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VERO HEALTH & REHAB OF SYLVA	417 CLOVERDALE ROAD SYLVA, NC 28779

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{F 000}	INITIAL COMMENTS An onsite revisit was conducted on 11/30/23. Tag F697 was corrected as of 11/30/23. Repeat tags were cited. New tags were also cited as a result of the complaint investigation survey that was conducted at the same time as the revisit. The facility is still out of compliance.	{F 000}		
{F 689} SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interviews with resident, staff, and the Medical Director, the facility failed to use a mechanical lift to transfer a non-ambulatory resident (Resident #1) for 1 of 3 residents reviewed for accidents. Resident #1 sustained a distal femoral periprosthetic (structure in close relation to an implant) fracture of the left knee after Nurse Aide #1 attempted to transfer her from bed to wheelchair by putting his hands on her and supporting her by holding the back of her pants after her knees buckled as soon as she stood up. The findings included: Resident #1 was admitted to the facility on 6/28/23 with diagnoses that included cerebral infarction (stroke), generalized muscle weakness,	{F 689}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/01/2023

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and cognitive communication deficit.

Resident #1's care plan initiated on 7/18/23 indicated Resident #1 had an activities of daily living self-care performance deficit related to stroke. She did not stand or ambulate. She preferred to remain in bed much of the time. Resident #1 required mechanical lift with staff assistance for transfers. Resident #1's care plan further indicated that she was at risk for further injury from falls related to impaired cognition. She believed that she could walk but she had not ambulated in over three years per her family member. Interventions included mechanical lift for transfers and no ambulation.

The quarterly Minimum Data Set (MDS) assessment dated 9/30/23 indicated Resident #1 was severely cognitively impaired and required extensive assistance by one person physical assist with bed mobility. Transfer occurred only once or twice during the assessment period, and she required extensive physical assistance. She also required substantial/maximal assistance with lying on her back to sitting on the side of her bed.

An untitled and undated report sheet listed all the residents on 200 hall with their shower information, assistance needed, transfer and continence status. Included in this list was Resident #1 and it indicated that she required total assistance and used a mechanical lift for transfers.

An incident report dated 11/7/23 at 8:30 AM for Resident #1 indicated that at approximately 8:30 AM, the nurse aide (Nurse Aide #1) was getting Resident #1 up for breakfast when the nurse (Nurse #1) informed him that the resident did not

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get up for breakfast. Nurse #1 continued with her medication pass when Nurse Aide (NA) #1 came out of Resident #1's room and stated that she was on the floor and asked if she would help him get her back into bed. Nurse #1 asked what happened and was told that her legs gave out while transferring her to the wheelchair from the bed, and that he assisted her to the floor to get help. Nurse #1 walked into the room and Resident #1 was sitting on the floor. She performed a head to toe assessment and took her vital signs. Resident #1 denied hitting her head or having any pain other than left knee pain. Vital signs were within normal limits and two nurse aides (NA #1 and NA #2), and Nurse #1 helped Resident #1 back into bed. Nurse #1 medicated the resident for pain and notified the Physician Assistant (PA) who was in house at the time of the fall. The PA assessed Resident #1 and ordered x-rays. Resident #1's family member came to visit and was notified.

A typed statement of NA #1 taken via phone by the Interim Director of Nursing on 11/10/23 indicated that on 11/7/23 early morning, Resident #1 was trying to get out of bed. The resident said she could walk. NA #1 said let's try. Resident #1 slid to the floor and landed on her knees. There was no one else in the room at the time. NA #1 called for assistance. Nurse #1 and NA #2 helped NA #1 pick her up to put her back in bed. NA #1 told Resident #1's family member what happened when she came to the nursing station later day.

An initial phone interview with NA #1 on 11/28/23 at 4:15 PM revealed during the fall incident on 11/7/23, Resident #1 slipped and fell to the floor from her bed. NA #1 stated that right before the

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incident, he asked her if he needed to use a mechanical lift on her and she told him no. Resident #1 had stated she was able to walk and get up by herself and that she had been working with therapy. She tried to get up and slid to the floor while he tried to ease her to the floor.

A follow-up phone interview with NA #1 on 11/29/23 at 10:39 AM revealed when he was assigned to care for Resident #1 on 11/7/23, he was not familiar with Resident #1 but when he went into her room, she was anxious, and she was trying to get up. Her upper body was up but her legs were still on the bed. NA #1 stated that this was the first time he saw Resident #1 moving in her bed and she usually stayed in her bed. NA #1 stated that he told her to slow down, hold on and wait but he couldn't stop her from getting on her feet. NA #1 stated that he was not aware of Resident #1's transfer status and he did not receive report from the outgoing shift. NA #1 denied being told by Nurse #1 not to get up Resident #1 for breakfast. NA #1 further revealed that he usually asked his residents if they wanted to get up or not, and whether he needed to use a mechanical lift or not. He stated he did not know anything about a report sheet or a Kardex and that the facility did not have a system of communicating the transfer status of each resident to the nurse aides especially to the agency aides. NA #1 stated that he was an agency aide, and he was used to this practice at any facility he worked. He emphasized that Resident #1's fall was not his fault and that it was Resident #1's fault because she told him that she could stand up and she even said to him to get out of her way. Then she slid down to the floor from a sitting position on the side of her bed. NA #1 shared that Resident #1 was not able to stand

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up on her legs when her legs gave out, so he supported her by holding the back of her pants through the waist. Resident #1's buttocks hit the floor first with her legs straight out in front of her. NA #1 alerted Nurse #1 who came to the room to assess Resident #1. NA #1, NA #2 and Nurse #1 assisted Resident #1 off the floor back to her bed by manually lifting her up as directed by Nurse #1. NA #1 and NA #2 lifted Resident #1 by holding her under each arm while Nurse #1 held Resident #1's ankles.

A typed statement signed by Nurse #1 on 11/12/23 indicated that on 11/7/23 at approximately 8:30 AM, NA #1 was getting Resident #1 up for breakfast. Nurse #1 informed him that Resident #1 did not get up for breakfast. Nurse #1 continued with her medication pass. NA #1 came out of Resident #1's room and stated that she was on the floor and asked if she would help him get her up and back to bed. Nurse #1 asked him what happened. NA #1 told Nurse #1 that as he was transferring her from the bed to the wheelchair, she had weakness in both legs, and he assisted her to the floor. Nurse #1 walked in the room and did a head-to-toe assessment and took her vital signs. Resident #1 was complaining of left knee pain. Two nurse aides and Nurse #1 assisted her off the floor to bed. Nurse #1 medicated her for pain, notified the PA who was in-house at the time of her fall. The PA assessed Resident #1 and ordered x-rays. Resident #1's family member came in to visit and was notified.

A phone interview with Nurse #1 on 11/29/23 at 10:28 AM revealed on the morning of 11/7/23, NA #1 was getting the residents up for breakfast and he went into Resident #1's room to get her up.

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Nurse #1 stated that she told NA #1 that Resident #1 usually stayed in bed for breakfast, but NA #1 stated that Resident #1 was on his list of residents to get up, so he was going to get her up. Nurse #1 stated that she proceeded with her medication pass when she heard NA #1 asking for help in Resident #1's room. NA #1 told her that he was transferring Resident #1 from the bed to her wheelchair and both of her legs gave out. NA #1 assisted Resident #1 to the floor. Nurse #1 shared that she obtained Resident #1's vital signs and assessed her for any signs of injuries. She asked Resident #1 if she was having any pain and Resident #1 complained of pain of the left knee. After she assessed that Resident #1 was safe to be moved off the floor, NA #1 and NA #2 both grabbed under each arm while Nurse #1 held both ankles. Nurse #1 stated that Resident #1's legs were straight out, and she tried to move her legs as little as possible, so she grabbed her by both ankles. Nurse #1 further revealed that Resident #1 complained of pain the whole time they moved her from the floor to the bed. She stated that Resident #1 usually favored her left side and she tended to lean towards the left and when she was back in the bed, she complained of pain to the whole left lower extremity from the hip to the ankle. Nurse #1 propped Resident #1's left leg on a pillow and when she palpated over her left knee, Resident #1 complained of pain. Resident #1 was not able to give a pain rating, but she was crying and grimacing. Nurse #1 did not observe any obvious deformities. She medicated Resident #1 for pain with Acetaminophen and notified the PA who was at the facility at that time. The PA ordered an x-ray and then she notified Resident #1's family member. Nurse #1 further shared that she was not entirely sure about Resident #1's transfer

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status and that she would have to look it up, but she knew that the nurse aides had a report sheet that indicated the residents' transfer status. Nurse #1 stated that since being back from the hospital, Resident #1 had not been eating much and she stayed asleep all the time because they kept her medicated for pain. Nurse #1 said that she asked Resident #1 frequently about her pain level and she received pain medications as needed. Resident #1 did not get up out of the bed anymore and had refused to get up due to pain on her left knee. Nurse #1 stated that prior to the fall, Resident #1 was not able to get herself to a sitting position on the side of the bed. She required total assistance from staff to do this.

Resident #1's November 2023 Medication Administration Record (MAR) indicated Resident #1 was monitored for pain every shift. On 11/7/23, she had a pain level of 7 out of 10 (0 being no pain and 10 being severe pain) on the day shift after the fall and she received Acetaminophen 650 milligrams (mg) at 9:00 AM. During the evening shift on 11/7/23, she was assessed as having pain level of 3 out of 10 but she did not receive any pain medication. On 11/8/23, Resident #1 had a pain level at 8 out of 10 and was given Acetaminophen 650 mg at 2:07 PM.

An interview with NA #2 on 11/29/23 at 2:28 PM revealed she was the other nurse aide who worked with NA #1 on 11/7/23 but she was assigned to the other side of the hall. NA #2 stated that Nurse #1 alerted her and told her that she needed assistance with a fall. When she entered Resident #1's room, NA #1 was in the room with Resident #1 who was sitting up on the floor. NA #2 stated she grabbed the mechanical

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lift to get Resident #1 off the floor, but the mechanical lift would not lower all the way down to the floor. NA #1 stated the battery probably needed to be charged so they couldn't use the lift. Nurse #1 instructed NA #1 and NA #2 to grab Resident #1 under both arms while Nurse #1 grabbed her ankles. NA #2 stated that she had not taken care of Resident #1 before the fall incident and was not familiar about what her transfer status was at that time. NA #2 shared that the residents' transfer status information could be found in a report sheet at each of the nurses' station and copies were kept in a folder. NA #2 stated that these sheets were given to the nurse aides especially the agency aides and they used them as reference so they would know how to take care of each resident.

A progress note dated 11/7/23 by the Physician Assistant (PA) indicated Resident #1 reported sliding out of chair to the floor, landing on her bottom and pain going all the way from her left hip to left knee, difficulty moving her leg. She did not believe she had lower back pain but did land on her tailbone. She denied numbness or tingling in extremity but reported left hip and left knee pain. She recently took Acetaminophen and Ibuprofen with some pain relief, but still hurting. She denied hitting her head. No loss of consciousness. No chest pain or shortness of breath. Resident #1's family member present during exam. No erythematous (red) or bruised joints noted. No joint tenderness over left ankle. Significant knee joint line tenderness on exam and painful range of motion. Mild diffuse left hip discomfort and hip range of motion. Unable to examine the patient's coccyx as she was unable to turn due to left leg discomfort. Sensation in extremities grossly intact and capillary refill

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normal in toes. Pedal pulses present bilaterally. Lower extremities of equal length, without rotation. Plan: Concerned with patient joint pain, significant weight, and history of injury. Ordering left hip and left knee x-ray as well as sacrum/coccyx x-ray. Non-weightbearing until x-ray results are in. Putting on hold order to change position every 2 hours due to concern of possible fracture. No evidence of neurovascular compromise on exam. Continue monitoring. Acetaminophen as needed for pain. Nursing to report if pain not well-controlled.

A review of the physician's orders dated 11/7/23 in Resident #1's medical record indicated the following: coccyx x-ray 2 views, left hip x-ray 2 views, left knee x-ray 2 views to rule out fractures, no weight-bearing until x-ray results are in.

A progress noted dated 11/8/23 by the Medical Director (MD) indicated Resident #1 continues with pain at left knee today. X-ray was ordered, results arrived at noon on 11/8/23 and showed fracture of the distal medial condyle of left femur (inner part of the upper expanded section of the thighbone) with prosthesis noted. She was placed on non-weightbearing status and hold on every two hour positioning order yesterday. Patient is at higher risk for fracture at this site due to prosthesis, female and age over 65 years old. Suspect osteopenia (condition that occurs when the body doesn't make new bone as quickly as it reabsorbs old bone) due to her limited mobility and postmenopausal status. Immediately following review of the results, emergency medical services (EMS) was contacted, and resident transported to emergency department (ED).

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Resident #1's hospital discharge summary dated 11/10/23 indicated she was transferred to the hospital on 11/8/23 after presenting for left knee pain after a reported fall at the nursing facility where she resided. Radiographic imaging of the knee demonstrated complex fracture. Computed tomography of left knee showed mildly impacted distal femoral periprosthetic fracture. She was admitted to orthopedic surgery with hospital medicine consulting. Initially, they had planned for surgery but ultimately (the Orthopedist) opted for non-operative conservative care due to the patient's underlying medical conditions and baseline mobility limitations. Per family, she was bedbound at baseline and had been for the last three years. Because of her baseline status and the fact that she had no operative needs, she was discharged back to her living facility. May take Ibuprofen and Acetaminophen for pain, as well as ice and elevation for pain and swelling. Non-weightbearing left lower extremity. Wear hinged knee brace on left lower extremity.

Resident #1's November 2023 MAR further indicated that on 11/11/23, she was started on Gabapentin 300 mg by mouth two times a day for pain and on 11/16/23, she received a new medication order for Hydrocodone-Acetaminophen 5-325 mg 2 tablets by mouth every 6 hours as needed for moderate pain.

An interview with Resident #1 on 11/28/23 at 10:41 AM revealed she did not remember what happened, but she remembered having fallen off the bed. Resident #1 stated that she broke her leg, but she was not sure which one. Resident #1 stated her leg hurt whenever they moved her, but

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she couldn't rate her pain level. She also stated that she was currently working with therapy but did not know how often therapy worked with her. During the interview, Resident #1 kept dozing off after each question.

An observation of personal care on Resident #1 was made on 11/28/23 at 10:53 AM. Resident #1 was lying in bed asleep with her left leg elevated on a pillow with a knee immobilizer in place. Resident #1 had soft boots in place on both feet. Although Resident #1 was given a pain medication prior to care, she complained of intermittent pain whenever she was turned and moved in bed. She was observed grimacing and would say "ow, that hurt." She was unable to rate her pain level.

An interview with the Rehabilitation Manager (RM) revealed therapy worked with Resident #1 from July to August 2023 but she only worked with Occupational Therapy (OT) and Speech Therapy. The RM stated that Resident #1 refused an evaluation with Physical Therapy (PT). She stated that Resident #1 was admitted to the facility with a history of a left knee fracture for which she had a prosthesis, so she did not like therapy and did not receive an evaluation from PT because she refused to get up and be moved off her bed. The RM stated that since Resident #1 did not receive a PT screen upon admission to the facility, her transfer status would be obtained from her past medical history. During the interview, the RM pulled up Resident #1's discharge summary from another facility from which she came and noted that Resident #1 was listed as non-ambulatory. The RM stated that using a mechanical lift would be the safest way to transfer Resident #1. She shared that this

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information was in Resident #1's medical record but she would have to look it up. The RM stated that she found out about Resident #1's fall wherein she obtained a leg fracture, and she did not know how it could have happened. She said that she found out later that a staff member had attempted to transfer Resident #1 without using a mechanical lift. The RM stated that if Resident #1 was attempting to get up from the bed unassisted and she witnessed this, she would have called for help from another staff member and educated Resident #1 to stay in bed until they could get a lift because it was not safe to move her without using a mechanical lift. The RM further shared that after Resident #1 came back from the hospital, PT and OT had started working with her, but she had refused three out of five treatments from PT and said that it was painful, and she was not participating. She was not able to state whether she would have had the ability to get herself to sitting position on the side of the bed prior to the incident because PT never worked with her, and they never got her up out of the bed.

An interview with the Medical Director (MD) on 11/29/23 at 12:27 PM revealed the PA was informed that Resident #1 had slid out of chair to the floor, but the MD stated that she did not know that a staff member had attempted to transfer her without using a mechanical lift. The MD stated attempting to let Resident #1 ambulate and stand up possibly led to the fracture on her left leg and this could have been avoided if they had used a mechanical lift on her.

An interview with the Interim Director of Nursing (DON) on 11/29/23 at 11:17 AM revealed during her clinical review on 11/8/23, she noted that

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	345302	A. BUILDING _____ B. WING _____	R-C 11/30/2023

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VERO HEALTH & REHAB OF SYLVA	417 CLOVERDALE ROAD SYLVA, NC 28779

(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
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Resident #1 had been complaining of pain, so she placed her on the doctor's list to be seen for management of pain. The Interim DON stated clinical review included reading the 24-hour report. Resident #1 was noted to have a fracture on her left knee near her prosthesis, so this was reported to the Administrator, and they started an investigation. The Interim DON stated she only found out about the fall incident when Resident #10 was coming back from the hospital on 11/10/23. The Interim DON stated she interviewed the nurse on 11/12/23 and found out that Resident #1 had a fall that was not reported to her, but it was reported to the PA. The Interim DON stated that she was not satisfied with the care approach by NA #1 and when she interviewed him, he stated to her that he didn't know how to care for the resident. He said he did not ask other staff members and attempted to get Resident #1 up without using a mechanical lift. He told her that Resident #1 slid down to her knees when she fell, and he also told her that he didn't know how to transfer Resident #1. The Interim DON stated she had educated NA #1 about where to find information regarding transfer status, but he wasn't receptive, and he would not take responsibility for Resident #1's fall. The Interim DON stated this education was just verbal and she didn't document this anywhere, but she did it before he took his first assignment. The Interim DON stated Resident #1 should have been transferred using a mechanical lift with two staff members assisting. She added that she did not believe that Resident #1 was trying to get out of bed on her own because she did not have trunk control and in order to sit up on the edge of her bed, he must have assisted her to do that. The Interim DON stated the nurse should have filled out an incident report and documented the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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fall incident in Resident #1's medical record. After she found out about the fall, the Interim DON asked Nurse #1 to fill out an incident report for Resident #1's fall on 11/7/23.

An interview with the Administrator on 11/30/23 at 5:05 PM revealed she learned of Resident #1's fall on 11/7/23 when it was reported at the clinical team meeting. Her initial understanding was that it was an injury of unknown origin, and they did not know how the injury occurred. The Interim DON started an investigation which involved talking to the staff members who were involved, and other staff members were working that day. Resident #1 was immediately assessed but she could not say anything about the fall. An x-ray was obtained which revealed a fracture. The Administrator stated when she talked to NA #1, he stated that he had just walked in to the building, and he happened to walk by the room. He immediately tried to assist Resident #1 to the floor. NA #1 told her that he learned from Resident #1's family member that Resident #1 tried to get up all the time, thinking that she could walk. The Administrator stated that NA #1 presented the situation as if he had assisted her from falling on her face and he just intervened. After the Interim DON talked to him, they decided to place him on Do Not Return status on 11/9/23.