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	345092	A. BUILDING _____ B. WING _____	C 11/21/2023

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted 11/13/2023 to 11/21/2023. Event ID # GOUD11. The following intake was investigated: NC002009065. 1 of 6 complaint allegations resulted in deficiency. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity D. The survey began on 11/13/2023 to conduct a complaint investigation survey and exited on 11/14/2023. The survey obtained additional information and exited on 11/21/2023. Therefore, the exit date was changed to 11/21/2023.	F 000		
F 689 SS=D	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, observations, and staff interviews the facility failed to prevent 1 of 3 residents (Resident #1), reviewed for accidents, from falling from bed. Resident #1 fell from the bed when it was left at the highest level by a staff member which put him at increased risk of injury. Findings included:	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 12/01/2023

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Resident #1 admitted to the facility on 8/2/2023 with diagnoses of stroke and weakness.

An admission Minimum Data Set (MDS) assessment dated 8/7/2023 indicated Resident #1 was severely cognitively impaired and required extensive assistance with bed mobility and transfers from the bed.

Resident #1's Care Plan dated 8/7/2023 indicated he was at increased risk of falls due to limited mobility and weakness due to a stroke. The Care Plan further indicated Resident #1 should have his bed in the lowest position to prevent injury.

Review of Resident #1's medical record revealed a Progress Note written by Nurse #1 on 8/22/2023 at 10:09 pm which stated Resident #1 was found on the floor beside his bed on his stomach and his bed was in the highest position by Nurse Aide #1. The Progress Note also stated Nurse #1 assessed Resident #1 for injuries and he complained of pain in his left upper extremity and right lower extremity. Nurse #1 notified the Physician and obtained orders to send Resident #1 to the emergency department for evaluation.

Nurse #1 was interviewed on 11/14/2023 at 11:48 am and she stated Nurse Aide #1 notified her she found Resident #1 on the floor, and she immediately assessed him. Nurse #1 stated when she entered the room Resident #1's bed was in the highest position. Nurse #1 also stated Nurse Aide #1 told her Resident #1's bed was in the lowest position and the Family Member was visiting shortly before she found Resident #1 in the floor. Nurse #1 stated she called the Family Member and was told by the Family Member Resident #1 was with the Physical Therapist

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when she left the Resident #1's room. Nurse #1 spoke to the Physical Therapist, and he stated he must have left Resident #1's bed in the highest position. Nurse #1 stated she did an in-service on ensuring resident's beds are left in the lowest position with the Physical Therapist and Nurse Aide #1 and notified the Director of Nursing.

On 11/15/2023 at 12:13 pm an attempt was made to telephone the Physical Therapist, but his phone number was no longer in service, and he no longer worked for the facility.

An Emergency Department Provider Note dated 8/22/2023 stated Resident #1 was evaluated for injury. Resident #1 had laboratory bloodwork which was unremarkable; x-rays of his bilateral knees which showed no acute abnormality; and a Computed Tomography Scan (CT) of his head showed no acute abnormality. The Emergency Department Provider Note stated Resident #1 did not have any significant injuries and he was sent back to the facility.

The Director of Nursing (DON) was interviewed on 11/14/2023 at 5:00 pm and she stated the facility had tried several interventions to prevent Resident #1 from falling and when he fell on 8/22/2023 his bed was in the highest position; and it should have been in the lowest position because of his history of falls. The DON stated they immediately put a plan of correction in place to prevent further injuries for Resident #1 and all other residents.

On 11/15/2023 at 3:44 pm the Administrator was interviewed and stated the Physical Therapist should have ensured Resident #1's bed was in the lowest position since he had a history of falls

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to prevent him from being injured. The Administrator stated the facility had put a plan of correction into place to prevent Resident #1 and any other resident from a bed being left in the highest position.

The facility began a Plan of Correction on 8/22/2023:

Identify Problem: Bed was left in high position when resident, WM, fell from bed.

Interventions to correct problem:
1. Resident Resident #1 fell from his bed on 8/22/23 while it was in a high position. The Charge Nurse assessed Resident #1 on 8/22/2023 immediately after the fall, in which he complained of pain to his left and right upper extremities. A physician's order was given to send Resident #1 to the hospital for further evaluation.
2. Resident #1's bed was placed at an appropriate lowered height for the resident on 8/22/23 by the Charge Nurse.
3. All residents have the potential to be affected. On 8/22/23 all in-house residents' bed height was assessed for correct height by unit managers. Any issues identified were immediately addressed.
4. The Director of Nursing, Staff Development Coordinator and Unit Managers initiated an in-service education on 8/22/23 for all licensed nurses, certified nursing assistants, certified medication aides, housekeeping, therapy, and all department heads on keeping bed height at an appropriate level for the resident when residents are in the bed. No staff were allowed to work after 8/23/23 until in-service was completed. The education was added to the new hire orientation

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F 689	Continued From page 4 by the staff Development Coordinator on 8/29/23. 5. The Director of Nursing or designee will conduct audits for each unit one time a week x 4 weeks for correct bed height of resident in bed after staff provide care. The audits will be staggered throughout each shift. These audits will continue 3 times a week x 4 weeks, then weekly x 4 weeks. 6. The Director of Nursing or designee will bring the audit results to the Quality Assurance Committee Meeting x 3 consecutive months. At this time, the Quality Assurance Committee will determine if further monitoring is needed. Date of Compliance: 8/29/23	F 689		
F 867 SS=D	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	F 867		12/19/23

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not limited to the facility assessment required at §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

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ensure that improvements are sustained.

§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)

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F 867	Continued From page 7 functioning as a governing body regarding its 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 record review and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place following the 5/24/2022 recertification and complaint investigation survey. The deficiency was in the area of supervision to prevent accidents F689. The continued failure during two federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: The tag is cross-referenced to: F689-Based on record review, observations, and staff interviews the facility failed to prevent 1 of 3 residents reviewed for accidents (Resident #1) from falling from the bed. Resident #1 fell from the bed when it was left at the highest level by a staff member which put him at increased risk of injury. During a recertification and complaint investigation survey completed 5/24/2022 the	F 867	1. The charge nurse assessed resident WM on 8/22/23 immediately after the fall, in which he complained of pain to his left and right upper extremities. A physician□s order was given to send resident WM to the hospital for further evaluation. Resident WM□s bed was placed at an appropriate lowered height for the resident on 8/22/23 by the charge nurse. 2. All residents have the potential to be affected. On 8/22/23, all in house residents bed height was assessed for correct height by unit managers. Any issues identified were immediately addressed. 3. The Director of Nursing, staff development coordinator and unit managers initiated an in service on 8/22/23 for all licensed nurses, certified nursing assistants, certified medication aides, housekeeping, and all department heads on keeping bed height at an appropriate level for the resident when resident is in bed. This education was	

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F 867	Continued From page 8 facility failed to provide safe care to a dependent resident which resulted in the resident falling out of bed and sustaining injuries. On 11/21/2023 at 3:01 pm the Administrator was interviewed by phone and stated the facility's Quality Assessment and Assurance Committee had failed to delved into the trends and patterns of resident falls and getting processes into place to improve falls in the facility. The Administrator stated improving the Quality Assessment and Assurance Committee was a priority and the facility would continue to work to improve the processes they have in place.	F 867	added to the new hire orientation by the staff development coordinator on 8/29/2023. The Administrator initiated education to the quality assurance members on 11/29/2023 regarding quality assurance performance improvement and the importance of determining the root causes regarding F 689 Free of Accident hazards/supervision/devices and other identified areas of concern. Education also included evaluating the effectiveness and individualizing the plan. A.Quality assurance members will meet monthly to discuss specific problems that are identified. B.The Administration department will ensure that designated quality assurance members are in attendance. C.The quality assurance committee will look at processes and drill down into the “why” of presented issues, to ensure the root cause is identified. 4. The Administration will review and be responsible for the facility□s quality assurance programs and any audits brought forth to the monthly quality assurance meeting to ensure a root cause analysis is conducted with appropriate interventions in place. The designated programs from the quality assurance master checklist will be reviewed monthly X 3 months, results will be forwarded to the quality assurance meeting for 3	

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