated to 2 person assist for incontinence care on 2/16/2022. # 2 - Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On November 1, 2021 Director of Nursing implemented in-service training for all Nursing staff on Safe Positioning of Resident when Turning and Providing Incontinence Care Independently. In service covered positioning a resident in lateral position, using proper body mechanics, assure residents face is not obstructed. Use supporting devices. This education is covered in orientation and was used as a refresher to remind the nursing staff to be cognizant of the residents position on the bed during incontinent care and required no additional steps for implementation. On February 16, 2022, Director of Nursing, MDS RNS, and Nursing Supervisors reviewed all other resident□s	

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F 689	Continued From page 12 6/29/15 with diagnoses that included a persistent vegetative state with chronic ventilator usage and severe osteoporosis. A physician's order dated 8/1/19 indicated Resident #1 was to receive Xarelto (an anticoagulant- blood thinner) 20mg (milligram) daily at bedtime. A quarterly Minimum Data Set (MDS) dated 09/10/21 indicated Resident #19 required physical assistance from two or more persons with bed mobility, transfers, and toileting. She had a urinary catheter and was always incontinent of bowel. She received special respiratory treatments including oxygen, suctioning, tracheostomy care and was on a ventilator. She also received tube feeding for nutrition and anticoagulant medication. A self-care deficit care plan revised on 1/24/22 indicated Resident #19 was dependent for transfers and incontinence care with rounds and as needed. The care plan did not indicate how many staff should provide incontinence care or how to transfer the resident. According to the DON, on 2/15/22 at 5:00 PM, most ventilator residents in a vegetative state are transferred using a mechanical lift which required the assistance of 2 staff members. NA #1's statement read, "while I was changing Resident #19, she "started coughing and bouncing. I couldn't catch her before she rolled off the bed." RT/NA #2 and I put a bed pad under her and lifted her back into bed. We then took her to the bath."	F 689	residing in the facility to determine those who needed two person assistance with incontinence care and those residents who required a mechanical lift for transfers. The MDS nurses then reviewed each Resident□s Kardex (tool used in the electronic health record to inform staff of care requirements) and made changes where necessary to provide information to staff on amount of assistance needed for safe transfer of resident, the mobility status of a resident and the required number of staff to provide safe toileting/incontinence care to a resident while in bed. This was completed on 2/16/2022. # 3 - Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; All resident falls are reviewed in Morning Standup meetings. The Director of Nursing presents the review of falls to the clinical team. Clinical team consists of DON, MDS Nurse, Wound Care Nurse, Nursing Supervisors, Administration, Director of Rehab, Social Worker, Director of Respiratory Therapy, Root cause of why the fall occurred is investigated by the DON and shared with all disciplines participating in the review. Interventions are put in place to keep the resident from having a recurring fall. MDS Nurse adds interventions to the care plan which populates the Kardex. Nursing Supervisors inform hall staff of any updates in plan of care. Previous	

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Multiple attempts to contact NA #1 were made without success.

A review of a document written by RT/NA #2 dated 10/31/21 read, in part, "walking past resident's room. C.N.A (NA #1) asked for assistance getting resident in bed. Assisted C.N.A. in getting into bed. Resident covered in BM (bowel movement). C.N.A took resident to shower. "

An additional typed witness statement signed by RT/NA #2 on 10/31/21 read, in part, "Resident #1 was sitting on the floor/leaned up against bed in between the bed and the wall air conditioner. Resident #19 was covered in BM. Resident #19's fully inflated catheter was lying on the floor under Resident #19. NA #1 stated he just needed help getting Resident #19 back in the bed. RT/NA #2 indicated NA #1 had already conversed with the nurse and NA #1 just needed help to transfer Resident #19 back to bed. NA #3 ' s assistance was requested to help clean Resident #19 and she was taken to the shower room for bathing. RT/NA #2 wrote after this conversation, he alerted the nurse, shared what he had observed and notified her that the catheter needed to be replaced. At this time, he learned she was unaware of the fall.

An interview with RT/NA #2 on 02/15/22 at 3:53 PM revealed he recalled the events surrounding the fall sustained by Resident #19 on 10/31/21. RT/NA #2 stated he was walking by Resident #19's room and NA #1 was in the hallway and asked for help to transfer Resident #19 from the floor to the bed. He noticed Resident #19 lying on the floor on her right side with her catheter no longer intact. RT/NA #2 explained that he and NA

implemented interventions are reviewed at our monthly At Risk meetings to determine effectiveness. If the intervention does not work and a resident has a repeat fall, root cause is evaluated again and additional interventions put in place or previous interventions removed. Interventions are updated in the care plan immediately after the meeting and staff notified by Nursing Supervisors. CNA□s have access to both the care plan and the Kardex.

On February 16, 2022, the Director of Nursing implemented in-services for all Nursing Staff including Agency on Locating Required Staff Assistance for Toileting and Incontinence Care. Any nursing staff or agency nursing staff reporting to work after this date will receive this in-service prior to working. Information included:

Locating information in electronic Kardex which indicates residents need for number of staff required to provide safe toileting/incontinence care .

Use the correct number of staff when providing care.

Informing supervisor if additional staff is needed to provide incontinence care to resident safely.

Use correct equipment/assistance devices for lifting and/or transfers according to the assessment and care plan of the resident.

Reviewed location of Care Plan and Kardex within the Electronic Records.

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F 689	Continued From page 14 #1 placed a cloth incontinence pad under Resident #19 then lifted her up to the bed. RT/NA #2 indicated before NA #1 left the room to retrieve the shower stretcher, NA #1 stated he would need to reinsert Resident #19's catheter because it had come out during the fall. When NA #1 returned to the room with the shower stretcher, NA#3 entered the room and she assisted NA #1 to slide Resident #19 from the bed to the shower stretcher using the cloth bed pad used to lift her from the floor. RT/NA #2 stated he left the room to go back to the unit and he stopped and told Nurse #1 about the incident because he knew the catheter was no longer intact. RT/NA #2 stated normally Resident #19 was transferred using a mechanical lift and two-person physical assistance. He stated for some reason they were just in a hurry and did not use the lift. RT/NA #2 stated that he assumed NA #1 had already reported the fall to Nurse #1 but stated he told her about it on his way back to his unit which he stated was five to ten minutes after he had assisted NA #1 to transfer Resident #19 back to the bed. There were no written statements written by NA #3 provided by the facility. An interview with NA #3 on 02/16/22 at 7:15 PM revealed she was familiar with Resident #19 and was working on the 500 Hall on the night of 10/31/21. NA #3 indicated she was approached and asked for assistance by NA #1 when he was enroute to retrieve a shower stretcher for Resident #19 after she had a large BM and needed to be bathed. NA #3 reported she followed NA #3 back to Resident #19's room where she found Resident #19 lying in the bed with her catheter lying on the floor near the bed.	F 689	New educational material has been added to the New Hire Orientation packet for Nursing and Nurse Aide staff, Agency staff, as well as the Clinical version. Kardex Information Care Plan Information # 4 - Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. The Director of Nursing implemented new audit tool titled Transfers and Incontinence Care on 3/1/22. The DON and/or her designee will observe the care provided to at least three (3) residents requiring two person assistance with incontinence care and two (2) residents requiring a mechanical lift for transfer to assure compliance. These observations will be done weekly for four weeks, then every other week for two months, and then monthly for two months for a total of 6 months of performance monitoring. The results will be recorded on the audit tool titled Transfers and Incontinence Care. Results will be reported to the Quality Assurance Performance Improvement committee by the Director of Nursing monthly for review and discussion. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.	

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NA #3 indicated she and NA #1 transferred Resident #19 from the resident ' s bed to the shower stretcher using a cloth incontinence pad and NA #1 took Resident #19 to the shower room independently. Approximately 20-30 minutes later, when NA #1 returned with Resident #19 from the shower room, she assisted NA #1 to transfer Resident #19 from shower stretcher to the resident ' s bed via a clean cloth incontinence pad. NA #3 vocalized she was aware Resident #19's transfer status was a mechanical lift with 2-person physical assistance, but stated staff never transferred Resident #19 using a mechanical lift and always used a cloth incontinence pad for transfers.

An interview with NA #4 on 2/17/22 at 11:00 AM revealed she was familiar with Resident #19 and cared for her often. NA #4 indicated she tried to have 2-person assist for incontinence care, bed mobility, but there were times when they must provide incontinence care and bed mobility with only one person if other staff were busy helping other residents.

An interview with Nurse #3 on 2/17/22 at 11:00 AM indicated staff were required to provide 2-person physical assistance for transfers of Resident #19 and make attempts to provide 2-person physical assistance for bed mobility and toileting.

An incident report dated 10/31/21 at 5:50 AM written by Nurse #1 read, in part, "I assessed resident for injuries and noted abrasions on right forearm and left lower abdomen. Also, right lower leg swelling just below the knee and some discoloration noted. I was not informed of fall until after she was back in bed and taken to shower

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and put in bed again. C.N.A. said he was changing her, and she rolled off bed into floor."

A nurses' note written by Nurse #1 on 10/31/21 at 7:00 AM indicated Resident #19 had noted swelling to her right lower extremity.

An interview with Nurse #1 on 2/15/21 at 1:42PM revealed she cared for Resident #1 on the night of 10/30/21 (7:00 PM to 7:00 AM). Nurse #1 indicated she was made aware that Resident #19 had fallen earlier in her shift while Resident #19 was being provided incontinence care by NA #1. Nurse #1 explained NA #1 reported Resident #19 began coughing and jerking after she was rolled on her side during incontinence care. She subsequently fell out of bed because NA #1 was unable to catch her before she came off the bed and landed on the floor. According to Nurse #1, Resident was found bathed and back in bed when she assessed Resident #19. She found her to have abrasions to her abdomen and right forearm as well as swelling in her right lower extremity. Nurse #1 described Resident #19's right lower extremity appeared to be "more flexible and different." Nurse #1 indicated Resident #19 was dependent for transfers using the mechanical lift. Nurse #1 did not feel Resident #19 was injured and did not feel contacting the physician before the end of her shift which was approximately 1 hour later was warranted.

A physician's order written by Nurse #2 and dated 10/31/21 at 6:59 AM indicated Resident #19 was to have an anterior/posterior (AP) and lateral x-ray of the right lower extremity.

An interview with Nurse #2 on 2/15/22 at 4:45 PM revealed he arrived to work on 10/31/21 at

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approximately 6:45 AM. Nurse #2 explained that he and Nurse #1 went to Resident #19's room to assess her. He stated that her right leg was positioned "differently" and was very "flexible" at the top, near her knee, which was abnormal for Resident #19. Nurse #2 stated that during the assessment and thereafter Resident #19 remained at her baseline with no visible facial grimacing or nonverbal signs of pain that he could recall. Nurse #2 stated Resident #19 was dependent for transfers using a total body mechanical lift and 2 staff physical assistance for safety. He elaborated Resident #19 should not have been lifted using an incontinence pad after she fell from her bed.

A review of x-ray reports from both the contracted in -house company and the hospital dated 10/31/21 confirmed acute fractures to the right tibia and fibula.

According to an Emergency Room (ER) report dated 10/31/21, Resident #19 was transported to the ER after a traumatic injury of the right lower leg. Per the report, it was unable to determine if Resident #19 fell during incontinence care or if she was dropped during a transfer from the bed to the shower stretcher. Resident #19 was splinted and ordered to be non-weight bearing and subsequently discharged back to the facility on 11/1/21.

During an interview with the Director of Nursing (DON) on 2/15/22 at 5:00 PM, additional documentation titled, "Fall Investigation-[Resident #19] 10/31/21 5:50 AM," signed by the DON on 11/2/21, was provided which indicated the DON investigated and determined that the NAs involved in the incident surrounding Resident

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#19's fall did no wrong and the root cause of the fall was due to the air mattress' slick surface and the resident's coughing. The document further indicated "in an abundance of caution and concern for our resident safety, all facility nurses and NAs were reeducated on positioning a resident in lateral position." The DON reported that following any fall in the facility, when a resident was found to be on the floor, a staff member should immediately notify a nurse prior to moving a resident. Once the resident was assessed not to have an injury, the resident may be transferred based on their current transfer method.. Once the resident is transferred and safety established, the physician, responsible party, and the DON should be notified immediately for further orders and investigation. The DON verbalized she discovered during her investigation Resident #19 was transferred incorrectly using the incorrect transfer method.

An interview with the DON, Assistant Administrator, and Administrator on 2/16/22 at 12:00 PM revealed each expected all staff to notify the nurse if a resident had a fall. They stated they did not believe the mechanical lift wouldn't fit on that side of the bed where Resident #19 fell, but later acknowledged the bed was able to have been moved to allow for transfer using the mechanical lift.

The Administrator was notified of the Immediate Jeopardy on 2/16/22 at 12:11 PM.

The facility provided the following IJ removal plan.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance

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Resident #19 was provided incontinence care by a Certified Nursing Assistant (CNA) on 10/31/21. During the care the resident had a coughing spell and began bouncing around on the bed. Before the Certified Nursing Assistant #1 could reach the resident, she rolled from the bed. MDS indicated resident required 2 assist to provide incontinence care 1 time in the 7 day look back period. Information the resident required 2 assists when providing incontinence care was not available on the Kardex file. It is unknown if the side rail on the opposite side was up or down. Per CNA Resident #19 was rolled away from him. Resident #19 requires 2 person assist for incontinence care. Kardex and Care Plan was updated to 2 person assist for incontinence care on 2/16/2022.

Transfer status for Resident #19 was evaluated by the Physical Therapist Doctor of Physical Therapy for patient safety and mobility 2/17/2022. Therapist determined resident is dependent on functional mobility and would benefit utilizing a draw sheet for lateral transfers with total assistance from 2+ staff.

This deficient practice has the potential to affect all residents residing within the facility who are incontinent and require assistance with care.

On November 1, 2021 Director of Nursing implemented in-service training for all Nursing staff on Safe Positioning of Resident when Turning and Providing Incontinence Care Independently. In service covered positioning a resident in lateral position, using proper body mechanics, assure residents face is not obstructed. Use supporting devices. This education is covered in orientation and was used

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as a refresher to remind the nursing staff to be cognizant of residents position on the bed during incontinent care and required no additional steps for implementation.

On February 16, 2022, Director of Nursing, MDS RNS and Nursing Supervisors reviewed all other resident's residing in the facility to determine those who needed two person assistance with incontinence care and those residents who required a mechanical lift for transfers. The MDS nurses then reviewed each Resident's "Kardex" (tool used in the electronic health record to inform staff of care requirements) and made changes where necessary to provide information to staff on amount of assistance needed for safe transfer of resident, the mobility status of a resident and the required number of staff to provide safe toileting/incontinence care to a resident while in bed. This was completed on 2/16/2022.

- Transfer Status
- Mobility Status
- Toileting Status

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

All resident falls are reviewed in Morning Standup meetings. The Director of Nursing presents the review of falls to the clinical team. Clinical team consists of DON, MDS Nurse, Wound Care Nurse, Nursing Supervisors, Administration, Director of Rehab, Social Worker, Director of Respiratory Therapy, Root cause of why the fall occurred is investigated by the DON and shared with all disciplines participating in the review.

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Interventions are put in place to keep the resident from having a recurring fall. MDS Nurse adds interventions to the care plan which populates the Kardex. Nursing Supervisors inform hall staff of any updates in plan of care. Previous implemented interventions are reviewed at our monthly "At Risk" meetings to determine effectiveness. If the intervention does not work and a resident has a repeat fall, root cause is evaluated again and additional interventions put in place or previous interventions removed. Interventions are updated in the care plan immediately after the meeting and staff notified by Nursing Supervisors. CNA's have access to both the care plan and the Kardex.

On February 16, 2022 the Director of Nursing implemented in-services for all Nursing Staff including Agency on Locating Required Staff Assistance for Toileting and Incontinence Care. Any nursing staff or agency nursing staff reporting to work after this date will receive this in-service prior to working.

· Locating information in electronic Kardex which indicates residents need for number of staff required to provide safe toileting/incontinence care .
· Use the correct number of staff when providing care.
· Informing supervisor if additional staff is needed to provide incontinence care to resident safely.
· Use correct equipment/assistance devices for lifting and/or transfers according to the assessment and care plan of the resident.
· Reviewed location of Care Plan and Kardex within the Electronic Records.
New educational material has been added to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

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F 689	Continued From page 22 New Hire Orientation packet for Nursing and Nurse Aide staff as well as the Clinical version . · Kardex Information · Care Plan Information Alleged IJ removal date: Requested for February 17, 2022 A credible allegation validation for supervision to prevent accidents was conducted in the facility on 02/17/22. Record review included Resident #19's Kardex and care plan. Notable revisions were as follows: Resident #19's transfer status has been updated to 2- person draw sheet on both the Kardex and care plan which are available to all nursing staff. The in-service training records reflected all staff to include nursing, housekeeping, maintenance, dietary, activities, and administrative staff were in-serviced on notification of a nurse with any changes in a resident's condition to include a fall and staff were not to move a resident without a nurses' assessment and direction to do so. Staff were observed to perform incontinence care using the appropriate turning education provided as well as residents were transferred using 2 person physical assistance when using the mechanical lift. The facility's IJ removal date of 2/17/22 was validated.	F 689		