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NC STATE VETERANS HOME - FAYETTEVILLE	214 COCHRAN AVENUE FAYETTEVILLE, NC 28301

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E 000	Initial Comments The survey team entered on 11/1/22 and exited on 11/4/22. A focused infection control survey was conducted. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 11/1/22 to conduct a complaint investigation and focused infection control survey. The survey team was onsite 11/1/22 to 11/3/22. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event ID# B7Y611 The following intakes were investigated: NC00192599, NC00193906, and NC00192121. 1 of the 9 complaint allegations was substantiated resulting in a deficiency. Past-noncompliance was identified at: CFR 483.10 at tag F580 at a scope and severity J CFR 483.25 at tag F684 at a scope and severity J The tag F684 constituted Substandard Quality of Care. Non-noncompliance began on 9/27/22. The facility came back in compliance effective 10/29/22. A Partial extended survey was conducted on 11/4/22. Therefore, the survey exit date was changed to 11/4/22.	F 000		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)	F 580		

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

Electronically Signed

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F 580	Continued From page 1 §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		

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F 580	Continued From page 2 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and physician interview for one (Resident # 3) of three sampled residents who experienced accidents, the facility failed to notify the physician that the resident had fallen on the date on which he fell. Failure to notify the physician resulted in delayed assessment and identification of multiple facial bone fractures Resident # 3 sustained from the fall. These fractures included fracture of the wall of the left maxillary sinus (near the nose), fracture of the left mandible (the jawbone), fracture of the lateral pterygoid process (which allows the jawbone to move while eating), and fracture of the left lateral orbital rim and lateral orbital wall (bones around the eye). The findings included: Resident # 3 resided at the facility from 11/5/21 until 10/21/22. Resident # 3's diagnoses included in part Parkinsons, Lewy Body Dementia, tremors, and chorea like uncontrolled body movements (jerky movements caused by a neurological disorder). Review of nursing notes for 9/27/22 revealed the first entry was entered at 6:28 PM. Nurse # 1 wrote at that time, "up in geri chair. Cont	F 580	Past noncompliance: no plan of correction required.	

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(continues) with uncontrollable body movements. Took meds crushed in apple sauce. Drank Two Cal. No S/S (signs and symptoms) pain or discomfort. Incontinent urine X 1. Remains very high risk for falls r/t (related to) uncontrollable body movement. Was informed by off going nurse and ADON (Assistant Director of Nursing) that resident has bruising to left orbit and a small laceration to left cheek from probably bumping his cheek because of his uncontrolled body movements. He is noted to have bluish swelling along left jaw line. He does not appear to be in pain. DOHS (Director of Health Services) notified, provider notified."

The next nursing entry was made on 9/28/22 at 6:18 AM by Nurse # 4 and read, "Resident rested in bed with eyes closed and NAD (no apparent distress) noted. Bed locked in low position and call bell within reach. Alert and oriented to self with confusion noted. Discoloration to left orbit, no active (bleeding) to laceration on upper cheek line, discoloration to left mandible. Monitoring for s/sx (signs and symptoms) of discomfort."

The next nursing entry was made on 9/28/22 at 3:04 PM as a "late entry" by Nurse # 2. Nurse # 2 noted the following. "Resident was observed on 9/27/22 in room at 9:45 AM by this writer. Lying on his right side with the right upper part of his body on his bed and his lower half on the floor mat with the bed in the lowest position. Resident was assisted back up on to his bed. At 12:00 CNA (certified nursing assistant) reported that resident had been making several attempts to stand unassisted. Nurse advised CNA to assist resident into chair so that he could be monitored closer by nursing staff for safety. At 12:25 PM resident present with a nose bleed. Resident also

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combative and has increase anxiety. NP (Nurse Practitioner) notified at 12:30 PM and advised nursing to assure resident wasn ' t on any blood thinners and if not to just continue to monitor resident. Resident ' s nose bleed was able to be stopped at roughly 2:15 PM. Resident has an abrasion to left face and a skin tear to left elbow reported to be from a recent fall. Resident ' s daughter (name of daughter) notified however was unable to be reached. VM (voice mail) left for call. Resident ' s daughter was contacted on 9/28/22 at 1:45 PM and was notified of incident. This writer asked res. daughter if she would like a CT scan and she states that if the MD feels it necessary then she would. MD notified."

On 9/28/22 at 4:21 PM an entry was made noting the physician had been in to see Resident # 3 and ordered that the resident be sent to the hospital emergency department.

NA (Nurse Aide # 1) had been Resident # 3 ' s assigned dayshift NA on 9/27/22. NA # 1 was interviewed on 11/2/22 at 1:50 PM and reported Resident # 3 had fallen the morning of 9/27/22 and Nurse # 2 had gone in the room and observed he had fallen also.

Nurse # 2 was interviewed on 11/2/22 at 3:35 PM and reported the following. On the morning of 9/27/22, she had gone by Resident # 3 ' s room and observed his legs were flopped over the low bed and resting on the floor mat. His upper body was in the bed, and she had assisted him in getting his legs back in the bed. Around lunch time, NA # 1 had approached her and informed her Resident # 3 kept trying to get out of bed. She had instructed NA # 1 to obtain the help of another NA, assist the resident up to the chair,

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and then place him at the nursing desk where they could watch him more closely. NA # 1 did not report the resident had fallen and she (Nurse # 2) had not gone in the room with NA # 1 and observed that the resident had fallen. Approximately 20 minutes after she had instructed NA # 1 to bring the resident to the nursing desk for closer monitoring, she observed that Resident # 3 was at the nursing desk and he had a rocking motion to his movement. Shortly after observing him at the nursing desk, she observed that his nose was bleeding. The nursing supervisor (Nurse # 3) was present and they both tried to work with applying ice and pressure to get the bleeding to stop. They called the on call provider about the nose bleed and the provided instructed them to make sure he was not on an anticoagulant. She did not inform the on call provider that the resident had fallen because she was not aware he had fallen. The bleeding slowed until it finally subsided. The resident did not have any apparent bruises during her shift. He had a small left check abrasion which looked like a "rug burn" and a small skin tear to his left elbow. She had talked to the nursing supervisor (Nurse # 3), who let her know he had fallen previously and it was felt those two areas were from his constant movements possibly reopening them. He kept picking at the one on his face and therefore it was plausible to her that they were old areas that had reopened. If she had known he had fallen she would have communicated this to the physician. The next day she learned there was an investigation into his care by administrative staff because bruises had appeared on his face on the shift following her dayshift of 9/27/22. As she was talking to administrative staff members on 9/28/22 along with NA # 1, NA # 1 reported Resident # 3 had

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fallen on the morning of 9/27/22. That was the first time she had been made aware Resident # 3 had fallen.

Nurse # 3 was interviewed on 11/2/22 at 8:30 PM via phone and reported the following. She had worked as the day shift facility supervisor on 9/27/22. Around lunch time on 9/27/22 she had observed Resident # 3 in a chair at the nursing desk. He was having a nose bleed and was refusing to eat. He also had a check wound which she thought was old and had reopened. No one had reported to her that he had fallen. She and Nurse # 2 worked to try to get the bleeding to stop and after it did not stop for about 30 to 40 minutes, they called the on call provider to report the nose bleed. It was not reported to the on call provider that the resident had fallen because no one had made her aware Resident # 3 had fallen.

Nurse # 1 had been the supervisor for the 3 PM to 11 PM shift on 9/27/22. Nurse # 1 was interviewed on 11/2/22 at 4:10 PM and reported the following. She had been informed by the ADON (Assistant Director of Nursing) and medication nurse that Resident # 3 had a laceration to his cheek. She checked on him near the start of her shift and saw the laceration. It was small and there was a small bruise which was "not bad." It was near his jaw bone. She checked on him a second time during her shift and at that point, the bruising had worsened. At this second check, she began to think that the bruising was more significant than what would have been caused by the small laceration on his check. She talked to the direct care nurse. She did call the Director of Nursing and the on call provider and inform them about the bruising, but she did not report he had fallen because no one had reported

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he had fallen. At the time, although the bruising was worsening, Resident # 3 was resting comfortably and the decision was made not to send him out at that point.

A review of the physician ' s progress note, dated 9/28/22 revealed the following notation, "I was called today by the nursing staff to see (Resident #3) who sustained a fall from standing position yesterday .....He has obvious left facial trauma. These is a small cut over the left zygom (check bone). There is left periorbital ecchymosis (bruising around the eye) with tenderness and swelling, left cheek tenderness and swelling, a large 10 cm (centimeter) area of bruising over the left lower face and mandible (jaw bone). The left glob. (as written) He said he can see me in front of him. He appears in pain and weak ....I believe he has multiple facial fractures, an infraorbital fracture and mandible fracture."

According to the nursing notes, Resident # 3 was transferred to the hospital on 9/28/22 at 4:51 PM.

Hospital records for the date of 9/28/22 revealed Resident # 3 had a CT (a computerized tomography scan) of his face which showed fractures of multiple bones in his face; including fracture of the medial wall of the left maxillary sinus, fracture of the left mandible, fracture of the lateral pterygoid process (which allows the jawbone to move while eating), fracture of the left lateral orbital rim and lateral orbital wall. The resident was transferred back to the facility for care on 9/30/22.

Resident # 3 ' s physician, who serves as the facility's medical director, was interviewed, on 11/3/22 at 12:11 PM and reported the following.

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She assessed the resident on 9/28/22 and could tell from visually looking at him that he had fractured his facial bones. It appeared he had taken a direct hard hit to his check area. If the facility staff had told the on call provider on 9/27/22 about the fall, then the resident would have been transferred out that day.

On 11/2/22 at 1:05 PM the Assistant Director of Nursing presented an investigation into Resident # 3's fall. According to the ADON, initially it was thought the bruise was from the resident ' s own movements and it was not made clear to administrative staff that he had fallen until 9/28/22. They started to investigate the incident on 9/28/22 and at that point it was reported that the resident had fallen.

The Administrator was interviewed on 11/3/22 at 10:40 AM and reported that they identified on 9/28/22 that there had been a lack of communication between her staff about the residen's fall. During the investigation, staff members reported different scenarios; with Nurse # 2 reporting that she never had been told the resident had fallen and with NA # 1 reporting that Nurse # 2 knew the resident had fallen. According to the Administrator, if the communication between her staff had occurred correctly then the physician would have been notified because they always told the provider of accidents. The Administrator stated the facility had done a complete plan of correction with a root cause analysis regarding the incident. The Administrator presented the plan of correction as follows.

The Administrator was notified of immediate jeopardy on 11/3/22.

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POC for Communication of changes in condition/falls to the MD

Step 1.

a. Resident #3 was assessed by the nurse due to bruises on his face, then assessed by the MD and ordered to go to the local Emergency Room on 9.28.22.

b. Root Cause Analysis was started on 9.28.22 by the Assistant Director of Nursing and Administrator. The Root Cause Analysis revealed that the nurse was not made aware by the nursing assistant that she found Resident #3 face down on the floor by his bed. The Root Cause Analysis was completed on 10.15.22.

Step 2.

a. All residents have potential to be affected.

b. All falls from 9.29.22 to 10.15.22 were reviewed by the Case Mix Director to ensure communication to the physician for falls and other significant changes in condition. The audit revealed that the Medical Director had been notified of each fall, interventions were put in place that limit the risk of falling, and each resident was assessed by a nurse.

Step 3.

a. 10.20-22 - Education was done for all Certified Nursing Assistants and Licensed Nurses by the Assistant Director of Nursing and Director of Nursing for the nursing staff on communication of changes in condition/falls, using the shift rounding checklist for Certified Nursing Assistants and

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Charge Nurses. C.N.A Shift Report is for the Certified Nursing Assistant coming on shift and leaving off shift to communicate any changes in condition, (ex. Falls, skin tear, etc), and any other concerns.

b. 10.28.22 - Additionally, included in the education to all licensed nurses was communication to the Medical Director/Nurse Practitioner, provided

by the Assistant Director of Nursing and Director of Nursing. New staff will continue to be educated upon hire, annually, and as needed.

Step 4.

a. 10.28.22 - Monitoring of communication of changes in condition, falls and communication to the Medical Director/Nurse Practitioner using the shift rounding checklist will be done by the Director of Nursing and Assistant Director of Nursing.

Monitoring will occur 5 times per week for 4 weeks, then 2 times per week for 4 weeks, and monthly for 3 months. Results of the monitoring, with tracking and trending, will be reported by Director of Nursing (RN) and Assistant Director of Nursing (RN) monthly to the Quality Assurance Performance Improvement committee for recommendations and suggestions for improvements and changes.

Completion date 10.29.2022

On 11/3/22 and 11/4/22 the facility ' s credible allegation of compliance was validated by the following.

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F 580	Continued From page 11 The facility presented evidence of inservice education. It was found inservice education had been completed per the facility ' s plan of correction. The facility presented evidence of audits. It was found the facility had been conducting audits per their plan of correction. Multiple staff members were interviewed on 11/3/22 and reported they had received education regarding reporting changes of condition to the physician. The facility staff were knowledgeable of the rounding sheets and reported the sheets were being completed at end of shift to assure communication was being conducted about change in conditions. The facility's medical director was interviewed on 11/4/22 at 3:05 PM and reported the following. There had been no other incidents of which she was aware where facility staff had not reported a change in condition or accident to her or her Nurse Practitioners. The medical director stated the facility staff had her direct number and were very good about calling her. The facility's credible allegation of compliance was validated for the date of 10/29/22.	F 580		
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	F 684		

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F 684	Continued From page 12 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 by: Based on record review, staff interview, and physician interview for one (Resident # 3) of three sampled residents who experienced accidents, the facility failed to communicate the resident had fallen in order that the resident receive assessments, neurological checks, and care directly following the fall. The resident was sent out to the hospital the day following the fall and was identified to have multiple facial fractures which included a fracture of the wall of the left maxillary sinus (near the nose), fracture of the left mandible (the jawbone), fracture of the lateral pterygoid process (which allows the jawbone to move while eating), and fracture of the left lateral orbital rim and lateral orbital wall (bones around the eye). The findings included: Resident # 3 resided at the facility from 11/5/21 until 10/21/22. Resident # 3's diagnoses included in part Parkinsons, Lewy Body Dementia, tremors, and chorea like uncontrolled body movements (jerky movements caused by a neurological disorder). Resident # 3's Minimum Data Set Assessment, dated 8/16/22, coded the resident as unable to complete the interview for mental status. He was also coded as needing extensive assistance with his transfers and hygiene. He was also coded as having a history of falls.	F 684	Past noncompliance: no plan of correction required.	

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The resident's care plan included information that Resident # 3 was at risk for falls and had a history of falls. This was added to the care plan on 11/5/21 and remained as an active part of his care plan up until his discharge date.

According to hospital records the resident was hospitalized from 9/4/22 until 9/16/22 secondary to an altered mental status change. During this time, the resident underwent cranial surgery. Following his 9/16/22 hospital discharge, Resident # 3 was transferred back to the facility for care with hospice services.

Review of nursing notes for 9/27/22 revealed the first entry was entered at 6:28 PM. Nurse # 1 wrote at that time, "up in geri chair. Cont (continues) with uncontrollable body movements. Took meds crushed in apple sauce. Drank Two Cal. No S/S (signs and symptoms) pain or discomfort. Incontinent urine X 1. Remains very high risk for falls r/t (related to) uncontrollable body movement. Was informed by off going nurse and ADON (Assistant Director of Nursing) that resident has bruising to left orbit and a small laceration to left cheek from probably bumping his cheek because of his uncontrolled body movements. He is noted to have bluish swelling along left jaw line. He does not appear to be in pain. DOHS (Director of Health Services) notified, provider notified."

The next nursing entry was made on 9/28/22 at 6:18 AM by Nurse # 4 and read, "Resident rested in bed with eyes closed and NAD (no apparent distress) noted. Bed locked in low position and call bell within reach. Alert and oriented to self with confusion noted. Discoloration to left orbit, no active (bleeding) to laceration on upper cheek

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line, discoloration to left mandible. Monitoring for s/sx (signs and symptoms) of discomfort."

The next nursing entry was made on 9/28/22 at 3:04 PM as a "late entry" by Nurse # 2. Nurse # 2 noted the following. "Resident was observed on 9/27/22 in room at 9:45 AM by this writer. Lying on his right side with the right upper part of his body on his bed and his lower half on the floor mat with the bed in the lowest position. Resident was assisted back up on to his bed. At 12:00 CNA (certified nursing assistant) reported that resident had been making several attempts to stand unassisted. Nurse advised CNA to assist resident into chair so that he could be monitored closer by nursing staff for safety. At 12:25 PM resident present with a nose bleed. Resident also combative and has increase anxiety. NP (Nurse Practitioner) notified at 12:30 PM and advised nursing to assure resident wasn't on any blood thinners and if not to just continue to monitor resident. Resident's nose bleed was able to be stopped at roughly 2:15 PM. Resident has an abrasion to left face and a skin tear to left elbow reported to be from a recent fall. Resident's daughter (name of daughter) notified however was unable to be reached. VM (voice mail) left for call. Resident ' s daughter was contacted on 9/28/22 at 1:45 PM and was notified of incident. This writer asked res. daughter if she would like a CT scan and she states that if the MD feels it necessary then she would. MD notified."

There was no indication in the record that neurological checks were initiated and performed on 9/27/22.

On 9/28/22 at 4:21 PM an entry was made noting the physician had been in to see Resident # 3

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and ordered that the resident be sent to the hospital emergency department.

NA (Nurse Aide # 1) had been Resident # 3 ' s assigned dayshift NA on 9/27/22. NA # 1 was interviewed on 11/2/22 at 1:50 PM and reported the following. On the AM of 9/27/22 Resident # 3 was in his room in the bed with a mat beside his bed. The bed was in the low position near the floor. Nurse # 2 had seen him earlier part way off the bed, had assisted him back into the bed, and had told her to keep checking on him. She did so. She was aware Resident # 3 could stand up from the low bed. He had some diarrhea that morning and after cleaning him, she went to get Nurse # 2 to let her know. They both went back to the room and found that he had fallen. He was positioned as if he was trying to hold himself up off the floor and with his face pointed down towards the ground. He had a cut on his cheek and no bruising. Nurse # 2 was pregnant at the time and therefore she (NA # 1) told Nurse # 2 she would pick the resident up and put him in his chair. She did so. She then took him to the nursing desk. Later his nose started to bleed that day. NA # 1 reported he did not have any head injury from the fall of which she was aware.

Nurse # 2 was interviewed on 11/2/22 at 3:35 PM and reported the following. She had not been aware when she took care of Resident # 3 on 9/27/22 that he had had recent cranial surgery during his hospitalization of 9/4/22 to 9/16/22. That information had not been told to her in nursing report. On the morning of 9/27/22, she had gone by Resident # 3's room and observed his legs were flopped over the low bed and resting on the floor mat. His upper body was in the bed, and she had assisted him in getting his

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legs back in the bed. Around lunch time, NA # 1 had approached her and informed her Resident # 3 kept trying to get out of bed. She had instructed NA # 1 to obtain the help of another NA, assist the resident up to the chair, and then place him at the nursing desk where they could watch him more closely. NA # 1 did not report the resident had fallen and she (Nurse # 2) had not gone in the room with NA # 1 and observed that the resident had fallen. Approximately 20 minutes after she had instructed NA # 1 to bring the resident to the nursing desk for closer monitoring, she observed that Resident # 3 was at the nursing desk and he had a rocking motion to his movement. Shortly after observing him at the nursing desk, she observed that his nose was bleeding. The nursing supervisor (Nurse # 3) was present and they both tried to work with applying ice and pressure to get the bleeding to stop. They called the on call provider who instructed them to make sure he was not on an anticoagulant. She did not inform the on call provider that the resident had fallen or that he had a history of cranial surgery because she had not known either of those two things herself. The bleeding slowed until it finally subsided. The resident did not have any apparent bruises during her shift. He had a small left check abrasion which looked like a "rug burn" and a small skin tear to his left elbow. She had talked to the nursing supervisor (Nurse # 3), who let her know he had fallen previously and it was felt those two areas were from his constant movements possibly reopening them. He kept picking at the one on his face and therefore it was plausible to her that they were old areas that had reopened. She placed a steri strip on his cheek and she cleaned and placed a protected dressing to his elbow. If she had known he had fallen she would have communicated this to the physician.

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The next day she learned there was an investigation into his care by administrative staff because bruises had appeared on his face on the shift following her dayshift of 9/27/22. As she was talking to administrative staff members on 9/28/22 along with NA # 1, NA # 1 reported Resident # 3 had fallen on the morning of 9/27/22 and at one point during the investigation, NA # 1 reported the resident had fallen multiple times on the morning of 9/27/22. The date of 9/28/22 was the first time NA # 1 had reported that the resident had fallen on 9/27/22.

Nurse # 3 was interviewed on 11/2/22 at 8:30 PM via phone and reported the following. She had worked as the day shift facility supervisor on 9/27/22. Around lunch time on 9/27/22 she had observed Resident # 3 in a chair at the nursing desk. He was having a nose bleed and was refusing to eat. He also had a cheek wound which she thought was old and had reopened. No one had reported to her that he had fallen. She and Nurse # 2 worked to try to get the bleeding to stop and after it did not stop for about 30 to 40 minutes, they called the on call provider. It was a facility nursing expectation that a resident who had fallen and hit their head or had experienced an unwitnessed fall would have routine neurological checks on a set schedule. These had not been done by her or Nurse # 2 because neither of them knew that the resident had fallen. They were able to eventually get the nose bleeding to stop and checked on him frequently. At no time on the day shift of 9/27/22 did she observe any bruising to Resident # 3 ' s face. She was made aware the following day that he had bruises.

Nurse # 1 had been the supervisor for the 3 PM

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to 11 PM shift on 9/27/22. Nurse # 1 was interviewed on 11/2/22 at 4:10 PM and reported the following. She had been informed by the ADON (Assistant Director of Nursing) and medication nurse that Resident # 3 had a laceration to his cheek. She checked on him at the first of the shift and saw the laceration. It was small and there was a small bruise which was "not bad." It was near his jaw bone. She checked on him a second time during her shift and at that point, the bruising had worsened. At this second check, she began to think that the bruising was more significant than what would have been caused by the small laceration on his check. She talked to the direct care nurse. Neither she nor the direct care nurse did any neuro checks because there had been no reported falls for him. He did have a history of constantly moving and it was plausible to her that he had still bumped his face on something. She did call the Director of Nursing and the on call provider and inform them about the bruising. At the time, he was resting comfortably and the decision was made not to send him out at that point.

A review of the physician ' s progress note, dated 9/28/22 revealed the following notation, "I was called today by the nursing staff to see (Resident #3) who sustained a fall from standing position yesterday .....He has obvious left facial trauma. These is a small cut over the left zygom (check bone). There is left periorbital ecchymosis (bruising around the eye) with tenderness and swelling, left cheek tenderness and swelling, a large 10 cm (centimeter) area of bruising over the left lower face and mandible (jaw bone). The left glob. (as written) He said he can see me in front of him. He appears in pain and weak ....I believe he has multiple facial fractures, an infraorbital

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fracture and mandible fracture."

According to the nursing notes, Resident # 3 was transferred to the hospital on 9/28/22 at 4:51 PM.

Hospital records for the date of 9/28/22 revealed Resident # 3 had a CT (a computerized tomography scan) of his face which showed fractures of multiple bones in his face; including fracture of the medial wall of the left maxillary sinus, fracture of the left mandible, fracture of the lateral pterygoid process (which allows the jawbone to move while eating), fracture of the left lateral orbital rim and lateral orbital wall. The resident was transferred back to the facility for care on 9/30/22.

Resident # 3 ' s physician, who serves as the facility ' s medical director, was interviewed, on 11/3/22 at 12:11 PM and reported the following. She assessed the resident on 9/28/22 and could tell from visually looking at him that he had fractured his facial bones. It appeared he had taken a direct hard hit to his check area. If the facility staff had told the on call provider on 9/27/22 about the fall, then the resident would have been transferred out that day for evaluation.

On 11/2/22 at 1:05 PM the Assistant Director of Nursing presented an investigation into Resident # 3 ' s fall. According to the ADON, initially it was thought the bruise was from the resident's own movements and it was not made clear to administrative staff that he had fallen until 9/28/22. They started to investigate the incident on 9/28/22 and at that point it was reported that the resident had fallen.

The Administrator was interviewed on 11/3/22 at

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10:40 AM and reported that they identified on 9/28/22 that there had been a lack of communication between her staff about the resident's fall. During the investigation, staff members reported different scenarios; with Nurse # 2 reporting that she never had been told the resident had fallen and with NA # 1 reporting that she had reported the fall. According to the Administrator, if the communication between her staff had occurred correctly then the resident would have been assessed on the day of the fall for injuries. The Administrator stated the facility had done a complete plan of correction with a root cause analysis. The Administrator presented the plan of correction as follows.

On 11/3/22 the facility Administrator was notified of immediate jeopardy.

POC for Communication of changes in condition/Falls

Step 1.

Resident #3 was assessed by the nurse due to bruises on his face, then assessed by the MD and ordered to go to the local Emergency Room on 9.28.22.

Root Cause Analysis was started on 9.28.22 by the Assistant Director of Nursing and Administrator. The Root Cause Analysis revealed that the nurse was not made aware by the nursing assistant that she found Resident #3 face down on the floor by his bed. The Root Cause Analysis was completed on 10.15.22.

Step 2.

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All residents have the potential to be affected.

All falls from 9.29.22 to 10.15.22 were reviewed by the Case Mix Director to ensure communication between parties for identifying the events and circumstances that resulted in the fall and for identifying interventions that limit the risk of fall; and ensure all residents with falls were assessed by a nurse. The audit revealed that the Medical Director had been notified of each fall, intervention were put in place that limit the risk of falling, and each resident was assessed by a nurse.

Step 3.

10.20-22 - Education was done for all Certified Nursing Assistants and Licensed Nurses by the Assistant Director of Nursing for the nursing staff on communication of changes in condition/falls, using the shift rounding checklist for Certified Nursing Assistants and Charge Nurses. C.N.A Shift Report is for the Certified Nursing Assistant coming on shift and leaving off shift to communicate any changes in condition, (ex. Falls, skin tear, etc), and any other concerns.

10.20.22 - Education included the importance of assessment by a nurse after a fall for all licensed nurses; New staff will continue to be educated upon hire, annually, and as needed.

Step 4.

10.28.22 - Monitoring of communication of changes in condition, falls, and communication to the Medical Director, using the shift rounding checklist, and ensuring that all residents are assessed by a nurse after a fall will be done by

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the Director of Nursing and Assistant Director of Nursing.

Monitoring will occur 5 times per week for 4 weeks, then 2 times per week for 4 weeks, and monthly for 3 months. Results of the monitoring, with tracking and trending, will be reported by Director of Nursing (RN) and Assistant Director of Nursing (RN) monthly to the Quality Assurance Performance Improvement committee for recommendations and suggestions for improvements and changes.

Completion date 10.29.2022

On 11/3/22 the facility ' s credible allegation of compliance was validated by the following.

The facility presented evidence of inservice education. It was found inservice education had been completed per the facility ' s plan of correction.

The facility presented evidence of audits. It was found the facility had been conducting audits per their plan of correction.

Multiple staff members were interviewed on 11/3/22 and reported they had received education regarding reporting and assuring education of falls and medical conditions. The facility staff were knowledgeable of the rounding sheets and reported the sheets were being completed at end of shift to assure communication was being conducted about change in conditions.

Multiple residents were interviewed on 11/1/22

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F 684	Continued From page 23 between the time of 10:30 AM to 12:00 PM. Residents reported they were pleased with nursing care. A family member was interviewed on 11/3/22 at 12:55 PM and reported they were pleased with nursing care. Review of the medical records of other residents, who had experienced accidents, revealed nursing staff were providing assessment and care. The facility's credible allegation of compliance was validated to be completed on 10/29/22.	F 684		