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	345137	A. BUILDING _____ B. WING _____	C 06/01/2023

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THE LODGE AT ROCKY MOUNT HEALTH AND REHABILITATION	3322 VILLAGE ROAD ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation was conducted from 5/31/2023 to 6/1/2023. Event ID #TOQV11. The following intakes were investigated NC00202736 and NC00199215. 1 of the 2 complaint allegations did not result in deficiency. Intake NC00202736 resulted in immediate jeopardy. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity IJ. The tag F689 constituted Substandard Quality of Care. Non-compliance began on 5/12/2023. The facility came back in compliance effective 5/16/2023. A partial extended survey was conducted.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and Medical Director interviews the facility failed to provide ADL (activities of daily living) care safely for a dependent resident for 1 of 3 residents	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 06/09/2023

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reviewed for supervision to prevent accidents (Resident #1). On 5/12/23 Resident #1 fell off the bed face first onto the floor, when Nurse Aid #1 stepped away from the bed to get more supplies. Resident #1's bed was left up, in the waist height level position, and the resident fell off the oscillating air mattress/bed face first onto the floor. An oscillating air mattress redistributes air throughout the mattress creating movement within the mattress. Resident #1 sustained a moderate/large volume right cerebral subarachnoid hemorrhage (bleeding in the space that surrounds the brain), small volume left cerebral subarachnoid hemorrhage, and large right scalp hematoma (a pool of mostly clotted blood that forms in an organ, body tissue or body space). Resident #1 was seen at local emergency department, but required higher level of care and was transferred to a trauma center due to intercranial hemorrhage and hypotension. At the trauma center, Resident #1 suffered multiple seizures, computerized tomography (CT) scans (x-ray images from different angles) revealed the intercranial hemorrhage continued to increase from 1-2 mm (millimeter) to 6mm. Resident #1 was intubated due to respiratory failure, continued to have seizures, entered palliative care and expired on 5/30/23 in the hospital.

The findings included:

Resident #1 was readmitted to the facility on 1/30/23 with diagnoses that included paraplegia, peripheral vascular disease, dementia, and history of seizure disorder.

Resident #1's Minimum Data Set dated 4/11/23 revealed she was severely cognitively impaired and was assessed as having upper and lower

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extremities impairment on both sides. Resident #1 was not coded for any falls since the prior assessment.

Review of Resident #1's undated Care Guide revealed she was dependent on staff for bathing, dressing, toileting, personal hygiene and required one physical assistance with positioning.

Review of the Nurse Note written by Nurse #1 and dated 5/12/23 read in part: called to resident room by Nurse Aid (NA #1). Observed Resident lying on floor near bedside. NA #1 states she fell out of bed face down. Occurred when the resident was being repositioned by NA. Small amount of blood noticed from mouth. Some swelling to left side of face. Resident unable to verbalize. Transferred to hospital for evaluation by emergency medical services (EMS).

Review of the facility Event Report (falls incident report) completed by Nurse #1 on 5/12/23 revealed Resident #1 fell face down off the bed and occurred when resident was being repositioned by NA. Message was sent to the MD (Medical Doctor) via (physicians' medical group). The Resident left facility alert and responsive via stretcher with county EMS. Immediate Actions taken: included Resident #1 was transferred to the ER for evaluation and staff were to ensure proper bed positioning during care.

An Emergency Department report dated 5/12/23 revealed Resident #1 presented to hospital as a trauma from fall at nursing facility. Patient was being moved when she fell face down and struck her head. Resident was noted to be paraplegic and non-verbal at baseline. A CT scan of her head showed subarachnoid hemorrhage with

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1-2mm midline shift (MLS) (being a sign of increased intracranial pressure, MLS is also an indicator of reduced brain perfusion caused by an intracranial mass or mass effect). Resident #1 was transferred to trauma hospital for higher level of care.

Hospital #1's record dated 5/12/23 indicated Resident #1 was initially accepted as a Trauma Green patient. She was upgraded to Trauma Red due to hypotension and acute injuries that posed a threat to life and sent to a secondary hospital (Hospital #2) for intercranial hemorrhage with mass effect.

Hospital #2's record revealed that on 5/12/23 the initial CT scan performed there on Resident #1 noted subarachnoid hemorrhage increased from previous with 4 mm midline shift. There had been an interval increase in extent of the moderate to large volume right cerebral subarachnoid hemorrhage. There was associated left midline shift on the order of 6 mm, increased from previously 4 mm. The subdural hemorrhages estimated to measure approximately 10 mm in greatest thickness, dated 5/12/23. An EEG (electrocardiogram) of the resident on 5/12/23 indicated seizure activity throughout the 24-hour monitoring period. On 5/14/23 Resident #1 was intubated due to respiratory distress, respiratory failure and the need for air way protection.

Hospital #2's records documented on 5/15/23 Resident #1's seizures continued at the frequency of two -five seizures an hour. Further EEG testing from 5/15/23 through 5/30/23 documented Resident #1 continued to experience seizure activity. On 5/23/23 the LPDs (lateralized periodic discharges) (are seen in acute cerebral lesion)

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lab value indicative of heightened risk of seizures from the area as well as the potential acute to subacute brain injury. The Discharge Summary dated 5/30/23 revealed the resident continued to require ventilator support during admission. Due to poor overall prognosis, family decided to transition to comfort care. Palliative Care team was consulted to assist with transition to comfort care. The resident was transferred to palliative care unit on 5/27/23 and plan was to compassionately withdrawal life prolonging measures today. However, patient died prior to withdrawal. Death pronounced on 5/30/23 at 4:28 am.

A phone interview was conducted with NA #1 on 5/31/23 at 12:42 pm. She revealed she was ready to give Resident #1 a bath the morning of 5/12/23 when she found the resident was soiled with bowel movement. NA #1 indicated the bed was at waist height as she rolled the resident towards her to clean her and realized she needed more washcloths to complete her care. NA #1 stated she rolled the resident onto her back and left the resident to go to the door to ask for help. She indicated the air mattress had shifted and by the time she realized the resident was falling, she was on the floor.

Nurse #1 was interviewed on 5/31/23 at 3:21 pm. She indicated she was called to the room and found Resident #1 face down on the floor with a small amount of blood near her mouth. Nurse #1 revealed she assessed the resident and prepared to send her out for evaluation. The Nurse indicated NA #1 thought she had positioned the resident in the center of the bed before going to the door to request more washcloths. NA #1 stated she checked the Resident Care Guide,

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before providing care and Resident #1 was a one person assist with activities of daily living.

In an interview with the Administrator on 5/31/23 at 1:34 pm, she indicated after the fall nursing immediately assessed Resident #1, called their medical doctor group and sent the resident to the ER for evaluation. She revealed NA #1 received immediate education to not leave a resident during care, have all supplies that are needed, and ready for patient care.

An interview with the Director of Nursing (DON) on 5/31/23 at 2:15 pm she revealed Resident #1's care guide coded her as one-person physical assistance with positioning. The DON revealed from NA #1 's description of the incident it seemed the resident was on the edge of the bed and not quite centered, when the fall occurred. She indicated that staff should have lowered the residents' bed before she stepped away to get more supplies.

A telephone interview was conducted with the Medical Director on 6/1/23 at 10:36 am. He revealed If the hospital could not control or stop her intercranial bleeding, it could worsen her seizures and hasten her death.

The Administrator was notified of Immediate Jeopardy on 6/1/23 at 12:48 PM.

The facility provided the following corrective action plan with a completion date of 5/16/23:

1.Resident #1 was immediately assessed after the fall by a licensed nurse and transported to the Emergency Room for further evaluation. Nursing Assistant (NA) #1 was provided immediate

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education on not leaving a resident while providing care and appropriate bed height.

2. On 5/12/2023, Nursing Administration, to include Director of Nursing (DON), Assistant Director of Nursing, Unit Managers, and Staff Development Coordinator audited all residents to ensure appropriate bed height. 100% of all residents who require assistance with Activities of Daily Living care while in the bed were observed for bed safety to include height and to ensure all supplies were readily available. All residents on an alternating air mattress were included in audit. Any discrepancy was corrected, and education provided by Director of Nursing or Designee. Completed 5/12/2023.

3. On 05/12/23, the Director of Nursing and Staff Development Nurse provided education to all nursing department (active nurses and NAs) on proper "Turning and Repositioning" of residents. Included was bed safety (height), ensuring you have all your supplies before starting tasks; and Certified Nursing Assistants to check their care guide before the start of the shift. Any nursing staff who did not complete education prior to 5/15/2023 would not be allowed to work as of 5/16/2023 until the education is completed. This education was added to the new hire orientation by the Staff Development Coordinator on 5/16/2023.

4. DON and/or designee will conduct random weekly observations and audits included checking that supplies were readily available; bed height was appropriate; and bed safety with alternating pressure air mattress. Any non-compliance will be addressed, and further education provided as needed. The frequency of

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the weekly observations is: Ten residents weekly for each unit times four weeks followed by ten residents' weekly times four weeks and then five residents weekly for four weeks. Each week to include a minimum of two residents on alternating pressure air mattress for bed safety.

5.The Administrator and Quality Assurance/Performance Improvement (QAPI) committee analyzed the data for any patterns/trends. Findings will be reported to the QAPI committee monthly for three months to ensure continued compliance and any further recommendations.

Onsite validation was completed on 6/1/23 through staff interviews, observation, and record review. Staff were interviewed to validate in-services completed on not leaving a resident while providing care, turning and repositioning and bed height safety. Observation of a transfer with mechanical lift onto an air mattress for Resident #2 revealed no issues. A review of audits for bed height and supplies gathered as required for residents needing ADL assistance. Review of residents audited for bed safety and resident interviews verified no additional issues were identified. The facility's action plan was validated to be completed as of 5/16/23.