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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 07/19/23 through 07/20/23. Event ID #VME211. The following intake was investigated: NC00201288 1 of the 1 allegation resulted in a deficiency.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.	F 583		8/9/23

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

Electronically Signed | 08/08/2023

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F 583	Continued From page 1 (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interviews, the facility failed to provide privacy during a bed bath when the privacy curtain was not pulled back and the door was left open for a resident (Resident #1) who resided in a semiprivate room in the bed closest to the door for 1 of 1 resident observed. Findings included: Resident #1 was admitted to the facility on 06/05/23 with diagnoses including, in part, fractured femur, aphasia, stroke with weakness, and paraplegia. The admission Minimum Data Set assessment dated 06/07/23 revealed Resident #1 was moderately cognitively impaired. He required total dependence with 2 staff physical assistance with bed mobility, dressing, personal hygiene, bathing, and toileting. An observation on 07/20/23 at 11:00 AM from the hall revealed Resident #1's door was open about 18 inches and he was observed lying in bed closest to the door with a brief on but no other clothes or bed covers. Resident #1 was receiving a bath by Nurse Aide #4. Resident #1's privacy curtain was not pulled around the resident. There was a privacy curtain pulled between the two beds in this semiprivate room.	F 583	F 583 Privacy/Dignity • Nurses Aid received 1:1 education on 07/20/2023, by DON and CRC. Resident # 1 currently receiving care with privacy and dignity. • Social Services interviewed all alert and oriented residents regarding care being provided with Dignity and Privacy on 8/07/23. The Director of Nursing made complete walking rounds on 7/20/23 to evaluate care practices and specifically those associated with dignity and privacy to evaluate if others could be affected by the stated practice. • Education was initiated with all nursing staff on 07/20/2023 related to providing care with dignity and included closing the door and pulling privacy curtains. Education provided by the Nurse Practice Educator. The new orientation, annual education and center agency guide was updated to assure education on privacy and dignity. • Nursing Administration and Social Services will round in the center weekly to evaluate ongoing practices to address concurrent. Nursing Leadership (Director	

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F 583	Continued From page 2 An interview with Nurse Aide (NA) #4 on 07/20/23 at 11:00 AM revealed she was waiting for another aide to come and assist her to complete Resident #1's bath. She stated the door did not always shut tight and that was why it was left open. She stated she forgot to pull the privacy curtain around Resident #1 while she was bathing him. An interview with Resident #1 on 07/20/23 at 11:46 AM revealed he did not like being left exposed with his door opened and the privacy curtain not being drawn. Resident #1 stated he has told the staff to close the door and when they closed the door it would shut all the way. He was not aware of his door not being able to close shut. He stated he could not remember if he told NA #4 to close the curtain or the door. An observation of the door on 07/20/23 revealed the door would close shut all the way, however with repeated tries of opening and closing the door, it would at times not latch and secure to shut. An interview with the Director of Nursing on 07/20/23 at 12:18 PM revealed he would have expected the staff to advise the maintenance department regarding the door if it was not closing properly, but the Nurse Aid should have absolutely provided privacy with the privacy curtain during care especially if the door did not shut securely.	F 583	of Nursing, Assistant Director of Nursing, Infection Preventionist, Nurse Practice Educator and Supervisors) will audit 3 random staff performing ADL care five days per week for four weeks, then twice weekly for two weeks, then weekly for four weeks. All observations will be presented to the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. • Date of Compliance: 08/09/2023	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		8/9/23

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F 689	Continued From page 3 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 observations, record review and physician, resident, and staff interviews, the facility failed to provide care safely to a dependent resident when a resident (Resident #1) fell out of bed during care on 05/29/23 resulting in a fall with fracture to the right leg and an abrasion to his right knee with bleeding. Resident #1 was hospitalized and no surgical treatment was provided to treat the fracture due to paralysis of his right leg. After the 05/29/23 fall, the facility implemented a corrective action plan that included an intervention to follow the care plan for two staff assistance with bed mobility and to turn the resident toward the care giver during care instead of away from them to prevent from any further falls out of bed. The facility failed to consistently implement this corrective action plan and on 06/23/23, Resident #1 sustained another fall with no injury when care was provided by one staff and that staff member did not turn and reposition Resident #1 toward them while providing care for 1 of 3 residents reviewed for accidents. Findings included: Resident #1 was admitted to the facility on 02/11/2016 with diagnoses to include, in part, anemia, aphasia, stroke with weakness, osteopenia, paraplegia and neurogenic bladder with urinary catheter.	F 689	F 689-Accidents • The Licensed Nurse completed a new Lift Transfer Assessment for Resident # 1 on 7/25/23 and resident is a 2 person assist for bed mobility and transfers with a mechanical lift with the assistance of 2 persons. Director of Nursing and/or designee reviewed and revised the residents plan of care as needed on 7/25/23. • Director of Nursing conducted an audit to identify level of ADL assistance/support needed for bed mobility of all current residents on 7/19/23 to verify the level of ADL assistance/support is depicted on the plan of care or point of care task. • Director of Nursing, Nurse Practice Educator, and/or designee re-educated Nursing personnel on the Safe Resident Handling Policy and Procedure and Fall Management Policy and Procedure with specific emphasis on providing ADL physical functioning support with bed mobility according to the plan of care or point of care task to prevent accidents.	

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F 689	Continued From page 4 A care plan updated on 12/15/22 revealed a plan of care for at risk for falls related to immobility, fall without injury, and stroke with right sided hemiparesis. Interventions included to utilize low bed, provide verbal cures for safety and energy conservation techniques, place call light within reach at all times and all personal items within reach. The Minimum Data Set (MDS) quarterly assessment dated 03/14/23 revealed Resident #1 was cognitively intact and demonstrated no behaviors. Resident #1 required two person assistance with extensive assistance with bed mobility, dressing, toileting , personal hygiene, and bathing and he had impairment to both sides to upper and lower extremities. Resident had an indwelling urinary catheter and was incontinent of bowel. Resident #1 had no falls during this look back period assessment and was not receiving anti coagulants (medication to thin blood). Review of an incident report completed by Nurse #1 for a fall on 05/29/23 revealed nurse aide (Nurse Aide #1) was in with Resident #1 giving activity of daily living (ADL) care. The nurse aide rolled the resident to the left side and resident missed the side of the bed to maintain his balance and fell off the left side of the bed. A head to toe assessment was completed per hall nurse (Nurse #1). Resident complained of right knee pain, with swelling noted to same, small laceration noted to the right lateral knee. Small skin tear to left big toe. Resident stated his pain was 1 (barely noticeable, very mild) out of 10 (worst pain possible) on the pain scale. Resident was assisted back to bed and a dressing placed to right knee per wound protocol. The on call provider was contacted and orders were obtained	F 689	Education on proper lift use including the number of staff to do so has been added to new employee education, annual education and agency guide book to support full understanding. The Director of Nursing and/or designee will review new admissions/readmissions/ and changes in ADL assistance/support level for bed mobility in the Clinical Morning meeting to verify the plan of care or point of care task has been updated as needed. The Unit Manager or designee will round daily to make observation. • The Director of Nursing and/or designee will randomly audit 3 residents for bed mobility/transfers five days a week for four weeks, then three times a week for four weeks, then two times a week for four weeks to ensure ADL assistance/support for bed mobility is provided as needed to prevent accidents. • The Administrator and/or designee will review the results of the audits and/or observations in the monthly Quality Assurance Performance Improvement Committee meeting for one quarter to ensure compliance is achieved and sustained. Subsequent plans of corrections will be implemented as necessary • Date of Compliance: 8/09/23	

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to transfer resident to the emergency department.

An interview was conducted with Nurse Aide (NA) #1 on 07/20/23 at 2:00 PM. NA #1 stated she worked with Resident #1 often as she was most often assigned to his hall. NA #1 stated on 05/29/23, she was giving Resident #1 his bath, and told him to hold on to the dresser on the side of his bed when she turned him on to his left side and his hand slipped off the dresser and he fell on the floor. NA #1 stated she could not stop him from falling. NA #1 stated Nurse #1 arrived at the room and assessed him and at the time he was not complaining of pain. NA #1 stated she and three other staff members (the nurse, another aide, and the physical therapist) assisted him back to bed using the mechanical lift. She stated after about 15 minutes, Resident #1 reported to her that his leg hurt and Nurse #1 assessed him again and he was sent to the hospital. NA #1 stated after 05/29/23, Resident #1 required two people to do his care and she was educated to make sure two staff were doing his care at all times. She stated she had always done Resident #1's care by herself up until 05/29/23 and he had never fallen. NA #1 added that he had the ability to hold on to the side table when he was turned on his side.

An interview was conducted with Nurse #1 on 07/19/23 at 4:36 PM. Nurse #1 reported Resident #1 required two staff to do his bathing and incontinence care because of his paraplegia, contractures, and the way he would sometimes have "jerky" movements after the 05/29/23 fall. She stated nursing aide staff had been providing care to Resident #1 by themselves before the 05/29/23 fall, but since he had a recent fall, it was required that he should have two staff assisting

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him with ADLs. She stated on 05/29/23, when NA #1 was rolling Resident #1 away from her to clean him, he had kept rolling and fell off the bed. Nurse #1 reported staff notified her that Resident #1 fell out of the bed and when she went to assess Resident #1, he told her to get him off the floor. She stated "we used a mechanical lift" with assist of four staff (NA #1, another nurse aide, and a Physical Therapist) to get him back to bed. Nurse #1 reported he had no complaints of pain at that moment, but he did have an abrasion to his right knee that was bleeding. She stated after they transferred him back to bed he complained of pain of a 1 out of 10 on the pain scale. She stated his knee was still bleeding and she had to put another dressing on it. She stated, "it was not a very large abrasion."

A review of the hospital records dated 05/29/23 revealed [Resident #1] presented to the emergency department via emergency medical service from the facility after slipping out of bed during a sponge bath. An x-ray of the right knee indicated a comminuted (a bone broken in at least two places) fracture of the right femur. The hospital record indicated the resident would be admitted under inpatient status due to requiring admission for complicated urinary tract infection and was at risk for decompensation given the age and comorbidities.

A review of the fall investigation completed by the Director of Nursing (DON) dated 05/29/23 revealed the root cause of Resident #1's 05/29/23 fall was determined that Resident #1 required two staff assistance with bed mobility. Staff education was provided on 05/29/23 on use of two person assistance with larger residents with poor bed mobility and trunk control and when turning and

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repositioning [Resident #1] to be sure staff turned the resident toward the caregiver during ADL care.

A care plan updated on 05/29/23 included at risk of falls related to fall with injury with a goal that resident would have no falls with injury for 90 days. The new interventions included, in part, staff education provided for turning and repositioning of Resident #1 related to fall 05/29/23 and staff to utilize two person assist with bed mobility. The plan of care included Resident #1 required assistance and was dependent for mobility related to right femur fracture and would be able to be safely moved from side to side in the bed with staff assistance.

An orthopedic consult dated 05/30/23 during Resident #1's hospitalization recommended a knee immobilizer with no surgical intervention at this time due to immobility and bedbound. The orthopedic assessment and plan stated, in part, there was question of the chronicity of the fracture, but the patient denied any other falls or injuries in the last 6 months. The resident's hemoglobin (red blood cells that carry oxygen to the tissues) was noted to be 9.9 (range is 13.2 to 16.6 grams for men) in the emergency department on 05/29/23 and had decreased during his hospital stay to 5.3 on 05/31/23 and he required 4 units of pack red blood cells. The hospital records indicated acute blood loss anemia from trauma. Resident #1 was discharged from the hospital on 06/05/23 with a goal to have hemoglobin at 8. The record indicated the iron panel was consistent with anemia of chronic disease.

A review of in-services dated 05/29/23 was

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conducted regarding accidents/incidents and fall management. The in services included to identify risk for falls and minimize the risk of recurrent falls, to ensure the resident centered care plan was reviewed and resident centered interventions were being implemented according to individual risk factors in the residents' plan of care. Education was provided by the Director of Nursing (DON) to all nursing staff and included NA #1 who turned (Resident #1) away from herself while providing the resident with care. Education included that all nursing staff would care for residents as guided by the care plan, staff were educated on turning and repositioning and demonstrated competency by the DON, and nursing staff would not care for residents alone that required assistance of two staff members.

An interview was conducted with the Director of Nursing (DON) on 07/20/23 at 2:17 PM. The DON reported after the first fall on 05/29/23 the training and education and audits were done on all nursing staff by the DON to be sure to follow the care plan to have two staff assisting with bathing and incontinence care, and bed mobility for dependent residents requiring two assist. Additionally, the intervention to turn the resident toward the staff while doing care was implemented. The DON stated the plan of correction that was put in place after the 05/29/23 fall was ineffective because many staff were not savvy in navigating the computer system to read the care plan and further education was required.

Resident #1 was readmitted to the facility on 06/05/23 after a discharge to the hospital on 05/29/23 with diagnoses of right femur fracture, urinary tract infection, and acute blood loss from trauma.

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The MDS admitting assessment dated 06/07/23 revealed Resident #1 was moderately cognitively impaired and demonstrated no behaviors and required total dependence with 2 staff physical assistance with bed mobility, dressing, personal hygiene, bathing, and toileting. Resident had an indwelling urinary catheter and was incontinent of bowel and was coded as having a fall with fracture.

A review of an incident report completed by Nurse #2 dated 06/23/23 revealed Nurse Aide (NA #2) informed this writer (Nurse #2) that resident fell on the floor. Resident was having peri-care performed and resident started to scratch himself on his back, he propelled forward while scratching himself on his back and fell on the floor. When this writer (Nurse #2) entered the room, the resident was on the floor face down. Resident did not hit his head per NA (NA #2). Resident was asked if he hit his head and resident denied hitting his head. Resident denied any injuries, pain, or discomfort. Resident informed this writer (Nurse #2) he wanted to go to the hospital. Resident initially reported he would like to be transferred to the hospital and later declined. On call provider was notified and left a message that resident wanted to go to the emergency room (ER), but now he was refusing to go to the ER. Resident was asked again and he refused to go the ER. Responsible Party called and informed of all the above information. Resident continued to deny pain, deny injuries, and deny discomfort.

A phone interview was conducted with NA #2 on 07/19/23 at 9:26 PM. NA #2 reported she received education on 05/29/23 regarding how

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many people were required when doing ADL care on dependent residents who required two assist. She stated she was aware Resident #1 required two staff assistance with bed mobility including bathing and incontinence care. She stated she received education on 05/29/23 on turning and repositioning and to be sure staff were turning the resident toward themselves during care to prevent him from rolling off the bed. She stated on 06/23/23, she went in to change Resident #1 and as she was changing him, she turned him away from her and he began to scratch himself on his back and he lifted up his hip and rolled off the bed. She stated she was the only one in the room providing care and she should have asked the nurse to help her, but she was doing her medication pass and she did not want to bother her. NA #2 stated if she had turned the resident toward her she could have prevented the fall. NA #2 stated Resident #1's care could be done with one person safely if the staff member turned the resident toward them instead of away from them. NA #2 could not say why she turned him away from her instead of toward her.

A phone interview was conducted with Nurse #2 on 07/20/23 at 6:00 AM. Nurse #2 reported on 06/23/23, NA #2 informed her Resident #1 had a fall. She stated she went to assess him. He was lying on the floor. He had no complaints of pain and no injuries and was assisted off the floor with 4 staff using the mechanical lift back to bed. She stated she asked him to go to the hospital, but he refused. She stated she called the provider and responsible party and notified them of the fall with no injury and that he was refusing to go to the hospital. Nurse #2 stated the nursing staff received education on 05/29/23 regarding making sure to use the appropriate number of staff

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required whenever doing ADL care for dependent residents. She stated Resident #1 required two staff with his bathing and incontinence care per the education that was provided on 05/29/23. She stated NA #2 did not ask her to assist with Resident #1 and if she had, she would have helped.

An observation of Resident #1 on 07/19/23 at 12:17 PM revealed an alert and oriented Resident lying in his bed. The bed was noted to be an oversized bed with no side rails. He had an end table on either side of the bed and it was in low position. He had contractures to his upper extremities but was able to move his arms. Resident #1 had an immobilizer on his right leg.

An interview with Resident #1 on 07/19/23 at 12:17 PM revealed he had no complaints of pain. He reported he had a bed bath this morning with Nurse Aide #3 and she completed his bed bath by herself. He reported that more often than not, his care was done by one aide and not two. Resident #1 stated he felt safe with one staff member providing his care. Resident #1 reported on 06/23/23, the nurse aide turned him to side and he rolled off the bed, but he did not have any injury. He reported he was scratching his back and not holding on to the table.

An interview with Nurse Aide #3 on 07/19/23 at 2:30 PM revealed she was assigned to Resident #1 on 07/19/23. NA #3 stated she was assigned to Resident #1 often and usually provided care to Resident #1 alone. She reported she bathed him and changed him. She stated when she turned him she made sure there was enough room on the bed so he would not roll over and made sure he was not too close to the edge. She stated she

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F 689	Continued From page 12	F 689		

kept a hand on him while doing care and he was facing her while she washed his back. She stated she was made aware of the new interventions to ask for assistance with turning and reposition, but she bathed Resident #1 alone and provided incontinence care on him alone and she should have gotten help. She added, she was able to do his bath alone as she had done in the past, so she did it alone. NA #3 stated as long as Resident #1 was facing her during the care and he was, she would have been able to stop him from falling.

A phone interview was conducted with the facility Physician on 07/20/23 at 1:45 PM. The Physician recalled the hospital record for Resident #1 and stated sometime during his hospital stay from 5/29/23 through 6/5/23, his hemoglobin dropped from 9.9 in the emergency department on 05/29/23 to 5.3 and he required a blood transfusion. The Physician stated he could not say with 100% certainty that the blood loss was a result of the fall. The Physician added he had never seen a resident who was not receiving anti coagulants (blood thinning medication) require 4 units blood as a result of a fall with fracture but confirmed the hospital record indicated it was a blood loss from trauma.

An interview was conducted with the Director of Nursing (DON) on 07/20/23 at 2:17 PM. The DON stated after the fall on 06/23/23 additional training and coaching was reiterated with Nurse Aid #2. The DON stated after the 06/23/23 fall for Resident #1, he created a paper list on 06/23/23 of all the residents who required two staff assistance and posted it in the nutrition rooms, the employee lounge, at the time clock, the nursing station assignment books, and provided a

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F 689	Continued From page 13 list to the all the nurses to attach to their clipboards that they used during their shift. An observation of the paper lists was conducted with the DON on 07/20/233 at 2:30 PM and confirmed the paper list was in each location with Resident #1's name on the list. The DON reported Nurse Aide #3 should have followed the care plan and used two staff to assist with bathing Resident #1 on 07/19/23. The DON added, more education and audits would need to be done to make sure the staff understand and follow the expectation to prevent falls.	F 689		
F 867 SS=G	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at	F 867		8/9/23

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F 867	Continued From page 14 §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.	F 867		

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F 867	Continued From page 15 §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its	F 867		

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F 867	Continued From page 16 activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with the physician, resident, and staff, the Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and effective monitoring of interventions to ensure residents were provided with the necessary supervision to prevent accidents (F689). This deficiency was cited on the recertification and complaint survey of 07/06/21, the revisit and complaint survey of 06/29/23, and the current revisit and complaint survey of 07/20/23. The continued failure during 3 federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA Program. During the current survey of 07/20/23 it was determined Resident #1 was not provided with the necessary supervision to prevent accidents as evidenced by 2 falls out of bed during care with one of the falls resulting in a fracture to the right leg and an abrasion to his right knee. Findings included: This tag is cross referenced to: F689: Based on observations, record review and	F 867	F 867 Quality Assurance • Facility received repeat citation of F 689 during Revisit/Complaint/Annual survey which had been cited on two prior surveys in the last three years. Revised plan has been developed to address Accidents and Hazard prevention with ongong montioring by the Quality Assurance and Performance Improvement Committee. • All residents have potential to be affected. Root Cause Analysis completed by the Interdisciplinary Quality Assurance Team for F 689/ Accidents & Hazards Prevention to determine the systemic break that led to the deficient practice with revised plan to address. • Education provided to the Quality Assurance and Performance Improvement Committee (QAPI) by the Senior Administrator. (QAPI Team consists of: Administrator, Director of Nursing, Dining Director, Business Office Director, Human Resource Manager,	

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F 867	Continued From page 17 physician, resident, and staff interviews, the facility failed to provide care safely to a dependent resident when a resident (Resident #1) fell out of bed during care on 05/29/23 resulting in a fall with fracture to the right leg and an abrasion to his right knee with bleeding. Resident #1 was hospitalized and no surgical treatment was provided to treat the fracture due to paralysis of his right leg. After the 05/29/23 fall, the facility implemented a corrective action plan that included an intervention to follow the care plan for two staff assistance with bed mobility and to turn the resident toward the care giver during care instead of away from them to prevent from any further falls out of bed. The facility failed to consistently implement this corrective action plan and on 06/23/23, Resident #1 sustained another fall with no injury when care was provided by 1 staff and that staff member did not turn and reposition Resident #1 toward them while providing care for 1 of 3 residents reviewed for accidents. During the recertification and complaint survey of 07/06/21, the facility failed to provide safety interventions as ordered. During the revisit and complaint investigation survey of 06/29/23, the facility failed to follow a physician order for fall mats at both sides of the bed for a resident with a history of falls. An interview with the Administrator on 07/20/23 at 2:20 PM revealed the Quality Assurance and Performance Improvement (QAPI) plan for providing supervision to prevent accidents was ineffective and more education, audits and monitoring would need to be conducted.	F 867	Maintenance Director, Social Services Director, Housekeeping/Laundry Manager, Nursing Supervisors, Activities Director, Infection Preventionist, Medical Director and Therapy Director). Education included review of Quality Assurance and recognizing areas for Performance Improvement, Root Cause Analysis and monitoring of Plans for improvement. • The Administrator to conduct Monthly Quality Assurance Performance Improvement Meetings, with oversight provided by the Medical Director. The QAPI Committee to review all active Performance Plans for compliance, any deviations noted will be addressed by the QAPI Committee to determine Root Cause Analysis of non-compliance with revisions to plan as indicated. Regional Nurse to review all monthly QAPI Minutes x 6 months and attend QAPI Meetings Quarterly to ensure that the Committee is maintaining implemented procedures/interventions to prevent recurring non-compliance. The Administrator will be responsible for implementation of the plan. • Date of Compliance 08/09/23	