STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345381	A. BUILDING _____ B. WING _____	C 01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

(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 The surveyor entered the facility on 1/10/2024 to conduct a complaint survey and exited on 1/11/2024. Following review of the citation, immediate jeopardy was identified on 1/17/2024. An offsite partial extended survey was completed on 1/19/2024 and therefore the exit date was changed to 1/19/2024. A complaint survey was conducted from 1/10/24 through 1/19/24. Event ID# 60CL11. The following intake was investigated NC00211003. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity J F689 constituted substandard quality of care. Non-noncompliance began on 12/7/2023. The facility came back in compliance effective 12/19/23.	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 and interview of staff, physician, resident, the facility failed to protect Resident #1 from rolling out of bed during the provision of personal care.	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 01/26/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345381	A. BUILDING _____ B. WING _____	C 01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

(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 689	Continued From page 1	F 689		

Resident #1 fell from her bed to the floor. Resident #1 was sent to the emergency room and was diagnosed with a distal femur fracture (fractures of the thighbone that occur just above the knee joint) of both legs. The fractures resulted in hospitalization, treatment with Heparin (blood thinner) to prevent blood clots in the lower legs and Fentanyl (a controlled substance used to treat severe pain) for pain. The resident had to wear knee braces to both legs for stability until healed which can cause skin breakdown and significantly limit her ability to move/transfer during care, dialysis, or simple shifting herself in the bed. This deficient practice affected one of two sampled residents (Resident #1).

Findings included:

Resident #1 was admitted to the facility on 1/11/23 with diagnoses of a history of falling, and muscle and right-sided weakness, diabetes, neuropathy, and renal failure.

Resident #1 had a quarterly Minimum Data Set (MDS) dated 9/3/23 that documented she had severely impaired cognition. The resident required one-person physical assistance with bed mobility. The active diagnoses were end-stage renal disease dependent on hemodialysis, diabetes, cognitive communication deficit, dementia, and muscle weakness. The resident had scheduled and as needed pain medication. Her pain was occasional and mild. She was not coded for anticoagulant and coded no falls since the prior assessment.

Resident #1's care plan dated 10/7/23 documented she had an activity of daily living deficit and required assistance with hygiene by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345381	A. BUILDING _____ B. WING _____	C 01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

(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 689	Continued From page 2	F 689		

one staff, impaired mobility, pain, and was at risk for falls.

On 1/10/24 at 12:20 pm an interview of Resident #1 was completed. The resident was alert and oriented to self and situation. She remembered falling from her bed by herself. She did not remember staff being present. The resident stated that she had very bad pain when the staff tried to move her after the fall (does not remember how many days after). The pain with movement was a 10 (scale of 1 to 10, with 10 being the worst), the worst she ever had. The resident had no pain at this time and no other concerns.

A review of Resident #1's Medication Administration Record for December 2023 which documented the resident was assessed for pain each shift. Her pain level was none or below a 4 from 12/1/23 to 12/8/23. On 12/9/23 the pain level had increased to a 10 (the resident was sent to the Emergency Department).

A nurses' note dated 12/7/23 at 7:36 am by Nurse #2 (night shift) documented she was called to Resident #1's room by Nursing Assistant (NA) #1. NA #1 informed Nurse #2 that during peri care, the NA rolled the resident over onto her right side and the resident rolled out of bed. According to NA #1, the resident will sometimes continue to roll when being turned for peri care but not out of bed. The resident was assessed, and her range of motion did not change per the resident's baseline, and she had no pain. The resident was known to moan and groan often, but no injuries were noted at this time. There was no swelling, deformity, discolorations, or redness noted. The resident's vital signs were unchanged from her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345381	A. BUILDING _____ B. WING _____	C 01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

(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 689	Continued From page 3	F 689		

normal baseline. The resident was assisted back up and into bed. The bed was elevated for care when the resident fell out of the bed. A message was left for the on-call medical service. The call bell was within reach and bed was in low position.

On 1/10/24 at 4:11 pm Nurse #2 was interviewed. Nurse #2 stated NA #1 informed her Resident #1 had fallen out of the bed when the NA was changing her on night shift 12/6/23. The accident occurred close to the end of shift. The NA rolled the resident to the right side in the center of the bed and the resident held onto the quarter rail as usual, but she rolled out of bed. Nurse #2 stated she and NA #1 had taken care of the resident before and had no problems. The resident's right side was weaker, and the resident rolled over from time to time but not out of the bed. Nurse #2 stated she assessed the resident and there were no injuries, and the resident had no pain. The resident's extremities were moved and checked with no change. There was no head injury. Resident #1 informed Nurse #2 she fell out of bed. Nurse #2 stated she assisted the resident off the floor and put her back in the bed using a mechanical lift. There was no redness, swelling, or deformity of the extremities. There was a fall committee (date unknown) that evaluated the incident. The resident was changed to a larger/wider bed for safer rolling.

NA #1 was called and left a detailed message to return the call on 1/10/24 at 3:50 pm and again on 1/11/24 at 10:30 am. The NA was unable to be contacted.

On 1/11/24 at 10:30 am an interview was attempted with NA #3 but was unsuccessful. NA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345381	A. BUILDING _____ B. WING _____	C 01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

(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 689	Continued From page 4	F 689		

#3 was assigned to Resident #1 on 12/7/23 day shift.

A nurses' note dated 12/7/23 at 3:51 pm written by Nurse #5 documented follow up for Resident #1's fall. The blood pressure was 131/69 position was lying taken on the left arm. The pulse was 75 and regular, respirations were 19, temperature was 98.1 taken on the forehead, and oxygen saturation was 97.0 %. The resident was oriented to room location and was pleasant. Neurological checks were within normal limits. The resident had no complaint of pain. The pain level was 0 (pain score 0 to 10 with 10 being the worst). The resident's skin tone was normal, warm, and dry. The respirations were unlabored and lung sounds were clear. The resident had no edema, and pedal pulses were present. The resident required two-person physical assistance with transfers and bed mobility after the fall.

On 1/10/23 at 2:40 pm an interview was conducted with NA #2. NA #2 stated she was assigned to Resident #1 on day shift 12/7/23, 12/8/23, and 12/9/23. She stated the resident had no pain on 12/7/23 or 12/8/23 during care or assistance with her meals. On 12/9/23 the resident complained of acute pain in her left leg when moved and Nurse #1 was informed. Nurse #1 called the doctor and an x-ray was ordered. When she returned to work and was assigned to Resident #1 days later, she had been to the hospital and was wearing splints to both her legs and had no pain during care.

On 1/10/24 at 4:30 pm an interview was conducted with Nurse #5. Nurse #5 stated she was familiar with Resident #1. The resident had an accident on 12/7/23 and had no pain until

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345381	A. BUILDING _____ B. WING _____	C 01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

(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 689	Continued From page 5	F 689		

12/9/23. The resident had an x-ray and was sent out to the Emergency Department. The resident was able to inform staff if she had pain. The resident had an assessment on each shift twice a day for two days and on the third day after the accident she had pain and was sent out. The resident had neurological assessments each shift. The resident had gone to dialysis on Friday 12/8/23, the date she completed the head-to-toe form (assessment of the resident's body) after the resident returned. She had no pain, and her neuro check was negative.

A facility Head to Toe Evaluation form was completed by Nurse #2 dated 12/8/23. Nurse #2 documented Resident #1 had no swelling, discolorations, or redness noted on her body. The resident's vital signs were taken and at her baseline. The resident was assessed for pain and had none, score of a 0.

Nurses' note dated 12/8/23 at 5:44 pm written by Nurse #1 documented Resident #1's blood pressure was 117/62, pulse was 77 and regular, respirations 20 and non-labored, temperature was 97.8, and oxygen saturation was 98%. Neurological check was within normal limits for the resident. The resident had no complaints of pain, and the skin tone was normal. The staff will continue to monitor the resident.

Nurses' note dated 12/9/23 written by Nurse #1 documented Resident #1 had new onset pain to the left knee and the physician was called and tramadol 50 milligrams one time only for pain was ordered and administered.

Resident #1's Medication Administration Record documented on 12/9/23 her pain score level was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345381	A. BUILDING _____ B. WING _____	C 01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

(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 689	Continued From page 6	F 689		

10.

Resident #1 had a medication order dated 12/9/23 for Tramadol 50 milligrams one time only for pain and for radiographs of the left knee, leg, and hip.
Resident #1 had a medication order dated 12/9/23 for Tylenol 650 milligrams every 6 hours as needed for pain.

Resident #1's radiograph reading of the left knee, leg, and hip dated 12/10/23 reported a left acute distal femur fracture that was comminuted (more than 2 breaks) and closed. The bony structures appear osteopenic (weak bones) . The knee and hip joints were in place and unaffected.

Resident #1's hospital discharge summary dated 12/14/23 documented the resident was seen in the Emergency Department on 12/10/23 for a history of falling and knee pain and radiographs were completed. The resident was admitted for fractures. The resident's radiographs reported she had closed bilateral (both legs) closed distal femur fractures that were managed non-surgically. The resident was to be non-weight bearing with knee immobilizers. Heparin (blood thinner) was added to prevent deep vein thrombosis (clots of the lower legs). The resident was evaluated by an orthopedic physician and pain management medication and immobilizers were initiated for the fractures.

Resident #1 had a new pain medication order upon return from the hospital dated 12/14/23 for Norco 5-325 milligrams every 6 hours as needed for pain for 7 days.

On 1/10/24 at 12:00 pm an interview was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345381	A. BUILDING _____ B. WING _____	C 01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

(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 689	Continued From page 7	F 689		

conducted with Nurse #1. Nurse #1 stated she was assigned to the resident for a 12-hour day shift on 12/9/23 after the fall that occurred on night shift 12/6/23. It was on Sunday morning and the resident complained of left leg pain, score level of 10 when staff moved her for care. This was the first time the resident had complained of leg pain that Nurse #1 was aware of. The on-call medical practitioner was called and he ordered an immediate x-ray of the leg which was taken at the facility and pain medication. The x-ray result reported a distal fracture of the left femur on 12/10/23. There was no deformity, bruising, or edema of the legs or knees at this time (12/9/23). The resident was sent to the Emergency Department for evaluation on 12/10/23. Nurse #1 stated she readmitted the resident on 12/14/23 and the Emergency Department diagnosis was distal fracture of bilateral femurs. The resident was ordered a Fentanyl patch on 12/20/23 (a controlled substance used to treat severe pain) for pain because she attended hemodialysis. With the patch, pain would be more continuously controlled with dialysis and pain was under control. Nurse #1 stated the resident required one person assist for in bed care and was able to hold the quarter mobility rail for care and had no prior history of not being able to hold the rail and falling from the bed before the accident. On 1/14/24 the resident was changed to a two-person bed mobility assist to prevent falls. Nurse #1 also stated she thought the resident was now unable to hold the rail and balance when rolled was a change. Nurse #1 stated the resident now had knee immobilizers and was unable to bend her knees and move freely in her bed and the immobilizers had to be removed to check for skin breakdown. The immobilizers placed the resident at risk for skin breakdown.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345381	A. BUILDING _____ B. WING _____	C 01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

(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 689	Continued From page 8	F 689		

The resident was non-weight bearing and had to be transferred using a mechanical lift after the accident. Nurse #1 stated she was not aware of any other incidence where a resident rolled out of bed onto the floor.

Resident #1 had a change in pain medication dated 12/20/23 from Norco to Fentanyl transdermal (through the skin) patch 12 micrograms/hour change every 72 hours due to uncontrolled pain.

On 1/10/24 at 12:20 pm an observation of Resident #1 was completed. The resident was lying in a pressure reduction air mattress bed that was wider than the traditional foam mattress she was on prior to the fall. She had knee imobilizers in place to both legs.

On 1/10/24 at 1:10 pm an interview was conducted with the Administrator and Director of Nursing (DON). The accident was investigated, and the outcome determined was the resident had a large bottom and abdomen in comparison to the extremities which slid off the bed from the center when turned/rolled during care and hit her knees to the floor. The resident was still holding on to the bed mobility rail when she fell. There was a full investigation, education, and plan of correction. The Quality Assurance Committee was involved, and the Medical Director was informed. After the accident, NA #1 was observed to provide bed mobility for Resident #1 by the Administrator and Physical Therapist. No concerns were identified with the technique at this time.

On 1/10/24 at 3:00 pm an interview was conducted with the Physician. The Physician

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345381	A. BUILDING _____ B. WING _____	C 01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

(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 689	Continued From page 9	F 689		

stated on 12/7/23 he examined Resident #1 in the late morning of the day she fell previously on night shift, approximately 2:00 am. The resident was fully examined and there was no deformity, edema, redness, or pain. The resident had been able to verbalize pain or concerns in the past and on 12/7/23 during the exam the resident had no pain or concerns. The Physician stated the resident had normal vital signs (within her usual range) and no facial grimace or body language that would show pain. The Physician further stated Resident #1 had diabetes, neuropathy, and renal failure usually have decreased sensation and the diagnoses contribute to osteoporosis. The resident had no bone scan to diagnose osteoporosis, it was suspected. The Physician stated that the pain showing two days later was not unusual and the nursing staff had documented an assessment each shift of no pain or changes. The Physician stated that pain would cause increased vital signs and the resident's vital signs were normal and at her baseline until 48 hours later when the resident verbalized pain. The resident went to dialysis during the two days after the fall before she had experienced pain. The Physician stated the fall was an accident, the staff handled the situation appropriately, it was investigated, and shared at QA (quality assurance). The clinical staff also participated in education for bed mobility and falls.

On 1/10/24 at 3:40 pm an interview was conducted with the Physical Therapist (PT) Director who investigated Resident #1's fall. The PT volunteered to be a subject in the bed and evaluated the width and determined the root cause of the accident, observed NA #1 complete bed mobility with the PT as the resident, and provided education with return demonstration to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345381	A. BUILDING _____ B. WING _____	C 01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

(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 689	Continued From page 10	F 689		

all clinical staff, including therapy. The PT stated the morning of Resident #1's fall, the risk management morning meeting included the fall/incident, and the staff reviewed the plan of intervention for recurrence. The resident was handled by NA #1 and the resident fell out of the bed while being rolled to her right side for incontinence care. The resident had no pain until two days later, on the weekend. PT and the Administrator interviewed NA #1 and she provided a demonstration of bed mobility that was used for Resident #1 with the PT as the resident in the bed. It was determined the root cause for the accident was the resident was rolled from the center of the bed, held the mobility rail and was stable on one side but not the other. The second rollover of the resident to the right side was a weaker side and the resident could not hold her core muscles and leaned over and rolled out of bed. The NA overestimated the space and ability of the resident to remain on her side in the center of the bed, which had not occurred in the past. The resident was provided a wider bed for bed mobility and to prevent any further accident. Resident #1 was initially evaluated upon admission for use of the mobility rail by PT staff and then entrapment evaluation by nursing staff. PT stated this incident was isolated to one NA. There had not been this type of accident before or after the 12/7/23 accident. The NA took the proper steps after the fall and was forthcoming. All clinical staff, including therapy, were educated with return demonstration. The resident had a communication deficit and dementia. The fracture pain seemed to have shown when the swelling increased post injury two days later. The resident required maximal assistance for transfer.

Resident #1's PT note dated 12/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345381	A. BUILDING _____ B. WING _____	C 01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

(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 689	Continued From page 11	F 689		

documented the resident had minor generalized pain with movement before the fall at a level of 4 and had a level of 10 after the fall. The resident was sit to stand transfer before the fall and non-weight bearing after the fall which required maximum assistance for transfer.

The 12/20/23 significant change MDS assessment revealed that sit to stand, chair to bed, toilet and shower transfers were not attempted due to medical condition or safety concerns.

The Administrator was notified of immediate jeopardy on 1/17/24 at 4:20 PM.

The facility provided the following corrective action plan with a completion date of 12/19/23:

F689

1.Corrective action for resident(s) affected by the alleged deficient practice:

On 12/10/23 the Resident was transferred to the hospital for evaluation and treatment. She returned to the facility on 12/14/23 with bilateral knee immobilizers.
2. Corrective action for residents with the potential to be affected by the alleged deficient practice:
One on one education with the staff member identified in the incident was provided on 12/11/23 by the facility Rehab Director.

To identify other residents with this same issue on 12/18/23 the Director or Nursing or Designee audited all residents who have had a fall in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345381	A. BUILDING _____ B. WING _____	C 01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

(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 689	Continued From page 12	F 689		

last 7 days for issues related to bed mobility and for injuries related to the fall. No other issues were identified.

3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice:
To prevent this from recurring on 12/18/23 the Director of Nursing, Assistant Director of Nursing and Rehab Director designee educated all licensed nurse, certified nurse aides and therapists on resident handling with bed mobility. As the training was being completed, the facility rehab director made unannounced in room visits while resident care was being provided by staff to observe for any safety concerns. None were observed.

All agency and new licensed nurses, certified nurse aides and therapist will receive this same education prior to working with residents.

4. Monitoring Procedure to ensure that the plan of correction is effective, and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

To monitor and maintain ongoing compliance beginning 12/25/23 the Director of Nursing or designee will audit 3 residents per week with falls for injuries and issues related with bed mobility, and will observe 3 staff providing care with bed mobility x 12 weeks.

Compliance Date: 12/19/23

Validation of the corrective action plan was completed on 1/10/24:
There was a signed roster of 120 clinical staff who received in-service for the fall incident of a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345381	A. BUILDING _____ B. WING _____	C 01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

(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 689	Continued From page 13	F 689		

resident who rolled out of bed onto the floor during care. 97 staff members were educated onsite and 23 staff were educated by telephone completed by 12/19/23. There were 81 staff who signed a check off procedure for return demonstration of proper bed mobility of a resident to include rolling a resident during care.

There was documentation of on-going monitoring of random bed mobility observation for 3 clinical staff per week for the past 2 weeks (1/10/24) as part of the quality assurance plan.

On 1/10/24 Nurses #1, #2, and #5 and NAs #2 and #5, the Director of Nursing, Physical Therapy Director, and the Physician were all interviewed during validation and were able to state nursing and therapy staff received education for resident safety, care, and bed mobility. The Director of Nursing provided documentation of the on-going audits of staff provide care and bed mobility. The completion date of 12/19/23 was validated.