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F 000	INITIAL COMMENTS A complaint and revist survey was conducted by Healthcare Management Solutions, LLC on behalf of the Centers for Medicare & Medicaid Services (CMS) from 10/28/24 - 10/30/24 with additional activity conducted by the State Agency on 11/7/24 (Event ID 5PBI11). A deficiency was related to intake IDs NC0022249, NC00222253, NC00223007 and NC00223038 at F689. No deficiencies were issued related to intake IDs NC00222323, NC00222861, NC00222898, NC00222915 and NC00222968. On 11/07/24 the State Agency returned to the facility to validate the corrective action plan for F689. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity of (G) Substantial compliance was found 10/14/24.	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 observations, staff and physician	F 689	Past noncompliance: no plan of	

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

Electronically Signed | 11/19/2024

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F 689	Continued From page 1 interviews and record review, the facility failed to provide care safely to (Resident (R) 5 and R8) resulting in the residents sustaining injury. On 10/7/24 during the provision of incontinence care to R5 by Certified Nurse Aide (CNA) 1, the CNA utilized the draw sheet to pull the resident toward her resulting in the resident rolling in the opposite direction and onto the floor. R5 sustained a right hip fracture requiring surgical repair. On 9/19/24, R8, a resident who was dependent on staff assistance and was at high risk for injury related to a history of osteoporosis, was identified with bruising to her left leg and her feet. An x-ray revealed a "probable" fracture of the fifth toe on her left foot. Additionally, the facility failed to investigate and analyze R8's unwitnessed fall that occurred on 9/24/24 to determine causative factors. This deficient practice affected 2 of 2 residents reviewed for accidents. Findings included: 1.Review of R5's "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed R5 was admitted to the facility on 06/03/23 with diagnoses that included chronic pain syndrome, muscle weakness, and communication deficit. R5 was discharged from the facility on 10/08/24. Review of R5's Quarterly Minimum Data Set (MDS) located in the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of 09/16/24, indicated a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R5 was cognitively intact. The MDS indicated R5 had an impairment on both sides of their lower extremities.	F 689	correction required.	

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Review of R5's Care Plan, dated 08/08/24, located in the "Care Plan" tab of the EMR, indicated, "The resident is at risk for falls." Intervention in place included, "Non-skid socks while out of bed (initiated 08/08/24); Place bed in lowest position while residents in bed (Initiated 08/08/24); Place common items within reach of the resident (Initiated 08/08/24); Remind resident to use call light to ask for assistance with ADLs [Activities of Daily Living] (Initiated 08/08/24); and Send to ER [Emergency Room] for evaluation and treatment (Initiated on 10/09/24)." The resident also had a Care Plan which indicated, "The resident requires assistance with ADLs," initiated on 08/08/24 which indicated, "Refer to skilled therapy as needed."

Review of R5's undated CNA Kardex (a care guide for CNAs), located in the "Tasks" of the EMR, indicated, "Bed mobility-one person assist." R5's toileting ability did not indicate how many staff were needed for assistance.

Review of the facility's document titled, "Corrective Action," dated 10/07/24, accompanied a statement by CNA1 which indicated, "On the night of the patient accident. I walked in the room to give patient care. Patient was on her back sleeping on her right side. Head of bed in the up position. I let the head of patient down for the change [sic]. Walk to the dresser for a new brief. With pull sheet, pulled patient to me before the care was completed, and the patient rolled off the bed. No guard rail for patient support from rolling off bed to floor. I, as the caregiver, couldn't and had no time to stop the fall of patient. The nurse came with another CNA."

Interview with the CNA1 on 10/29/24 at 5:09 PM,

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CNA1 stated "on 10/07/24 I walked in the room and grabbed the 'diaper' and began care. I was standing at the resident's bedside between the two beds. I used the draw sheet to pull the resident towards me. As I pulled the draw sheet the resident rolled in the opposite direction. I then yelled for help and a nurse, and another aide came to assist with the resident." When asked if the resident required a mechanical lift, CNA1 stated she had never seen the resident outside of bed. She stated she reviewed the Kardex and spoke to nursing and the resident who ensured the resident one person assist.

Review of R5's "Progress Notes" found in the "Progress Notes" tab of the EMR documented by Licensed Practical Nurse (LPN)1 effective date, 10/08/24 at 7:45 AM indicated on 10/07/24, "Resident was observed on her right side on the floor between her bed and the wall with her back towards the wall. Her right arm pinned beneath her, facing the bed with her head towards the head of the bed and her feet towards the foot of the bed at 8:53PM. Resident was moaning and complaining of a lot of pain to her right hip. Resident reported that she had struck her head on the wall and wanted staff to call her daughter as well as send her to the hospital.. Call placed to 911 [10/07/24] at 8:57PM. EMS arrived at facility at 9:06PM."

Review of the "Witnessed Fall" documentation provided by the facility dated 10/08/24, indicated on 10/07/24, "Resident observed on her right side of the floor between her bed and the wall with her back towards the wall, her right arm is pinned beneath her, facing the bed with her head towards the head of the bed and her feet towards the foot of the bed. Patient stated that while being

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changed, she was being rolled over for incontinence care and rolled off the bed."

Review of the "[Hospital] Emergency Department [ED] Provider Note" provided by the State Agency (SA), dated 10/08/24, listed date of service as 10/07/24. The note indicated, "Patient was laying in the bed, she is not ambulatory, was being changed by nursing facility and rolled off the bed, hit the right side of her head as well as her right hip ....only complaint of pain of the right hip. On exam, her right leg is shortened and externally rotated ... Will obtain X-Ray of hip ..." Further review revealed, "ED Course ... right hip fracture ...surgery tomorrow."

Interview with LPN1 on 10/29/24 at 1:56 PM revealed CNA1 was working with the resident alone when the resident rolled out of bed. LPN1 stated the resident called for staff to come to assist. LPN1 stated R5 had always been one person assist with care and had no concerns with CNA1 assisting the resident alone.

During an interview with the MDS Coordinator on 10/29/24 at 5:18 PM, he stated, "I go and assess the resident myself. If there is a change on the resident status I then write up a care plan. I would notify the DON and change it on the Kardex so CNAs can do their charting."

Interview with the Medical Director on 10/29/24 at 7:29PM, the Medical Director stated he was aware that R5 sustained a fall but stated he did not know all the details of the fall. He stated R5 was sent out to the hospital and from his knowledge sustained a fracture.

Interview on 10/29/24 at 7:48 PM, the DON stated

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that instead of pulling the resident back, CNA1 proceeded to roll the resident to clean her. R5 rolled in the opposite direction. The DON stated she was not aware if R5 was a two person assist. The DON stated R5 probably should have been a two-person assist but agreed the Kardex indicated one person assist.

2. Review of R8's Admission Record located in the electronic medical record (EMR) under the "Profile" tab, revealed she was admitted to the facility on 04/11/24 with diagnoses that included dementia, muscle wasting and atrophy, osteoarthritis, and other lack of coordination.

Review of the admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 09/30/24, located in the EMR under the "MDS" tab, revealed a brief interview for mental status (BIMS) score of two out of 15 which indicated R8 was severely cognitively impaired. The MDS assessed R8 with an impairment on one side of the lower extremity and was dependent on staff for transfers from bed to chair.

Review of R8's comprehensive Care Plan, dated 09/11/24, located in the EMR under the "Care Plan" tab, revealed a focus area of R8 required assistance with activities of daily living (ADLs) with an intervention for one-person assistance with transfers.

2a) Review of R8's Nursing Progress Notes, dated 09/19/24, located in the EMR under the "Prog Note" tab, revealed, "Change of Condition: Resident had bruising on L/T [left] leg black, blue, yellow in color and bruising on the feet. Golf ball sized knot in the left calf, MD [physician] made aware and gave orders for doppler and x-ray. ..."

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Review of R8's "Complaint Intake and Health Personnel Investigations Report," dated 09/19/24, provided by the facility, revealed the former Administrator reported, "R8 had bruising of unknown origin on left leg. This bruising was found to have occurred from the transfer from the bed to the shower chair in the resident's room. R8 had a history of osteoporosis. The bruising was a result of the toe being broken during the transfer. CNA6 was the only witness. Staff were educated on properly transferring residents ... Staff was transferring R8 properly, but due to osteoarthritis diagnosis, R8 was at risk for fractures. R8 would be transferred with extra care and therapy would evaluate if R8 needed a different modality of transferring."

An interview was attempted with CNA6 on 11/01/24 but unsuccessful. CNA6 did not return the phone calls.

An interview was attempted with the former Administrator on 11/01/24 but was unsuccessful because he was out of the country.

Review of R8's Radiology Report, dated 09/20/24, located in the EMR under the "Results" tab revealed, " ... LEFT FOOT ... Impression: 1. There is a probable non-displaced fracture of the distal fifth metatarsal (bones located between the toes and the ankle) of indeterminate age ..."

Review of R8's "Physicians Orders," dated 09/21/24, located in the EMR under the "Orders" tab revealed an order to "Tape 5th and 4th metatarsal together for stability for one month. Change tape every seven days/PRN [as needed if] soiled. Monitor every shift."

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During an interview on 10/30/24 at 11:56 AM, Physical Therapy Assistant (PTA) stated R8's physical therapy notes indicated no transfer assessment prior to 09/24/24 could be found. The PTA stated R8 slept in a hook lying position in bed, and that she could not locate any transfer recommendations prior to 09/24/24.

During an interview on 10/30/24 at 12:15 PM, Family Member (F)1 stated that R8 could not bear weight on her feet, laid in a fetal position for the last six months, and her knees were contracted.

During an interview on 10/30/24 at 1:08 PM, the Medical Director confirmed R8 could not stand, bear weight on her feet, was bed bound, lay in bed in a fetal position, and had knee contractures. The Medical Director stated it would not be safe for one staff person to transfer R8 from the bed to the chair and it caused a fracture to her toe and bruises on her legs.

During an interview on 10/30/24 at 2:52 PM, CNA5 stated she was assigned to R8 when she worked at the facility for the last three or four months of R8's stay at the facility. R8's Kardex stated she required physical assistance of one-person for transfers dated 09/11/24, but she [CNA5] asked for assistance from another person when she transferred her due to her contracted knees and not being able to bear weight on her feet.

During an interview on 10/30/24 at 4:45 PM, CNA7 revealed she was assigned to R8 in August and September 2024 and that R8 could not straighten her legs fully and could not bear weight

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on her feet. CNA7 stated R8 required two staff to transfer her safely. CNA7 also stated she [CNA7] placed her arm under R8's arm on one side and the other staff member did the same on the other side and then lifted R8 off the bed and placed her in the chair.

b) Review of R8's SBAR (Situation Background Assessment) Recommendation, dated 09/24/24, located in the EMR under the "Prog Note" tab, revealed "Situation: The Change In Condition/s reported on this Evaluation are/were: Falls Other change in condition ... Functional Status Evaluation: Fall ... Pain Status Evaluation: Does the resident/patient have pain? Yes ... Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: Send to ER [emergency room] for eval [evaluation] B. New Testing Orders: - Other - Send to ER for eval C. New Intervention Orders: - Other - Fall mats and wedges to prevent fall/further injury."

Review of R8's "Skin Assessment," dated 09/24/24, located in the EMR under the "Prog Notes" tab revealed R8 had bruising to the right temple.

Review of R8's "Physical Therapy Progress Notes," dated 09/24/24, provided by the facility, revealed this assessment was conducted in response to R8 falling out of the bed on 09/24/24. The progress note stated the Physical Therapist (PT) educated the CNA on use of a lift for patient transfers.

During an interview on 10/30/24 at 11:06 AM, the Director of Nursing (DON) indicated she expected the nurse to complete an incident report,

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interview the nurse aide that reported the fall to the nurse and get a statement, and complete a progress note in the EMR when fall occurred in the facility. The DON verified a post fall investigation, incident report and interviews with staff were not completed for R8's 09/24/24 fall.

During an interview on 10/30/24 at 11:41 AM, LPN1 stated an aide found R8 on the right side of the bed when she was making rounds on the residents on 09/24/24 in the AM. LPN1 also stated she assessed the resident and stayed with her because she struck her head on the floor and was bleeding from her right temple. LPN1 indicated when a fall occurred a post fall investigation was completed which would determine the root cause of the fall. LPN1 confirmed she did not complete the post fall investigation because she thought the nurse supervisor was going to do it.

The facility provided corrective action plans dated 10/09/24 which included the following:

Immediate Action Implemented: R5 is currently in the hospital no other action taken for R5. On 10/09/24, the DON completed CNA1's competence evaluation on providing incontinent care residents in bed. The emphasis was on ensuring the resident is centered in bed when care is provided. ADL care plan interventions, located on the Kardex, are followed including the number of staff required for bed mobility, and the importance of pulling the resident towards an employee when one person assistance is provided per care plan.

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Identification of Other Residents who Might Be Affected: DON, Director of Nursing, Unit Coordinator, and/or designated nurse #1 completed bed mobility assessment of all current residents in the facility on 10/09/24 to identify the appropriate number of staff required for bed mobility. Findings of this audit are documented on the bed mobility assessment tool located in the facility Quality Assurance and Performance Improvement (QAPI) binder.

100% audit of current resident care plans completed by MDSC on 10/10/24, to assure each resident has an ADL care plan that indicates the amount of assistance required during ADL care and ensure the Kardex is updated with such information. Findings of this audit are documented on a care plan and ADL audit tool located in the facility QAPI binder.

100% audit of resident records for the last 30 days for all residents in the facility completed by the Regional Director of Clinical services on 10/10/24 and 10/11/24 to identify any other resident with an accident with staff presence. No other resident identified with a fall during care.

During the audit of residents' records, one resident identified with a fall from bed. R8 rolled out of bed to the floor on 09/23/24. No incident report noted in the system for R8.

Systemic Changes and Modification:

Effective 10/10/24, all new residents will have a bed mobility assessment completed on admission, quarterly, and with any changes in their bed mobility status, by the licensed nurse on duty. This will be reviewed in the daily clinical

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meeting and documented on the facility medical records under ADL care plan. Moving forward, residents' ADL assistance needs will be added on the Kardex located electronically in the Kiosks.

Effective 10/10/24 any resident with an incident/accident will have an incident report completed in EMR with a detailed incident investigation. The investigation will indicate the root cause of the incident, and the care plan will be updated timely. This will be reviewed in the daily clinical meeting and documented on the facility medical records under ADL care plan.

Effective 10/10/2024, all residents will be centered in bed before being turned from one side to side during care. This will be accomplished by ensuring staff members who provide care to a dependent resident are centered in bed before turning from one side to the other during care. Staff members will also use appropriate number of staff based on resident's care plan effective 10/10/24.

Effective 10/10/24, the Regional Director of Clinical services in collaboration with the facility clinical team to include the DON, ADON and Unit Coordinator #1 revised the process of reviewing all new admits/readmits in a daily clinical meeting and included the provision for bed mobility assessment to ensure it is completed and documented in electronic medical records. Any discrepancies identified will be corrected promptly. Any negative Findings of this systemic change is documented on the daily clinical meeting "homework sheet" located on the daily clinical meeting binder.

100% education of all current Licensed nursing

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staff to include full time, part time, and as needed nursing employees will be completed by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (1, 2). The emphasis of this education includes but is not limited to, the importance of completing incident report after each incident, completing incident investigation, bed mobility assessment on admission, quarterly and with changes of bed mobility status.

This education will be completed by 10/14/2024. Any Licensed nursing staff members (Registered nurses, and/or Licensed practical nurses, not educated by 10/14/2024, will not be allowed to work until educated. This education will be provided annually and will be added to the new hire orientation for all new nursing employees effective 10/10/2024. This education will be provided by the Director of nursing and/or Staff development Coordinator effective 10/10/2024

100% education of all current nursing staff to include full-time, part-time, and as needed employees will be completed by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators. The emphasis of this education includes but is not limited to the importance of ensuring residents' care provided in bed is rendered in a safe manner, ensure residents are centered in bed during bed mobility, and appropriate number of staff is used during care per resident's individual plan of care. This education also emphasized the importance of turning a resident towards the care giver if one person is providing care in bed per resident's plan of care.

This education will be completed by 10/14/2024. Any nursing staff members (Registered nurses,

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F 689	Continued From page 13 Licensed practical nurses, Medication aides, and/or Certified nurse aides not educated by 10/14/2024, will not be allowed to work until educated. This education will be provided annually and will be added to the new hire orientation for all new nursing employees effective 10/10/2024. This education will be provided by the Director of nursing and/or Staff development Coordinator effective 10/10/2024 This education will be completed by 10/14/2024. Any nursing staff members (Registered nurses, LPNs, Medication aides, and/or CNAs not educated by 10/14/2024, will not be allowed to work until educated. This education will be provided annually and will be added to the new hire orientation for all new nursing employees effective 10/10/2024. Quality Assurance and Performance Improvement (QAPI). Monitoring Process Implemented: Effective 10/10/24, the DON,, ADON, MDSC and/or Unit Coordinators (1, 2) will complete incident/accident monitoring process. This monitoring process will be accomplished by reviewing 24 hours report from electronic health records to ensure an incident report is completed, and detail investigation contains root cause analysis. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the DON promptly. This monitoring process will be documented on an accommodation of needs monitoring tool located in the facility QAPI binder.	F 689		

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Effective 10/10/24, the DON, ADON, MDSC and/or Unit Coordinators (1, 2) will complete incident/accident monitoring process. This monitoring process will be accomplished by observing residents to ensure employees are providing services in the facility that assure an environment that is free from accidents and hazards. The monitoring process will be accomplished by observing three randomly selected staff members and residents. The observer will focus on observing ADL care specifically pertaining to bed mobility and ensure staff members keep residents at the center of the bed before turning from one side to another. The observer will also ensure an appropriate number of staff based on individual resident's care plan is adhered. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the DON promptly. This monitoring process will be documented on an accommodation of needs monitoring tool located in the facility QAPI binder.

Effective 10/10/24, the DON, ADON, and/or Unit Coordinators (1, 2) will review all new admissions for the last 24 hours or from last clinical meeting to ensure that a bed mobility assessment has been completed. Any negative findings will be corrected promptly. This monitoring process will be completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on the "bed mobility assessment tool for new residents"

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F 689	Continued From page 15 located in the facility QAPI binder. Effective 10/10/24, the DON and/or ADON will report the findings of this monitoring process to the facility's QAPI, for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is archived. Compliance date 10/14/24 Resident #8 is no longer in the facility, no other actions taken for resident #8. Identification of Other Residents who Might Be Affected: Director of Nursing, Unit coordinator #1, and/or designated nurse #1 completed resident transfer assessments of all current residents in the facility on 10/09/24 to identify the appropriate methodology to safely transfer the resident from one location to the other. The audit also focused on identifying residents with non-weight bearing status. Findings of this audit are documented on a resident transfer assessment tool located in the facility QAPI binder. 100% audit of current resident's care plans completed by MDS coordinator on 10/10/24, to assure each resident has an ADL care plan that indicates the amount of assistance required during ADL care, with specification of modality of transfer to include (Mechanical lift, one person. And/or two people assist and ensure the Kardex is updated with such information. The audit also ensured that residents who have a non-weight bearing status have a care plan that reflects so, and Kardex updated with such information. Findings of this audit are documented on a care plan ADL audit tool located in the facility QAPI	F 689		

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F 689	Continued From page 16 binder. 100% audit of resident records for the last 30 days completed for all residents in the facility completed by the Regional Director of Clinical services on 10/10/24 and 10/11/24 to identify any other resident with an accident with a staff presence. No other resident identified with a fall during care. Systemic Changes and Modification: Effective 10/10/24, all new residents will have a transfer assessment completed on admission quarterly, and with any changes in their transfer status, by the licensed nurse on duty. This will be reviewed in the daily clinical meeting and documented on the facility medical records under ADL care plan. Moving forward, residents, ADL assistance needs will be added on the Kardex located electronically in the Kiosks. Effective 10/10/24, the therapy department will screen on admission quarterly and with any changes with any transfer status to ensure the transfer status assessed by nursing is appropriate for patient safe transfer. Therapy screen will be documented in each resident's electronic clinical records. Any discrepancies on transfer status between nursing and therapy will be corrected promptly by licensed nurse on duty and/or therapy employee who completes the screening. Effective 10/10/24, any resident with a non-weight bearing status has a care plan indicating their non weight bearing status in resident's medical records. The non-weight status will be included in each resident's Kardex. This will be reviewed in the daily clinical meeting and documented on the facility medical records under ADL care plan.	F 689		

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Effective 10/10/2024, the Regional Director of Clinical services in collaboration with the facility clinical team to include the Director of Nursing, and Unit coordinator #1 revised the process of reviewing all new admits/readmits in a daily clinical meeting and include the provision for non-weight bearing status and transfer status to ensure it is completed and documented in electronic medical records. Any discrepancies identified will be corrected promptly. Any negative Findings of this systemic change is documented on the daily clinical meeting "homework sheet located on the daily clinical meeting binder.

100% education of all current licensed nursing staff (LPN, and RNs) to include full time, part time, and as needed nursing employees will be completed by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (1, 2). The emphasis of this education includes but is not limited to, the importance of completing transfer assessment and adding non weight bearing status to each resident's care plan and Kardex on admission, quarterly and with changes of transfer status.

This education will be completed by 10/14/2024. Any nursing staff members (Registered nurses, Licensed practical nurses, Medication aides, and/or Certified nurse aides not educated by 10/14/2024, will not be allowed to work until educated. This education will be provided annually and will be added to the new hire orientation for all new nursing employees effective 10/10/2024. This education will be provided by the Director of nursing and/or Staff development Coordinator.

100% education of all current nursing staff (LPN,

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RNs, and nurse aides) to include full-time, part-time, and as needed employees will be completed by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators. The emphasis of this education includes but is not limited to the importance of ensuring residents are transferred appropriately based on individualized care plan as indicated on the Kardex. This education will be completed by 10/14/2024. Any nursing staff members (Registered nurses, Licensed practical nurses, Medication aides, and/or Certified nurse aides not educated by 10/14/2024, will not be allowed to work until educated. This education will be provided annually and will be added to the new hire orientation for all new nursing employees effective 10/10/2024. This education will be provided by the Director of nursing and/or Staff development Coordinator effective 10/10/2024.

Monitoring Process Implemented:
Effective 10/10/2024, the Director of Nursing, Assistant Director of Nursing, MDS coordinators and/or Unit Coordinators (1, 2) will complete incident/accident monitoring process. This monitoring process will be accomplished by observing residents to ensure employees are providing services in the facility that assure an environment that is free from accidents and hazards. The monitoring process will be accomplished by observing three randomly selected staff members and residents. The observer will focus on observing ADL care specifically pertaining to resident's transfer and ensure staff members transfer resident based on resident's plan of care. The observer will also ensure an appropriate number of staff based on individual resident's care plan is adhered, and non-weight bearing status is adhered (if any).

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This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the Director of nursing promptly. This monitoring process will be documented on an accommodation of needs monitoring tool located in the facility QAPI binder.

Effective 10/10/2024, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (1, 2) will review all new admissions for the last 24 hours or from last clinical meeting to ensure that a transfer assessment has been completed. Any negative findings will be corrected promptly. This monitoring process will be completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on the "bed mobility assessment tool for new residents" located in the facility QAPI binder.

Effective 10/10/2024, the Director of Nursing and/or Assistant Director of Nursing will report the findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is archived.
Compliance date 10/14/2024.

The facility's corrective action plans for example #1 (R5) and example #2 (R8) were verified on

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F 689	Continued From page 20 11/07/24 by the following: Interviews and record review verified the DON completed CNA1's competence evaluation on 10/09/24; bed mobility assessments, transfer assessments, care plan audits, kardex review, and record review of all residents for the last 30 days were completed as indicated. Staff interviews verified the systemic changes were implemented as noted related to new admissions/readmissions bed mobility assessments and transfer assessments with review in the daily clinical meeting. Additionally, staff were aware of the systemic change for the therapy department to complete screens on admission. Record review confirmed ADL assistance needs as specified in the corrective action plans were on the kardex and care plan; incident reports were completed with investigations and root cause analysis for incidents/accidents; and care plans were updated as needed. Interviews and review of inservice logs revealed education was completed related to the following: the systemic changes; completing incident report and investigation after each incident; completing bed mobility assessments and transfer assessments on admission, quarterly and with changes of bed mobility/transfer status; completing transfer assessments and adding non-weight bearing status to care plan and kardex; ensuring resident care provided in bed is rendered in a safe manner with residents centered in the bed during bed mobility, turning a resident towards the care giver if one person is providing care in bed, and using the appropriate number of staff during care (to include transfers) per resident's individual plan of care and kardex. The education was added to new hire orientation. An observation of resident	F 689		

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F 689	Continued From page 21 care revealed no concerns with the provision of care in accordance with the care plan and kardex. Record review of the facility's monitoring documentation for each corrective action plan verified all monitoring has been implemented as specified. The compliance date of 10/14/24 was validated.	F 689		