STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345183	A. BUILDING _____ B. WING _____	C 10/02/2024

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F 000	INITIAL COMMENTS An onsite revisit and compliant investigation was conducted from 10/1/24 to 10/2/24. Tags F600, F609, F689, F755, F760 were corrected as of 10/1/24. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity D The facility is in compliance effective 10/1/24. Event 44KN11 The following intakes were investigated: NC00222625, NC00222002, NC00222222, and NC00222317. 1 of 9 allegations resulted in deficiency.	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, resident, physician, and staff interviews, the facility failed to provide care in a safe manner when a resident fell out of bed during incontinence care for 1 of 3 residents reviewed for accidents (Resident #7).	F 689	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/15/2024

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Nursing assistant (NA) #1 rolled Resident #7 away from her during incontinence care, and Resident #7 fell out of bed sustaining bruising to his face and skin tears to his arms. Resident #7 was prescribed an antiplatelet medication, which thins the blood.

The findings included:

Resident #7 was admitted to the facility 5/10/23 with diagnoses including respiratory failure, heart failure, peripheral vascular disease, right above the knee amputation, and atrial fibrillation.

A physician order dated 5/10/23 ordered clopidogrel (an antiplatelet drug that prevents blood clots) 75 milligrams to be administered once daily.

The Quarterly Minimum Data Set (MDS) assessment dated 8/15/24 assessed Resident #7 to be cognitively intact without behaviors. The MDS assessed Resident #7 to require moderate 1-person assistance with bed mobility. The MDS documented Resident #7 was taking an antiplatelet medication.

The Kardex (a brief description of the care required for a resident, including mobility and transfer needs) dated 9/9/24 documented Resident #7 required 1-person physical assistance with bed mobility.

An incident report dated 9/28/24 at 8:15 AM written by Nurse #1 documented Resident #7 was receiving incontinence care from NA #1 and as NA #1 rolled Resident #7 over, he rolled out of bed and fell to the floor. The incident report documented that Resident #7 reported NA#1 had

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pulled a blanket under him while he was rolling and that caused him to roll out of the bed. The incident report documented Resident #7 hit his head and had red discoloration to both eyes and his forehead, as well as a reddened area to his left palm. Emergency Medical Services (EMS) were called, and Resident #7 was transferred to the hospital for evaluation. The report indicated the on-call nurse practitioner was notified of the fall.

A nursing note written by Nurse #1 on 9/28/24 at 8:15 AM documented Resident #7 rolled out of bed and hit his face and right arm. The note documented Resident #7 was bleeding from a right arm skin tear and he was transported to the hospital by EMS. The note documented the on-call Nurse Practitioner was notified.

Nurse #1 was interviewed by phone on 10/2/24 at 3:44 PM. Nurse #1 explained she was on duty 9/28/24 assisting the medication aides with medication administration and NA #1 came out of Resident #7's room and told her he had fallen on the floor. NA #1 had reported to her she had pulled on the blanket under Resident #7 while he was turning over onto his left side, and he had rolled out of bed. Nurse #1 noted Resident #7 took blood thinners, he was bleeding, and he had reported hitting his head on the floor, so she called EMS to transport him to the hospital for evaluation. Nurse #1 obtained vital signs on Resident #7 and determined he was bleeding from a skin tear on his arm. Nurse #1 explained she did not have time to dress the wound because EMS arrived. Nurse #1 reported Resident #7 had not reported pain until he was transferred to the gurney for transportation.

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Resident #7 was interviewed on 10/1/24 at 12:35 PM. Resident #7 reported on 9/28/24 in the morning before breakfast, NA #1 came to his room to help him get ready for the day and was providing incontinent care. Resident #7 described how NA #1 asked him to roll over to his left side, and then pulled the blanket underneath him and he rolled out of bed. Resident #7 explained that NA #1 was behind him and pulled the blanket to her while he was attempting to roll, and this caused him to fall out of the bed and onto the floor. Resident #7 reported he hit his head on the floor, and he had to go to the hospital for evaluation. Resident #7 reported he had completed x-rays, as well as a computed tomography scan (CT scan) that showed he had no broken bones and no brain bleed. Resident #7 was observed to have dark purple bruising from his forehead, around both eyes and down his cheeks past the tip of his nose. Resident #7 reported he had chronic pain and as needed pain medications that helped, and he wasn't certain if he had more pain from the fall or if it was his normal amount of pain.

A phone interview was conducted with NA #1 on 10/1/24 at 4:26 PM. NA #1 reported she had checked the Kardex to find out what kind of help Resident #7 needed, and she saw that he was 1 person assistance with bed mobility. NA #1 reported she was providing incontinence care to Resident #7 on 9/28/24 before breakfast. NA #1 described standing on the right side of the bed (between bed A and bed B) and she had moved him in bed closer to the right side of the bed so Resident #7 could roll over on his left side. NA #1 explained that she did not assist Resident #7 to roll, he went over onto his left side, and he rolled out of the bed. NA #1 reported she heard

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Resident #7's head hit the floor, and he was bleeding from somewhere. NA #1 reported she had been trained to roll people towards her during care but thought that Resident #7 was able to move himself in bed and she could roll him away from her. NA #1 reported she had not pulled the blanket under Resident #7, and he had rolled himself out of bed. NA #1 reported she went out to the hall and yelled for Nurse #1 to help because Resident #7 had fallen out of bed.

The emergency room provider notes dated 9/28/24 documented Resident #7's assessment and evaluation at the hospital emergency room. The note documented Resident #7 sustained a fall from the bed and hit his forehead, but did not lose consciousness. The note documented Resident #7 denied pain to his neck, upper or lower body, or chest pain, and he reported a headache that he rated "3" on 1-10 scale (0=no pain, 10=extreme pain). The note documented Resident #7 had a 3-centimeter-wide hematoma (collection of blood under the surface of the skin) and a small skin tear to his right forearm. The chest x-ray didn't show rib fractures, and the CT scan of his head was negative, but did show the scalp hematoma to the forehead. Resident #7 was discharged back to the facility without new orders.

Nurse #4 was interviewed on 10/2/24 at 4:44 PM. Nurse #4 reported she was on duty when Resident #7 returned to the facility from the hospital, and he had no new orders. Nurse #4 reported Resident #7 did not complain of any increase in pain, but his face was bruised, and he had a skin tear on his right arm that had a dressing on it.

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A nurse practitioner (NP) note dated 9/30/24 documented a visit with Resident #7. The NP documented Resident #7 had reported to her he fell from the bed when NA #1 used a sheet to turn him onto his side and he fell from his bed and hit his face on the nightstand. The note documented he had been evaluated at the hospital and returned to the facility without new orders.

The NP was interviewed on 10/2/24 at 12:32 PM. The NP explained she was notified by the on-call provider on 9/28/24 that Resident #7 had fallen out of bed, and she came in to assess him on 9/30/24. The NP noted Resident #7 reported the NA had used the sheet to roll him on his side and he fell out of bed. The NP reported Resident #7 was not injured, other than bruising his face and arms and a skin tear.

NA #4 was interviewed on 10/2/24 at 2:29 PM. NA #4 reported she was not assigned to Resident #7, but she went to his room to help after he had fallen to the floor. NA #4 explained when she arrived Resident #7 was bleeding, but she wasn't certain where the blood was coming from. NA #4 reported she had provided care to Resident #7 in the past and he was unable to roll side to side in bed without assistance and she always stood in front of him and rolled him towards her because he was not able to pull himself onto his side.

An observation of bed mobility was conducted on 10/2/24 at 2:49 PM with NA #2, NA #3, and Resident #7. Resident #7 was unable to lift his hips to move over in bed and the NAs had to assist him. Resident #7 attempted to turn over to his left side, but he was unable to fully turn. NA #2 stood in front of Resident #7 and pulled his hips towards her to assist him to roll on his left

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side. NA #2 reported that any time she assisted a resident with bed mobility, she stood on the side of the bed the resident was turning, and always turned the resident towards her so they would not slip out of bed.

The physician was interviewed by phone on 10/2/24 at 3:54 PM and when asked if he was surprised Resident #7 had not sustained more serious injuries, the MD responded he was happy Resident #7 was not hurt and that clopidogrel protected the resident from brain bleeding with injury. Additionally, he reported the staff should use safe bed mobility methods to prevent residents from rolling out of bed.

Nurse #3 was interviewed on 10/2/24 at 4:04 PM. Nurse #3 reported Resident #7 had not had an increase in pain since the fall, and he had not increased his use of the pain medication.

The Unit Manager (UM) was interviewed on 10/2/24 at 5:28 PM. The UM explained she was called on 9/28/24 after Resident #7 fell out of bed and on 9/30/24 an ad hoc Quality Assurance Performance Improvement (QAPI) meeting was held to discuss the fall, start audits on residents, observe staff providing care and bed mobility, and provide education to staff. The UM reported the Director of Nursing (DON) led education to the NAs and the nursing staff about bed mobility on 9/30/24 and the UM conducted an audit on residents who required 2-person bed mobility assistance and observed care. The UM reported Resident #7 was determined to require 2-person assistance for his safety.

The DON was not available for interview on 10/2/24.

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The Administrator was interviewed on 10/2/24 at 6:52 PM. The Administrator reported she was notified of the fall on 9/28/24 and on 9/30/24 they had an ad hoc QAPI meeting and determined they would start a corrective action. The Administrator reported she expected residents to be turned towards the NA staff when in bed and receiving care, and the NA staff to review the Kardex to know what kind of assistance the resident required.

The facility submitted the following corrective action plan:

" Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

Resident #7 rolled from bed with nursing assistant (NA) #1 was assisting with activities of daily living. Resident #7 stated NA #1 asked him to turn over, when he did, she pulled the sheet and he fell, hitting his head on the nightstand and landing on his face and arm on the floor. Resident #7 was assessed for injury. Redness and discoloration were to both eye area and forehead. Redness and discoloration were noted to bilateral hands and arms. Neurological checks were initiated and were within normal limits. Resident #7 is his own Responsible Party. The physician was notified. Order was obtained to send Resident #7 to the emergency room for evaluation and treatment. Resident #7 returned to the facility with bruising noted to face, hands, and arms. No new orders. Physical Therapy is currently working with Resident #7 and will assess for bed mobility assistance.

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F 689	Continued From page 8 " Address how the facility will identify other residents having the potential to be affected by the same deficient practice. An ad hoc Quality Assurance Performance Improvement plan was conducted on 9/30/24 to review the incident and to initiate education and monitoring. On 9/30/24 the Unit Manager identified all residents requiring 2-person assistance with activities of daily living and bed mobility. Resident #7 was reassessed on 9/28/24 to require 2-person assistance with bed mobility. On 9/30/24 the Unit Manager completed a random observation of 10 residents requiring 2-person assistance to ensure the staff were providing the assistance required. No concerns were identified. Audit completed on 9/30/24. " Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Residents are assessed on admission, change of condition, and quarterly for assistance regarding activities of daily living care. Residents are discussed during the daily clinical meeting by reviewing progress notes for changes. NAs, including agency staff, were re-educated by the Director of Nursing to check the resident Kardex and care plan before providing care, turn the resident towards them while providing care and never away from them. Do not pull the linen, roll the linen under the resident to remove it. Education was completed on 9/30/24 by the Director of Nursing. Staff will not be permitted to work until education is completed. Education is included in new hires and new agency staff orientation. The Director of Nursing will be responsible.	F 689		

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" Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

Nurse management (the DON and the Unit Managers) will review each fall incident report during the daily clinical meeting to identify concerns that may have contributed to a fall 5 times per week for 4 weeks, 3 times per week for 4 weeks, and 2 times per week for 4 weeks. Nursing management will observe staff while providing activities of daily living to verify they are following the care plan and Kardex regarding the amount of assistance required 7 times per week for 4 weeks, 5 times per week for 4 weeks, then 3 times per week per week for 4 weeks. The Director of Nursing will report the results of the audit to the monthly QAPI committee for suggestions and/or recommendations until substantia compliance is achieved and maintained.

Completion date 10/1/24.

The facility corrective action plan dated 9/30/24 was validated on 10/2/24 by reviewing the audits conducted, reviewing the education provided to the nurses and NAs, observation of bed mobility with 2 NAs for Resident #7, interviewing nurses and NAs regarding bed mobility and activities of daily living assistance, checking the Kardex for resident care needs, and the QAPI meeting notes from 9/30/24 were reviewed.

The corrective action plan completion date of 10/1/24 was validated.