STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345560	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC State Veterans Home-Kinston	**2150 Hull Road , Kinston, North Carolina, 28504**

(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
F0000	INITIAL COMMENTS The surveyor entered the facility on 7/16/25 to conduct a complaint investigation and exited on 7/17/25. Additional information was obtained through 7/28/25 and therefore the exit date was changed to 7/28/25. The following intakes were investigated: 2562173, 819627, 819626, 819629, 2569490, and 819634. Intakes 819627, 819626, 819629, and 2569490 resulted in immediate jeopardy. Past-noncompliance was identified at: CFR 483.10 at tag F580 at a scope and severity (J) CFR 483.12 at tag F600 at a scope and severity (J) CFR 483.25 at tag F684 at a scope and severity (J) CFT 483.25 at tag F689 at a scope and severity (J) The tags F600, F684, and F689 constituted Substandard Quality of Care. Non-noncompliance and immediate jeopardy began on 7/3/25. Immediate jeopardy was removed on 7/15/25 and the facility came back in compliance effective 7/15/25. A Partial Extended Survey was conducted. Six of the eleven allegations resulted in deficiency.	F0000		
F0580 SS = J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;	F0580	"Past Noncompliance - no plan of correction required"	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0580 SS = J	Continued from page 1 (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on record review, and interviews with staff, Responsible Party, Manager at the facility's contracted x-ray company, and Physician the facility failed to	F0580		

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F0580 SS = J	Continued from page 2 ensure nursing staff reported a fall with injury to a physician/medical provider resulting in the physician/medical provider not having all relevant information as a treatment plan was developed and implemented. On 7/3/25 Resident # 1 sustained a fall while Nurse Aide # 1 and Nurse Aide # 2 were caring for him. The resident was crying in pain while on the floor and had obvious injury to his left knee. The on-call provider was erroneously informed that the resident had pain, warmth, and swelling to the left knee for no known reason. The provider's treatment plan included a STAT (right away) x-ray of the left knee but no orders for stabilization of the resident's leg. The knee was not stabilized, and nursing staff members continued to turn, reposition, and transfer the resident in and out of bed with a mechanical lift for more than 48 hours following the fall. The order for the x-ray of the left knee was not received by the x-ray services provider on 7/3/25 and this was not discovered by facility staff until 7/5/25 which further delayed medical treatment and interventions. A medical provider was not notified the STAT x-ray had not been completed on 7/3/25. Following 7/3/25 at 12:45 PM there was no further documentation in the medical record that the physician or on-call provider were notified on 7/3/25 or 7/4/25 about further issues with the resident's leg for a further treatment plan. The x-ray was completed on 7/5/25 and revealed a femur fracture. On 7/5/25 Resident # 1 was sent to the hospital for an evaluation and the hospital x-ray showed a comminuted fracture (broken in three or more pieces) of the femur (thigh bone) as a result of the fall. A diagnostic test showed the fractured bones were in close proximity to the resident's leg arteries. The resident underwent surgery for stabilization purposes, was placed on hospice care, and expired on 7/20/25. The facility also failed to notify Resident # 1's Responsible Party regarding the resident's fall and subsequent pain, warmth, and swelling which occurred on 7/3/25. This was for one of three sampled residents reviewed for supervision to prevent falls (Resident #1). Example 1.b. is being cited at a scope and severity level of "D." The findings included: 1.a. Record review revealed Resident # 1 was admitted to the facility on 2/7/22. Resident # 1's diagnoses included a history of stroke with left hemiplegia (paralysis) and hemiparesis (weakness), Parkinson's disease, chronic obstructive pulmonary disease, and muscle weakness. Review of nursing notes revealed no nursing narrative notes for the shift which began on 7/2/25 at 11:00 PM	F0580		

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F0580 SS = J	Continued from page 3 and ended at 7:00 AM. Nurse Aide (NA) # 1) was interviewed on 7/16/25 at 4:21 PM and again on 7/18/25 at 8:31 AM and reported the following information about the events of the shift which began on 7/2/25 at 11:00 PM and ended at 7:00 AM on 7/3/25. She had not been working at the facility very long and had recently completed orientation as a new facility Nurse Aide. She had been working as a team with NA # 2 on the shift which began on 7/2/25 at 11:00 PM and ended at 7:00 AM on 7/3/25. It was her first night working with Resident # 1. She and NA # 2 had entered the room around “6 something” in the morning to get Resident # 1 out of the bed. They were preparing to transfer Resident # 1 with the sit-to-stand lift. They had placed the sling on the resident, and he was sitting on the side of the bed. Before they started to mechanically lift Resident # 1 up in the sling, he slid from the side of the bed onto the floor and landed on his knees. While on the floor Resident # 1 was crying and she could tell there was something wrong, and he had hurt his knee. She and NA # 2 manually lifted Resident # 1 back into the bed and NA # 2 called Nurse # 1 into the room. Nurse # 1 came into the room and said it looked like his knee was dislocated. When interviewed about whether Nurse # 1 knew that Resident # 1 had fallen, NA # 1 reported he knew. When asked if they had told Nurse # 1 the resident had fallen, NA # 1 reported she could not recall if verbally she told him but that he knew something had happened and reiterated without further explanation that Nurse # 1 knew Resident # 1 had fallen. After Nurse # 1 checked Resident # 1, Nurse # 1 helped her (NA #1) and NA # 2 transfer Resident # 1 from the bed to the chair using the sit-to-stand lift. After Resident # 1 was in the wheelchair, the Night Shift Supervisor (Nurse # 2) came to also check Resident # 1’s leg. While in the wheelchair, Resident # 1 was still having some pain, but he was no longer crying. According to NA # 1, Nurse # 1 and NA # 2 wanted her (NA # 1) to not disclose that Resident # 1 had actually fallen. NA # 1 reported she had told the truth when she was further questioned about the incident by administrative staff members several days after the fall. NA # 2 was interviewed on 7/17/25 at 2:05 PM. According to NA # 2, Resident # 1 did not fall. NA # 2 reported the following information about caring for Resident # 1 on the shift which began at 11:00 PM on 7/2/25 and ended on 7/3/25 at 7:00 AM. Near the end of the shift she and NA # 1 were bathing Resident # 1. When they got to his knee, he would “holler oh-oh” indicating his knee hurt. She called out from the room for Nurse # 1 to come into the room. Nurse # 1 entered and did an	F0580		

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F0580 SS = J	Continued from page 4 assessment. Nurse # 1 then called the Night Supervisor (Nurse # 2). Before Nurse # 2 arrived, they asked Nurse # 1 to help them get Resident # 1 up to the wheelchair. They used a sit-to- stand lift. This was the lift that NA # 2 reported she always used as did other Nurse Aides. Nurse # 1 helped by making sure Resident # 1's leg did not touch up against the part of the lift as they transferred him and they gently put him in the chair. Nurse # 2 then came into the room and commented Resident # 1's knee might be dislocated. Nurse # 1 gave Resident # 1 some Tylenol and then she and Nurse # 1 placed Resident # 1 back in bed. When she left Resident # 1 was okay. Nurse # 1 was interviewed on 7/17/25 at 12:10 PM and on 7/18/25 at 4:37 PM and reported the following information. He had cared for Resident # 1 from 7:00 PM on 7/2/25 until 7:00 AM on 7/3/25. When he arrived at the first of his shift, Resident # 1 had no form of complaint. Around 6:30 AM NA # 2 called him into the room by verbally calling out from the room. Resident # 1 was in bed when he entered. NA # 1 and NA # 2 said they were giving Resident # 1 a bed bath and when they touched his knee, Resident # 1 screamed. They paused the bed bath and called him (Nurse # 1). Resident #1's left knee was swollen. Nurse #1 indicated Resident # 1 had not fallen, and he was not screaming. He (Nurse # 1) called the Night Shift Supervisor (Nurse # 2) and asked him to come look at the resident's leg. While they waited for Nurse # 2, he assisted the Nurse Aides to place Resident # 1 in the wheelchair. Once Resident # 1 was in the wheelchair, Nurse # 2 arrived. Nurse # 2 thought the resident's knee might possibly be dislocated and it was not an emergency. Nurse # 2 told him (Nurse # 1) to continue his work, and that he (Nurse # 2) would make a notation and pass along to the dayshift nursing supervisor as well to follow up about the resident's swollen knee. Nurse # 1's relief nurse for him was Nurse # 3. When Nurse # 3 came on duty, he reported to Nurse # 3 about Resident # 1's left knee pain and told him to make sure the dayshift Nursing Supervisor (Nurse # 4) knew about the issue and there was follow up. He (Nurse # 1) did not communicate with the physician or on-call provider because Nurse # 2 had told him to let the day shift nurse follow up since it was almost time for shift change. Nurse # 2 (the Night Shift Nursing Supervisor) was interviewed on 7/17/25 at 7:30 AM and reported the following information. On the morning of 7/3/25 Nurse # 1 had asked him to look at Resident # 1's knee because he was screaming when he was assisted to the wheelchair, but it was not reported that the resident fell. Nurse #1 told Nurse #2 the resident had not	F0580		

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F0580 SS = J	Continued from page 5 fallen when he asked him to assess the resident. Nurse #2 indicated at the time he (Nurse # 2) entered the room; Nurse # 1 was in the room and two other staff members. The resident was not screaming. He (Nurse # 2) assessed Resident # 1's knee, checked pulses, and checked for a Homan's sign (a way of flexing the ankle to check for a blood clot). The resident did not say ouch when this was being done. Given that there was no fall or trauma reported, and no deviation noted from his assessment, he thought something pathological might be causing the swelling. Nurse #2 explained it was nearly shift change, and he instructed Nurse # 1 to look and see if the resident could receive anything for pain. He further instructed Nurse # 1 to document the issue and report to his (Nurse # 1's) relief nurse that was about to come on duty. He (Nurse # 2) in turn planned to report to the oncoming dayshift Nursing Supervisor, which he did. He (Nurse # 2) did not communicate with the physician or on-call provider because it was almost shift change and the plan was for the on-coming day shift nursing staff to follow up. Nurse # 3 was interviewed on 7/18/25 at 11:04 AM and reported the following information. He worked from 7:00 AM to 7:00 PM on 7/3/25. When he arrived at work, Nurse # 1 reported Resident # 1 had some pain in his left knee. Nurse # 1 said, "Let's see him." They both went into Resident # 1's room. Both his knees looked the same but one of his knees was more tender when palpated. When the left knee was touched, he would scream out in pain but say no words. He (Nurse # 3) asked Nurse # 1 when this had happened, and Nurse # 1 reported when Resident # 1 was being transferred from the bed to the chair. Nurse #3 indicated Nurse # 1 did not report any type of fall. Nurse #3 recalled while he was giving morning medications, he could hear Resident # 1 from the hallway yelling and screaming. He went to the room, and the restorative aide was in the room trying to take Resident # 1 to breakfast. Resident #1 seemed to be in pain and wanted to be left alone. He instructed the restorative aide to leave the resident alone and he spoke to the dayshift Nursing Supervisor (Nurse # 4). He asked Nurse # 4 if Resident # 1 had been in the facility supervisor's report at shift change about his knee, and she reported that he had. Later that day, Nurse # 4 told him (Nurse # 3) that she had contacted the provider and lab work, and an x-ray were ordered. He (Nurse #3), was not aware if the x-ray was to be done stat or routine. During the morning medication pass, Resident # 1 refused to take medications. Later he checked back with him a second time, and he did take his morning medications. The interview further revealed Resident #1's yelling in pain seemed to stop after around 10:00 AM.	F0580		

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F0580 SS = J	Continued from page 6 Following the nursing note on 7/3/25 at 9:02 AM, the next nursing note was entered on 7/3/25 at 12:45 PM. This was the first notation in the nursing notes that the physician/provider was contacted. At this time Nurse # 4 (the day shift Nursing Supervisor) documented Resident #1 was presenting with left knee pain, the following. “Resident presenting with left knee pain, and swelling, warmth. No redness or open areas were noted and Resident #1 was afebrile. Orders were received from [the provider’s secure messaging application for communication] for a Stat (right away) CBC (complete blood count), CMP (comprehensive metabolic panel), 2 view x-ray of left knee, and venous doppler of LLE (left lower extremity). It was documented Resident#1 had refused blood work X 2 attempts at this time. The provider was notified [through the facility’s secure electronic messaging app] and Nurse #4 indicated she would continue to attempt. Record review revealed the details of the electronic communication between Nurse # 4 and the on-call NP (Nurse Practitioner) through the facility’s secure electronic messaging system were filed in the resident’s record. The record of communication was documented as follows: On 7/3/25 at 10:25 AM Nurse # 4 notified the on-call NP that Resident # 1’s left knee and above was swollen and warm with no redness noted and there had been no fall or injury. Nurse # 4 also noted to the on-call NP she was attaching a picture and that Resident # 1 was complaining of pain and “won’t let anyone do anything with him due to the pain.” The on-call NP responded electronically at 10:56 AM on 7/3/25 to draw stat blood work, obtain a 2-view x-ray of his left knee and a venous doppler of his left lower extremity. The on-call NP also responded electronically that the resident should be monitored for any acute changes and that there should be follow up with the primary provider. On 7/3/25 at 12:42 PM there was an electronic message sent to the on-call provider again through the secure electronic messaging app noting that Resident # 1 was refusing blood work at that time, the staff would continue to attempt, and they were not sure if Resident # 1 was going to allow the x-ray and doppler but they would let the x-ray company attempt it. The on-call provider responded electronically on 7/3/25 at 12:45 PM and instructed electronically to attempt the x-ray and doppler and notify the provider if he refused the doppler and x-ray. Nurse # 4 (the day shift Nursing Supervisor) was interviewed on 7/16/25 at 3:29 PM and reported the following information. Around 7:55 AM on 7/3/25 Nurse #	F0580		

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F0580 SS = J	Continued from page 7 3 had asked her to look at Resident # 1's knee because he was having some pain and the night shift Nurse had already given him Tylenol. At the time she looked at Resident # 1's knee, he was not in distress or yelling. She saw no signs of a fracture. The area above his knee was swollen and warm. Usually the resident was "nonchalant" about things and on that day, he indicated it hurt a little. The facility had a means of communication where they can electronically communicate with a provider via a secure messaging system. They can send a message and upload pictures if needed. She communicated with the provider through this system and sent a picture of Resident #1's left knee and she received orders back. One of the orders was for an x-ray and she entered the order. Nurse #4 explained through the facility's system when it is entered as an order then it is automatically sent electronically to the x-ray company that does their x-rays. Nurse #4 indicated she also called the x-ray company. She was on duty on 7/4/25 and nothing was mentioned about Resident # 1, and she was off on 7/5/25. Following 7/3/25 at 12:45 PM there was no further documentation in the record that the physician or on-call provider were notified on 7/3/25 or 7/4/25 about further issues with the resident's leg for a further treatment plan. Nurse # 1 had again cared for Resident # 1 on the shift which began at 7:00 PM and ended at 7:00 AM on 7/4/25. Nurse # 1 was interviewed on 7/18/25 at 3:44 PM and reported the following information. According to Nurse # 1 Resident # 1 was in bed and did not complain of pain during his shift. Nurse # 1 reported that Nurse # 3 had told him that the x-ray company had been in and done the x-ray before he (Nurse #1) arrived at work at 7:00 PM. Nurse # 1 was interviewed on 7/19/25 at 3:44 PM and reported the following information about his shift which began at 7:00 PM on 7/4/25 and ended at 7:00 AM on 7/5/25. The resident was not in pain that night. He (Nurse # 1) received the ultrasound report on his shift and saw they had not done any x-ray. He did not call the physician and report the x-ray was not done. He placed the ultrasound report in the medical provider's box for review. He passed along the shift report at 7:00 AM on 7/5/25 to Nurse # 5 that the ultrasound had been done, but an x-ray was supposed to have been done and for her (Nurse # 5) to tell one of the supervising nurses (Nurse # 8) on day shift. Restorative Aide # 2 was interviewed on 7/18/25 at 10:12 AM and reported the following information. On	F0580		

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F0580 SS = J	Continued from page 8 7/5/25 she assisted NA # 9 in getting Resident # 1 out of bed with the total mechanical lift. At that time his knee was red and hot to the touch. Nurse # 5 checked it when they got him up. Later after lunch and before 3:00 PM she helped NA # 10 put him back to bed. There was a definite difference in his two legs by visibly looking at them and she was careful. In addition to talking to Nurse # 5 about his knee, she reported the concern to Nurse # 7 and Nurse # 7 looked into it further. Record review revealed the first nursing narrative note on 7/5/25 was entered at 1:54 PM by Nurse # 7 who documented, “writer contacted mobile x-ray to obtain x-ray results; x-ray not performed. Order was refaxed and verbally requested STAT XR (x-ray) to L (left) knee.” A manager for the provider of x-ray services at the facility was interviewed on 7/18/25 at 10:38 AM and reported the following information. Their records showed they never received a fax on 7/3/25 for an x-ray of the resident’s leg. They had no record of a call about a needed x-ray or a fax until the date of 7/5/25 at 1:51 PM when their records showed Nurse # 7 called them. On 7/5/25 at 4:32 PM Nurse # 7 made a notation in the nursing narrative notes she had been called to the resident’s room by the x-ray technician, and that there was a concern the resident’s femur was broken. The X-ray technician did not feel comfortable further moving the resident. Attempts were made to notify the RP. Review of Resident # 1’s record revealed documentation of an electronic message sent to the on-call Physician Assistant by Nurse # 7 on 7/5/25 at 4:15 PM through their secure app. Nurse # 7 communicated that they did not have a hard copy of the x-ray result but the technician stated she did not feel comfortable doing any more bone x-rays because the femur bone appeared fractured and unstable, and that a picture was being uploaded to the on-call provider. Nurse # 7 further noted she was sending the resident to the hospital. The on-call Physician Assistant responded electronically at 4:17 PM on 7/5/25 that the bone looked fractured and displaced and to notify the provider when the resident returned/ follow up with the primary physician. On 7/5/25 at 4:32 PM Nurse # 7 noted 911 was called. On 7/5/25 at 4:39 PM Nurse # 7 noted the resident was transferred to the hospital. According to staffing sheets, Nurse # 7 was assigned to	F0580		

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F0580 SS = J	Continued from page 9 care for Resident # 1 on 7/5/25 from 7:00 AM to 3:00 PM shift. Nurse # 7 was interviewed on 7/17/25 at 3:51 PM and reported the following information. She (Nurse # 7) had gotten supervisor's shift change report and there was nothing in supervisor's report about Resident # 1 having a problem. She was in a dining room at lunch helping assist with feeding residents when there was a phone call from the front desk saying that Resident # 1's family was wanting to show something to one of the supervisors. At the time, she was assisting with feeding residents and asked the front desk to call the other supervising nurse (Nurse # 8). She later asked Nurse # 8 what the family wanted and was told that the family had taken pictures of Resident # 1's leg and wanted to show them to someone. She (Nurse # 7) went to Resident # 1's medical record and reviewed the record. She saw at that point that the resident was supposed to have had an x-ray done on 7/3/25 and there were no results. She called the x-ray company, and they said they had not received the order, and it had not been done. The x-ray company planned to come that day right away. After looking at the medical record and calling x-ray she went to look at Resident # 1 and saw his left leg had "minor bruises" and was swollen. Resident #1 was not able to report what had happened. Nurse #7 explained, as a nurse she had seen fractured legs before, and from looking Resident # 1's she would not have thought the resident's leg was fractured just by looking at it. The x-ray company came that afternoon and did the x-ray. The technician alerted them that she could see the initial film was showing his leg was broken and that the technician did not feel comfortable moving him any further to continue. The physician/provider was called at that time, and the resident was transferred out to the hospital. Nurse # 8 was interviewed on 7/18/25 at 9:07 AM and reported the following information. On 7/5/25 she had not known anything about an x-ray needing to be done on Resident #1's leg or a problem with his leg. An x-ray technician called her and was at the facility that afternoon doing an x-ray. She (Nurse # 8) was in another part of the facility at the time when the x-ray technician called from Resident # 1's unit. The x-ray technician reported she could tell the resident's leg was fractured and did not feel comfortable continuing with the x-ray. At that time Nurse # 9 had taken over the resident's care at 3:00 PM on 7/5/25. Nurse # 9 gave Resident # 1 some Tylenol and she (Nurse # 8) helped with transfer paperwork, and they had the resident sent to the hospital. Review of hospital records for Resident #1's hospital stay of 7/5/25 through 7/10/25 revealed the following	F0580		

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F0580 SS = J	Continued from page 10 information. There was a notation that the resident had extensive swelling, bruising and deformity to the distal femur. Hospital x-rays were done and showed Resident # 1 had a comminuted displaced fracture at the distal femoral shaft. (A comminuted fracture is one in which the bone breaks in three or more places and the femur is a leg bone). Labs were done and the resident's hemoglobin was 7.5 (Normal range for men 13.5 to 17.5). A CT (computerized tomography) scan showed that the fractured bones were in close proximity to the proximal popliteal and distal superficial femoral arteries (major artery in the thigh) in the resident's leg with no definite evidence of injury to the blood vessels. A discussion was held with Resident # 1's RP who was documented as saying that the resident had always wanted everything done for him and she wanted to talk to other family members before making a final decision about surgery. An orthopedic consult was obtained and the orthopedic recommended the resident's leg be placed in a left knee immobilizer and that surgery would be planned. Review of the orthopedic surgeon's note revealed surgery was done on 7/8/25 and it was more for comfort as opposed to fixation of the fracture. According to the orthopedic surgeon's note, the bone had not come through the skin until they took him to surgery and then the bone did so. The orthopedic surgeon noted the resident was in terrible pain. The surgeon also noted Resident # 1 had buttock wounds and debriding them would not improve his quality of life. Review of Resident # 1's hospital discharge summary, dated 7/10/25, revealed Resident # 1 was discharged to a facility for comfort care. A review of hospice records revealed Resident # 1 expired on 7/20/25 at 9:42 PM while under hospice care. Resident # 1's facility physician, who serves as the facility medical director, was interviewed on 7/18/25 at 1:40 PM and again on 7/22/25 at 2:35 PM and reported the following information. She was out of town during the week when the on-call provider was contacted on 7/3/25. For her or other providers, if the staff had reported that the resident had fallen and was yelling loudly enough to be heard in the hallway about his leg, then she or an on-call provider would have instructed the staff to get the x-ray, stabilize his leg, and not move him until the results were known. Without the x-ray, it would have been hard to tell what was wrong with the resident. The facility staff had not reported the fall, and they had delayed getting the x-ray. The physician was further interviewed about whether the bone fractured pieces could have severed the resident's leg arteries during the days he was not diagnosed and continued to be moved. The physician reported she was	F0580		

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F0580 SS = J	Continued from page 11 not an orthopedic physician, but she would think anything was possible. The physician reported that an undiagnosed comminuted femur fracture is in general associated with a difficult surgery and poor healing. The physician further reported prior to the fracture, the resident did have multiple diagnoses, and anyone could die unexpectedly at any moment, but Resident # 1's death was not expected to be imminent before he sustained the fracture. The physician felt the fracture had contributed to the resident's death which was earlier than expected. The medical director was interviewed about the resident's torn rotator cuff and reported that with normal aging some tears can also occur. As medical director, the Administrator had been in contact with her (the physician) and the facility had done a corrective action plan. The Administrator was interviewed on 7/16/25 at 3:00 PM and again on 7/17/25 at 6:00 PM revealing the following information. The reason the on-call provider was not informed about the fall initially was because Nurse # 1, NA # 1, and NA # 2 had not disclosed the fall. NA # 1 reported on 7/14/25 during the Administrator's investigation to the fracture that the resident had fallen. The Administrator reported the facility had done a corrective action plan. b. Resident # 1's RP (Responsible Party) was interviewed on 7/18/25 at 11:31 AM along with Resident # 1's second emergency contact relative who was listed on his chart. (The two were on speaker phone together). They reported the following information. Neither had been informed about any fall or problems with the resident's knee and knew nothing about any orders that had been given on 7/3/25. The RP arrived on 7/5/25 and did not understand why he was in bed and therefore asked that they get him out of bed. She (the RP) stood outside while the NAs transferred Resident # 1. From the hallway she could hear Resident # 1 yelling as they got him out of bed. His knees had "marks" on them and were swollen. She talked to Nurse # 5 who told her she did not know anything. As she left, she showed someone at the front desk the pictures she had taken and her concern. Shortly after she arrived home, the facility called to tell her that they were sending Resident # 1 to the hospital. The Administrator was informed of Immediate Jeopardy on 7/22/25 at 12:45 PM. The facility provided the following corrective action plan. Address how corrective action will be accomplished for	F0580		

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F0580 SS = J	Continued from page 12 those residents found to have been affected by the deficient practice: The facility failed to notify the physician when a cognitively impaired resident (Resident #1) sustained a fall with obvious signs of injury on 7/3/25 between 6:00 and 7:00 AM. This resulted in the physician not having relevant information as a treatment plan was developed and implemented. The investigation began 7/5/25 when the Administrator was informed by Nurse #8 there was a fracture of unknown origin on Resident #1. The Administrator was informed by Nurse #8 the resident complained of left knee pain on the morning of 7/3/25 to NA #1 and NA #2 who were providing care to him. NA #1 and NA #2 notified Nurse #1 to come to the resident's room. Nurse #1 was informed by both NA #1 and NA #2 that the resident complained of pain in his left knee while they were giving him a bed bath. Resident #1 was unable to state how the fracture occurred when asked by Nurse #8 on 7/5/25. Nurse #1, NA #1 and NA #2 were interviewed by the Administrator on 7/8/25 stating Nurse # 1 assessed the resident in bed on 7/3/25 and determined both knees did not look the same. Nurse #1 called Nurse #2 to assess the resident's left knee. Nurse #2 entered the room and assessed the resident while the resident was in the chair. Nurse #2 noted no pain on palpation, but possible kneecap deviation in size. Nurse #3, the 7AM -7PM charge nurse for Resident #1, requested Nurse #4 assess resident's knees. The left knee was noted to be swollen above the kneecap. The resident was administered Tylenol the morning of 7/3/25 by Nurse #1 due to complaints of pain. Notification of Resident #1 experiencing knee pain was entered in the medical provider electronic software by Nurse #4 at 10:26 AM on 7/3/25. Orders were received that included immediate Xray at10:56 AM. The Xray was positive for acute fracture with osteopenia on 7/5/25. The resident was transported to the hospital on 7/5/25 for positive acute fracture of left femur. During an interview with NA #1 on 7/14/25 by the Administrator, NA #1 stated the resident had fallen to the floor from sitting on the side of the bed on 7/3/25. NA #1 stated NA #2 and Nurse #1 assisted her in getting Resident #1 up from the floor and placing him in the chair. Nurse #2 entered the room to find the resident in the chair. Nurse #1 failed to report Resident #1's fall to the	F0580		

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F0580 SS = J	Continued from page 13 Medical Provider immediately after the fall. Nurse #1 was terminated on 7/14/25 for failure to report a fall. NA # 1 and NA # 2 were terminated on 7/14/25 for failure to report a fall. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to suffer a serious outcome as a result of this non-compliance. The Quality Assurance Nurse (QA Nurse), Director of Health Services (DHS), Assistant Director of Nursing (ADON), wound nurse and Infection Control Nurse completed a 100% body audit related to skin and potential signs of new fractures with no new findings. The audit started on 7/8/25 and was completed on 7/8/25. The QA nurse completed an audit on all falls from 6/7/25 to 7/8/25 to include timely notification of physician and/or physician extender to ensure the medical provider was notified accordingly. The audit was completed on 7/8/25. There were no issues identified that had not reported to the medical provider. The DHS and Senior Nurse Consultant reviewed the facility activity report in the electronic health records which includes change of conditions from 6/7/25 to 7/7/25. There were no significant changes in conditions for any resident that had not been reported to the medical provider. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. All Nurses, therapy and nurse assistants were in serviced by the Director of Healthcare Services (DHS), Quality Assurance (QA) nurse, and Assistant Director of Healthcare Services (ADHS) regarding changes in condition referring to a noticeable shift in a resident's physical or mental health status to include sudden changes in vital signs, altered mental status, change in eating habits, unusual pain or new onset of pain this includes any signs and symptoms of increasing pain, falls, difficulty breathing, unexpected weight gain or loss and any new skin issues (open areas, skin tears, redness, bruising and rashes). The nurse is responsible for notifying the Medical Provider face to face or via the electronic notification system. The	F0580		

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F0580 SS = J	Continued from page 14 nurse is responsible for notification of the responsible party either face to face or by telephone. Nurses are to notify the medical provider and the responsible party immediately once a change in condition has occurred. All staff members were in serviced on Immediate Reporting of Resident Events and Accidents involving a resident to their supervisor immediately, this includes falls, injuries, and other unexpected occurrences; this applies to all employees who interact with residents in any capacity. This is to ensure that all nursing home staff understand the critical importance of prompt reporting of resident events and accidents to ensure informed decision from the medical provider to promote and protect resident safety, comply with legal and regulatory requirements, and support continuous quality improvement. This in-service began on 7/14/25 and was completed on 7/15/25 with no staff working after 7/14/25 until education has been received. All in-services given in this plan of correction will be incorporated into the new hire orientation effective 7/15/25. Staff will not work after 7/14/25 until they have been in-serviced on all applicable in services. The QA nurse provides in-services and obtaining signatures on all newly hired staff. The QA Nurse is tracking education and the DHS, ADHS, and nurse managers are providing all of the education after 7/14/25. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The decision to monitor and take to QA was made on 7/10/25. The DHS or ADON will use the Facility Activity Report (FAR-includes all notes, resident events, vital signs, new orders, new wounds, healed wounds, and discontinued orders from the previous weekday or weekend) to ensure the physician and resident representative have been notified of significant changes in condition to include falls with injury. The Notification of Medical Provider would be in the nurse notes or in the events that occur. The audit tool will be used 5 x per week x 4 weeks and 2 x per week x 4 weeks, then weekly x 4 weeks. The results of the audits will be reviewed by the QA nurse weekly x 12 weeks. The results will be submitted to the Executive QA committee monthly x 3. This team includes the Director of Health Services, Assistant Director of Health Services, Administrator, Quality Assurance Nurse and Wound Nurse. The Medical	F0580		

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F0580 SS = J	Continued from page 15 Director will attend no less than once quarterly. The alleged date of IJ removal and compliance: 7/15/25. On 7/16/25 beginning at 9:50 AM multiple residents were interviewed regarding the care they received at the facility and residents reported they were pleased with care and services. There were no residents who reported medical conditions which had gone unreported to the physician. During interview with the physician on 7/18/25 at 1:40 PM, the medical director validated she had been involved in the facility's corrective action plan and that the steps in their corrective action plan had been taken. A family member of a cognitively impaired resident was interviewed on 7/16/25 at 5:00 PM and reporting no medical concerns that had not been addressed by the physician. The facility presented audits per their corrective action plan. The facility presented documentation of inservices per their corrective action plan with sign-in sheets. Staff members from different shifts were interviewed and reported they had attended inservice training. The facility's IJ removal date and corrective action plan compliance date of 7/15/25 was validated.	F0580		
F0600 SS = SQC-J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F0600	"Past Noncompliance - no plan of correction required"	

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F0600 SS = SQC-J	Continued from page 16 This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and interviews with staff, Responsible Party, a Manager at the facility's contracted x-ray company, and Physician the facility failed to protect a severely cognitively impaired resident's right to be free of neglect after he sustained a fall with obvious injury on 7/3/25 between 6:00 AM and 7:00 AM. Nurse Aide # 1 and Nurse Aide # 2 were preparing to use a sit-to stand lift to transfer Resident # 1, who was totally dependent on staff for sitting balance and required a total mechanical lift for transfers, from the bed to the chair when the resident slid off the side of the bed and landed on his knees. The resident was crying while on the floor and Nurse Aide # 1 reported she could tell something was wrong. Resident # 1 was lifted to the bed without a nursing assessment. Once in bed, the resident was transferred by Nurse Aide # 1, Nurse Aide # 2, and Nurse # 1 to the wheelchair with the sit-to-stand lift. The fall was not disclosed to further staff members who were assigned to care for the resident or to the medical provider while the resident resided at the facility. Following the fall, Resident # 1 experienced swelling of his knee, pain, and warmth. Following the fall, due to a lack of communication and follow -up, the resident did not receive comprehensive assessment, treatment, and an x-ray was not completed on 7/3/25 as ordered. On 7/5/25 Resident # 1 was hospitalized and identified to have a comminuted fracture (broken in three or more pieces) of the femur as a result of the fall. A diagnostic test showed the fractured bones were in close proximity to the resident's leg arteries. The resident underwent surgery for stabilization purposes, was placed on hospice care, and expired on 7/20/25. Resident # 1's physician reported that prior to Resident # 1's fall and fracture, his death was not expected to be imminent. Following the identification of the fracture on 7/5/25, Nurse Aide # 1, Nurse Aide # 2, and Nurse # 1 still did not come forward and disclose the fall. While investigating the fracture of unknown origin, the Administrator interviewed multiple staff members. Multiple days after the resident had been discharged, on 7/14/25 Nurse Aide # 1 reported to the Administrator the resident had fallen and there had been a plan to not disclose the fall although Nurse # 1, NA #2, and she knew the resident had been hurt. Nurse #1's, NA #1's, and NA #2's choice to deliberately withhold the fact that the resident fell despite Resident # 1 experiencing pain, warmth, and swelling following the fall was a complete disregard for the resident's needs, had a high likelihood of resulting in further injury, and constituted neglect. This was for	F0600		

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F0600 SS = SQC-J	Continued from page 17 one of one sampled resident reviewed for injuries which were initially reported to the state agency as being from an unknown cause (Resident # 1). The findings included: This tag is cross referenced to: F 580: Based on record review, and interviews with staff, Responsible Party, Manager at the facility's contracted x-ray company, and Physician the facility failed to ensure nursing staff reported a fall with injury to a physician/medical provider resulting in the physician/medical provider not having all relevant information as a treatment plan was developed and implemented. On 7/3/25 Resident # 1 sustained a fall while Nurse Aide # 1 and Nurse Aide # 2 were caring for him. The resident was crying in pain while on the floor and had obvious injury to his left knee. The on-call provider was erroneously informed that the resident had pain, warmth, and swelling to the left knee for no known reason. The provider's treatment plan included a STAT (right away) x-ray of the left knee but no orders for stabilization of the resident's leg. The knee was not stabilized, and nursing staff members continued to turn, reposition, and transfer the resident in and out of bed with a mechanical lift for more than 48 hours following the fall. The order for the x-ray of the left knee was not received by the x-ray services provider on 7/3/25 and this was not discovered by facility staff until 7/5/25 which further delayed medical treatment and interventions. A medical provider was not notified the STAT x-ray had not been completed on 7/3/25. Following 7/3/25 at 12:45 PM there was no further documentation in the medical record that the physician or on-call provider were notified on 7/3/25 or 7/4/25 about further issues with the resident's leg for a further treatment plan. The x-ray was completed on 7/5/25 and revealed a femur fracture. On 7/5/25 Resident # 1 was sent to the hospital for an evaluation and the hospital x-ray showed a comminuted fracture (broken in three or more pieces) of the femur (thigh bone) as a result of the fall. A diagnostic test showed the fractured bones were in close proximity to the resident's leg arteries. The resident underwent surgery for stabilization purposes, was placed on hospice care, and expired on 7/20/25. The facility also failed to notify Resident # 1's Responsible Party regarding the resident's fall and subsequent pain, warmth, and swelling which occurred on 7/3/25. This was for one of three sampled residents reviewed for supervision to prevent falls (Resident #1). Example 1.b. is being cited at a scope and severity level of "D."	F0600		

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F0600 SS = SQC-J	Continued from page 18 F 684: Based on record review, and interviews with staff, the facility's contracted x-ray company, Responsible Party, and Physician the facility failed to ensure nursing staff effectively communicated amongst themselves to ensure staff who cared for Resident #1 were aware of a fall with obvious injury that occurred and that Resident # 1 received comprehensive assessment and treatment. Resident # 1, who was severely cognitively impaired, sustained a fall on 7/3/25 between 6:00 AM and 7:00 AM. Night shift nursing staff members, who were assisting with Resident # 1 during the accident, were aware the resident was crying in pain as a result of the fall but did not disclose the fall. A comprehensive assessment was not completed prior to moving the resident after the fall. It was erroneously reported to the on-call medical provider and other nursing staff who cared for Resident # 1 in future shifts that the resident had pain and swelling to his left knee from no known cause. On 7/3/25 an x-ray was ordered when the provider was notified Resident # 1 had swelling, warmth, and pain to his left knee for no known reason. The x-ray was not completed until 7/5/25 which was over 48 hours after the fall and injury. The failure to communicate with other nursing staff and failure to obtain the x-ray as ordered resulted in a lack of ongoing assessment, monitoring, and treatment for over 48 hours. Nursing staff who were unaware of the fall continued to transfer, reposition, and provide care for the resident without professional stabilization of his leg despite indicators of problems with the resident's leg during this interim. On 7/5/25 Resident # 1 was hospitalized and identified to have a comminuted fracture (broken in three or more pieces) of the femur as a result of the fall. A diagnostic test showed the fractured bones were in close proximity to the resident's leg arteries. The resident underwent surgery for stabilization purposes, was placed on hospice care, and expired on 7/20/25. Resident # 1's physician reported that prior to Resident # 1's fall and fracture, his death was not expected to be imminent. This was for one of three residents reviewed for professional actions and care provided by nursing staff following falls. F 689: Based on observation, record review and interviews with staff, and physician the facility failed to provide the necessary supervision to prevent accidents and provide care in a safe manner for a severely cognitively impaired resident totally dependent on staff for care and required a total mechanical lift for transfers. On 7/3/25 between 6:00 AM and 7:00 AM Nurse Aide #1 and Nurse Aide #2 were preparing to use a sit-to stand mechanical lift to transfer Resident # 1 from the bed to the chair. On	F0600		

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F0600 SS = SQC-J	Continued from page 19 7/3/25 while seated on the side of the bed, the resident slid to the floor on his knees and was crying on the floor. The resident was manually lifted from the floor to the bed following the fall. NA #1 reported Nurse #1, who was the supervising nurse for NA # 1 and NA # 2, then helped them transfer Resident # 1 from the bed to the wheelchair with the sit-to-stand lift. On 7/5/25 Resident # 1 was hospitalized and identified to have a comminuted fracture (broken in three or more pieces) of the femur. A diagnostic test showed the fractured bones in close proximity to the resident's leg arteries. The resident underwent surgery for stabilization purposes, was placed on hospice care, and expired on 7/20/25. Resident # 1's physician reported that prior to Resident # 1's fall and fracture, his death was not expected to be imminent. This was for one of three sampled residents reviewed for falls. During the interviews with Nurse Aide # 1 on 7/16/25 at 4:21 PM and on 7/18/25 at 8:31 AM the Nurse Aide reported the following. When Resident # 1 fell on 7/3/25 and Nurse Aide # 2 and Nurse # 1 did not want her to disclose the fall, she (Nurse Aide # 1) did not report it because she did not want any trouble. Nurse Aide #1 indicated she was new at the time. She knew that NA # 2 could be aggressive, and she worried retaliation would be taken out against her. Nurse Aide #1 stated she also worried they would find out where she lived to retaliate against her and she had been very worried about the whole situation. During the interview with the Administrator on 7/17/25 at 6:00 PM, the Administrator was interviewed regarding how she knew Nurse # 1 was not telling the truth when he said that the resident was in bed when he entered and he did not know about the fall and that Nurse Aide # 1 was correct when she reported Nurse # 1 did know. The Administrator reported the following. In watching the video cameras, when she saw one of the staff members come out in the hall and retrieve the vital sign machine directly after Nurse # 1 entered the room this indicated to her that he knew. She reported as a nurse herself, she knew it was standard nursing practice when a resident fell to obtain vital signs, and he was in the room for a while. When interviewed about why they would not disclose the fall, the Administrator further reported that the employees knew if they were found to be using the wrong type of mechanical lift that meant automatic termination. According to the Administrator they wanted to avoid termination and Nurse # 1 had personal relationships with many of the employees and that is why she felt he would cover for the Nurse Aides although he had not reportedly been in the room when the fall happened.	F0600		

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F0600 SS = SQC-J	Continued from page 20 The Administrator was informed of Immediate Jeopardy on 7/22/25 at 12:45 PM and presented the following corrective action plan. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility failed to protect a severely cognitively impaired resident (Resident # 1) from neglect. The resident complained of left knee pain approximately 6:10 AM and July 3, 2025, to the two NA # 1 and NA # 2 who were providing care to him per the statements they gave on 7/8/25. The NAs notified the Nurse # 1. Nurse # 1 entered the room per his statement and assessed Resident # 1 in the bed. He noted both knees did not look the same. Nurse # 1 called in Nurse # 2 to assess the resident. Nurse # 2 stated he assessed Resident # 1 in his wheelchair. He noted pain on palpation but noted a difference in kneecap size. Nurse # 3 was notified by Nurse # 1 of Resident # 1 having knee pain. Nurse # 1 administered Tylenol to Resident # 1 at 7:00 AM. NA # 1 and NA # 2 stated Nurse # 1 request Resident # 1 be moved from the bed to the chair before Nurse # 2 arrived since Resident # 1 was an early riser. Notification of the medical provider was entered in the electronic notification system for the medical provider at 10:45 AM by Nurse # 4. The order was for immediate Xray and Ultrasound. Labs were also ordered to rule out gout. Resident # 1 refused the labs on 7/3/25 and the medical provider was notified with no further orders given. On 7/5/25 Nurse # 7 was working with Resident # 1 and noted the Xray results had not been received by the facility. Nurse # 8 contacted the Xray company 7/5/25 and The Xray company stated they received the orders on 7/3/25, but one of the Xray personnel called out sick on 7/3 and the ultrasound was obtained on 7/4/25. The Xray company stated there was a problem with their system that shows on the facility end the Xray has been received by the Xray company, but the Xray company cannot see the request for the Xray. On 7/5/25 an Xray order was faxed with a call from the facility to confirm the Xray request has been received. The Xray was completed by the Xray company on 7/5/25 and showed a comminuted fracture of the femur. The resident was sent to the Emergency Room. Resident # 1 underwent surgery for repair of the fracture, admitted to hospice services and expired. The Administrator continued the investigation into the	F0600		

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F0600 SS = SQC-J	Continued from page 21 injury of unknow origin. In written statements by Nurse # 1, NA # 1 and NA # 2, all included in their statements they had transferred, or helped transfer Resident # 1 using a lift that Resident #1 was not care planned to use safely. Nurse # 1, NA# 1 and NA # 2 continued to state Resident # 1 was not injured or did not fall the morning of 7/3/25. On 7/14/25 the Administrator called in NA # 1 and NA # 2 to the facility to terminate them for using the incorrect lift on Resident # 1. Nurse # 1 was to be terminated over the phone by Human Resources on 7/14/25. On 7/14/25, NA # 1 stated to the Administrator and DHS that Resident # 1 fell during the transfer on 7/3/25. NA # 1 stated on 7/3/25 between 6:00 AM and 7:00 AM NA # 1 and NA # 2 were preparing to use a Sit-to-stand lift to transfer Resident # 1 from the bed to the chair. NA # 1 stated they provided morning care and prepared to transfer Resident # 1 to his wheelchair. NA # 1 stated she clipped the sit to stand belt around Resident # 1s waist, and he slid to the floor on his knees prior to securing the lift belt to the sit-to-stand lift. NA # 1 and NA # 2 reported to Nurse # 1 the resident had fallen from the bed to the floor. Nurse # 1 assessed Resident # 1 finding his knee swollen and then assisted NA # 1 and NA # 2 by lifting him from the floor manually and placing Resident # 1 into his wheelchair. This is where Nurse # 2 found Resident # 1 when he entered Resident # 1s room. Resident # 1 continued to have his care needs met and transferred back and forth from bed to chair on 7/3/25, 7/4/25 and 7/5/25 while his leg was fractured and was heard by staff call out in pain at times. The facility failed to ensure nursing staff effectively communicated amongst themselves to ensure staff who cared for resident # 1 were aware of a fall with obvious injury that occurred on 7/3/25 between 6:00 AM and 7:00 AM for a severely cognitively impaired and dependent resident. Nurse # 1, NA # 2, and NA # 3 failed to report Resident # 1 fell causing a comminuted fracture of his femur and delay in medical and pain management. On 7/3/25, Nurse # 1 and Nurse # 2 failed to document their assessments of Resident # 1. Those assessments were taken in statements on 7/8/25 by the Administrator. Nurse # 3 failed to pass on in report to Nurse # 1 the	F0600		

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F0600 SS = SQC-J	Continued from page 22 night of 7/3/25 that the ultrasound and Xray results ordered 7/3/25 had not been completed. This prevented 7A -7P Nurse # 6 from knowing there was an outstanding Xray on 7/4/25. This miscommunication continued through the day of 7/5/25 when Nurse # 7 noted the Xray was not done and Nurse # 8 called the Xray company to order the Xray. NA #1, NA # 2 and Nurse # 1 were terminated on 7/14/25. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to suffer a serious outcome as a result of this non-compliance. The Quality Assurance Nurse (QA Nurse), Director of Health Services (DHS), Assistant Director of Nursing (ADON), wound nurse and Infection Control Nurse completed a 100% body audit related to skin and potential signs of new fractures with no new findings. The body audits included assessment of the scalp, face, neck, ears, chest, abdomen, shoulders, back, elbows, arms, hands, sacrum, hips buttocks, legs, inner knees, ankles, feet, heels, toes, toenails, reddened areas or areas of discoloration. The audit started on 7/8/25 and completed 7/8/25. The DHS and Senior Nurse Consultant reviewed facility activity report in the electronic health records which includes change of conditions from 6/7/25 to 7/7/25. There were no significant changes in conditions for any residents that had not been reported to the medical provider. The QA nurse completed an audit on all falls from 6/7/25 to 7/8/25. This audit also included timely notification of physician and/or physician extender – All falls during this period were reviewed to ensure the medical provider was notified immediately. A full assessment was completed on each resident in the audit. All significant information was reported to the physician or the physician extender without delay. None of the falls were related to mechanical lift transfer or incorrect transfer. The audit was completed 7/8/25 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: All employees were in-serviced on abuse and neglect by the QA Nurse, Director of Health Services and the Assistant Director of Health Services. The Inservice	F0600		

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F0600 SS = SQC-J	Continued from page 23 included injuries of unknown origin can be a case of possible abuse or neglect and that other abuse indicators could be fractures of unknown origin, use of the incorrect lift, or complaints of pain without injury. The Inservice also included that untreated medical conditions could be indicators of neglect. Failure to report resident abuse or neglect will result in disciplinary action up to termination and your license or certification suspension or loss. The in-service included that the facility would take measures to ensure that its policies and procedures involving the prohibition and prevention of patient abuse, neglect, exploitation, mistreatment, and misappropriation of property are followed and that abuse or neglect of residents will not be tolerated. It is also the policy of this facility that there should be no retaliation for good faith reporting of occurrences or allegations of patient abuse, neglect, exploitation, mistreatment, or misappropriation of patient property. The in-service was initialed 7/8/25 and ended 7/11/25. All staff in all departments were in-serviced by the DHS, ADHS and QA Nurse on immediate reporting of Resident Events and Accidents to their supervisor beginning 7/14/25 and completed 7/14/25. All staff who did not receive the education by 7/14/25 are being tracked by the QA nurse to ensure every employee understands and signs the in services prior to working the floor. All in services have been incorporated into the new orientation program by the QA Nurse, DHS and ADHS. All RN and LPNs were in serviced on reporting resident changes in condition, to include falls, and that it is crucial to report any change in resident condition to a healthcare provider immediately face to face or via electronic notification system. The Inservice was started 7/8/25 and was completed 7/11/25. All Nurses were re-educated on Pain Management policy by the DHS, QA nurse, DHS, and ADHS. The Inservice was started on 7/8/25 and completed on 7/11/25. This in-service was done as a precaution as the facility was not aware how the injury occurred until 7/14/25. All Nurses were re-educated on documentation of assessment notes and medication administration by the DHS and nurse managers beginning 7/7/25 and completed on 7/11/25. All Nurses, therapy and NAs were re-educated by the	F0600		

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F0600 SS = SQC-J	Continued from page 24 DHS, QA nurse, and ADHS regarding: 1) changes in condition referring to a noticeable shift in a resident's physical or mental health status to include sudden changes in vital signs, altered mental status, change in eating habits, unusual pain or new onset of pain this includes any signs and symptoms of increasing pain, falls, difficulty breathing, unexpected weight gain or loss and any new skin issues (open areas, skin tears, redness, bruising and rashes); 2) the use of the Stop and Watch Tool (Stop and Watch forms are for any staff member to utilize and report to Nurse Manager, DHS, or ADHS any observed changes in residents and serve as a first indication of a change in condition and should be given attention; and 3) resident profiles (a resident profile is the care guide that NAs and the Nurses access electronically and includes how to care for resident). Additionally, all nurses and NAs were educated to check the resident profile regularly for any changes and updates to resident care. The in-service was started on 7/8/25 and completed on 7/11/25 All nurses were educated by the QA nurse on use of the 24-hour sheet /shift report. 24-hour sheet is a summary of all activities within the nursing dept. It includes any change in condition, family and or provider communication, follow up on any orders and results from the orders. The in-service was started on 7/7/25 and completed on 7/14/25 All nurses were educated by the QA nurse on use of the Supervisor Rounding Sheet/shift to shift report. The shift report is a communication tool that is used between the nurse ending his/her shift to communicate information to the oncoming nurse. This information includes any change in condition, provider changes, outstanding x ray/labs and pending results. This tool is signed by the nurse at the end of their shift along with oncoming nurse. The in-service was started on 7/7/25 and completed 7/11/25. All nurses were in-serviced by the DHS, ADHS, QA Nurse on the Xray company process for completing x-ray and ultrasound orders. Nurses will continue to input orders electronically and will follow up with a phone call to ensure that the company has received the electronic order. The facility nurse is to contact the Xray company within two hours if the Xray company has not arrived to obtain the order Radiology test. This Inservice was started 7/10/25 and completed 7/14/25. Staff will not work after 7/14/25 until they have been in-serviced on all applicable in services. The QA Nurse provides in-services and obtains signatures on all	F0600		

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F0600 SS = SQC-J	Continued from page 25 newly hired staff. The QA Nurse is tracking education and the DHS, ADHS, and nurse managers are providing all the education after 7/14/25. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The decision to monitor and take to QA was made on 7/10/25. The DHS, ADHS or QA Nurse will use the Mode of Transfer audit tool to ensure clinical staff are checking the resident profile and using the correct mode of transfer as stated in the resident profile by randomly auditing 5 staff per week on all shift including weekends by the DHS, QA Nurse or Nurse Manager 5 x per week x 4 weeks and two x per week x 4 weeks, then weekly x 4 weeks. The results will be submitted to the Executive QA committee monthly x 3. This team includes the Director of Health Services, Assistant Director of Health Services, Administrator, Quality Assurance Nurse and Wound Nurse. The Medical Director will attend no less than once quarterly. The DHS or Supervisor will print the Facility Activity Report (FAR BOOK) and EMAR and supervisor shift to shift report 5 days per week for use during the clinical meeting to pull change in condition, pertinent information, pain management issues, documentation of assessments, medication administration, event and falls over to the FAR audit tool. The QA Nurse or Nurse Manager will use the Facility Activity Report audit tool to ensure that change in condition information, physician and resident representative notification, and any other resident information that has been addressed on the FAR has been documented on the 24-hour shift report by the nurses. The nurses in charge have been in serviced to document all change in condition information on their 24-hour shift report The QA nurse or Nurse Manager will compare the FAR audit tool to the 24-hour shift to shift audit tool. The audit tool will determine if effective reports are given shift to shift and nurse signatures are present to validate reports are given and received. Identified discrepancies will be transferred to the 24-hour shift report and education provided to the nurse that did not put the required information on the 24-hour report sheet. The QA Nurse will use the FAR audit and the 24-hour shift report audit tool 5 x per week x 4 weeks and 2 x per week x 4 weeks, then weekly x 4 weeks. The	F0600		

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F0600 SS = SQC-J	Continued from page 26 results of the audits will be reviewed by the QA nurse weekly x 12 weeks. The results will be submitted to the Executive QA committee no less than monthly x 3. The QA nurse or Nurse Manager will use the Supervisor Shift to Shift Report Audit tool to audit change of shift report to each other. The supervisors have been educated to follow up with supervisors to ensure change in condition information is reported and change in condition information has been passed along to the medical provider and the responsible party. The audit tool will determine if effective reports are being used shift to shift and nurse signatures are present to validate reports are given and outstanding issues are moved forward for resolution. The tool will be used 5 x per week x 4 weeks and two x per week x 4 weeks, then weekly x 4 weeks. The results of the audits will be reviewed by the QA nurse weekly x 12 weeks. The results will be submitted to the Executive QA committee monthly x 3. The FAR audit tool, the 24-hour shift report audit tool and the Nurse Supervisor Shift to Shift report tool will all be used together to ensure there is as much change in condition information shared among the nursing staff and resolved to ensure resident needs are met. 5 x per week x 4 weeks and two x per week x 4 weeks, then weekly x 4 weeks. The results of the audits will be reviewed by the QA nurse weekly x 12 weeks. The results will be submitted to the Executive QA committee monthly x 3. The Radiology report from the electronic medical records system to audit Xray order results. The radiology report will be printed daily out of the electronic medical record from the order entered in the system for the Xray to ensure results are obtained as ordered. The radiology report will be used 5 x per week x 12 weeks. The results of the audits will be reviewed by the QA nurse weekly x 12 weeks. The results will be submitted to the Executive QA committee monthly x 3. The facility alleges compliance with the plan of correction 7/15/25. Immediate Jeopardy removal date 7/15/25. The facility's corrective action plan was validated by the following measures: On 7/16/25 from 9:50 AM through 11:55 AM multiple residents were interviewed regarding the care they received at the facility and residents reported they were pleased with care and services. There were no residents who reported medical conditions or pain	F0600		

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F0600 SS = SQC-J	Continued from page 27 issues that were not being addressed by the nursing staff. There were no residents who reported neglect or mistreatment. There were no residents with outward physical signs of bruising that might signify neglect. Residents were observed to appear well cared for. A family member of a cognitively impaired resident was interviewed on 7/16/25 at 5:00 PM and reporting she was pleased and referred to the nursing staff as “perfect.” A current resident, who required assessment and monitoring related to end of life needs, was placed on the sample. Interviews and record review revealed monitoring, assessment, and care were being provided per this additionally sampled resident’s plan of care. Interviews with nursing staff revealed communication amongst direct care staff and supervising nurses was occurring for this additionally sampled resident. On 7/17/25 and 7/18/25 the facility presented audits per their corrective action plan and documentation of inservices per their corrective action plan with sign in sheets. Beginning on 7/16/25 staff members from different shifts were interviewed and reported they had attended inservice training and reported they were inserviced regarding communication (not waiting to communicate) and making sure there was follow up for residents when they noted something was wrong. Staff were able to report how to find resident care information to know residents’ needs and the plan of care (to include transfers) which was to be followed. Current staff reported being inserviced on neglect and reported no further incidences of neglect of which they were aware. The facility’s corrective action plan was validated with an Immediate Jeopardy removal date and compliance date of 7/15/25.	F0600		
F0684 SS = SQC-J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F0684	"Past Noncompliance - no plan of correction required"	

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F0684 SS = SQC-J	Continued from page 28 This REQUIREMENT is NOT MET as evidenced by: Based on record review, and interviews with staff, the facility's contracted x-ray company, Responsible Party, and Physician the facility failed to ensure nursing staff effectively communicated amongst themselves to ensure staff who cared for Resident #1 were aware of a fall with obvious injury that occurred and that Resident # 1 received comprehensive assessment and treatment. Resident # 1, who was severely cognitively impaired, sustained a fall on 7/3/25 between 6:00 AM and 7:00 AM. Night shift nursing staff members, who were assisting with Resident # 1 during the accident, were aware the resident was crying in pain as a result of the fall but did not disclose the fall. A comprehensive assessment was not completed prior to moving the resident after the fall. It was erroneously reported to the on-call medical provider and other nursing staff who cared for Resident # 1 in future shifts that the resident had pain and swelling to his left knee from no known cause. On 7/3/25 an x-ray was ordered when the provider was notified Resident # 1 had swelling, warmth, and pain to his left knee for no known reason. The x-ray was not completed until 7/5/25 which was over 48 hours after the fall and injury. The failure to communicate with other nursing staff and failure to obtain the x-ray as ordered resulted in a lack of ongoing assessment, monitoring, and treatment for over 48 hours. Nursing staff who were unaware of the fall continued to transfer, reposition, and provide care for the resident without professional stabilization of his leg despite indicators of problems with the resident's leg during this interim. On 7/5/25 Resident # 1 was hospitalized and identified to have a comminuted fracture (broken in three or more pieces) of the femur (thigh bone) as a result of the fall. A diagnostic test showed the fractured bones were in close proximity to the resident's leg arteries. The resident underwent surgery for stabilization purposes, was placed on hospice care, and expired on 7/20/25. Resident # 1's physician reported that prior to Resident # 1's fall and fracture, his death was not expected to be imminent. This was for one of three residents reviewed for professional actions and care provided by nursing staff following falls (Resident #1). The findings included: Record review revealed Resident # 1 was admitted to the facility on 2/7/22. Resident # 1's diagnoses included a history of stroke with left hemiplegia (paralysis) and hemiparesis (weakness), Parkinson's disease, chronic obstructive pulmonary disease, and muscle weakness.	F0684		

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F0684 SS = SQC-J	Continued from page 29 Resident # 1's quarterly Minimum Data Set Assessment, dated 5/6/25, coded Resident # 1 as severely cognitively impaired and as being totally dependent on staff for hygiene, bathing, dressing, turning in the bed, sitting up from a lying position, and transferring. He was not ambulatory and was assessed to be dependent on staff for wheelchair mobility. The resident was not coded as refusing care during the assessment period. A review of Resident # 1's care plan, last updated on 7/7/25, revealed Resident # 1 required a total mechanical lift for transfers. During an interview with the facility's Care Plan Nurse on 7/17/25 at 2:02 PM, the Care Plan nurse reported this information had been added to the care plan on 2/12/25. The care plan also noted Resident # 1 was incontinent of both bowel and bladder which placed him at greater risk for pressure sores. Review of nursing notes revealed no nursing narrative notes for the shift which began on 7/2/25 at 11:00 PM and ended at 7:00 AM. Nurse Aide # 1 (NA # 1) was interviewed on 7/16/25 at 4:21 PM and again on 7/18/25 at 8:31 AM and reported the following information about the events of the shift which began on 7/2/25 at 11:00 PM and ended at 7:00 AM on 7/3/25. She had not been working at the facility very long and had recently completed orientation as a new facility Nurse Aide. She had been working as a team with NA # 2 on the shift which began on 7/2/25 at 11:00 PM and ended at 7:00 AM on 7/3/25. It was her first night working with Resident # 1. She and NA # 2 had entered the room around "6 something" in the morning to get Resident # 1 out of the bed. They were preparing to transfer Resident # 1 with the sit-to-stand lift. She did not recall that it was her who had gotten the sit-to-stand lift. They had placed the sling on the resident, and he was sitting on the side of the bed. Before they started to mechanically lift Resident # 1 up in the sling, he slid from the side of the bed onto the floor and landed on his knees. While on the floor Resident # 1 was crying and she could tell there was something wrong, and he had hurt his knee. She and NA # 2 manually lifted Resident # 1 back into the bed and NA # 2 called Nurse # 1 into the room. Nurse # 1 came into the room and said it looked like his knee was dislocated. When interviewed about whether Nurse # 1 knew that Resident # 1 had fallen, NA # 1 reported he knew. When asked if they had told Nurse # 1 the resident had fallen, NA # 1 reported she could not recall if verbally she told him but that he knew	F0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345560	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/28/2025

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F0684 SS = SQC-J	Continued from page 30 something had happened and reiterated that Nurse # 1 knew Resident # 1 had fallen. According to NA # 1, Nurse # 1 and NA # 2 wanted her (NA # 1) to not disclose that Resident # 1 had actually fallen. After Nurse # 1 checked Resident # 1, Nurse # 1 helped her and NA # 2 use the sit-to-stand lift and transfer Resident # 1 from the bed to the chair. After Resident # 1 was in the wheelchair, the Night Shift Supervisor (Nurse # 2) came to also check Resident # 1's leg. While in the wheelchair, Resident # 1 was still having some pain, but he was no longer crying. NA # 1 reported she had not known the resident was not supposed to use the sit- to- stand lift. She felt very badly about what had happened, but "right was right" and "wrong was wrong," and she told the truth when she was further questioned about the incident by administrative staff members several days after the fall. NA # 2 was interviewed on 7/17/25 at 2:05 PM and reported the following information about caring for Resident # 1 on the shift which began at 11:00 PM on 7/2/25 and ended on 7/3/25 at 7:00 AM. Near the end of the shift she and NA # 1 were bathing Resident # 1. When they got to his knee, he would "holler oh-oh" indicating his knee hurt. She called out from the room for Nurse # 1 to come into the room. Nurse # 1 entered and did an assessment. Nurse # 1 then called the Night Supervisor (Nurse # 2). Before Nurse # 2 arrived, they asked Nurse # 1 to help them get Resident # 1 up to the wheelchair. They used a sit-to- stand lift. This was the lift that NA # 2 reported she always used as did other Nurse Aides. Nurse # 1 helped by making sure Resident # 1's leg did not touch up against the part of the lift as they transferred him and they gently put him in the chair. Nurse # 2 then came into the room and commented Resident # 1's knee might be dislocated. Nurse # 1 gave Resident # 1 some acetaminophen and then she and Nurse # 1 placed Resident # 1 back in bed. When she left Resident # 1 was okay. Nurse # 1 was interviewed on 7/17/25 at 12:10 PM and on 7/18/25 at 4:37 PM and reported the following information. He had cared for Resident # 1 from 7:00 PM on 7/2/25 until 7:00 AM on 7/3/25. When he arrived at the first of his shift, Resident # 1 had no form of complaint. Around 6:30 AM NA # 2 called him into the room by verbally calling out from the room. NA # 1 and NA # 2 said they were giving Resident # 1 a bed bath and when they touched his knee, Resident # 1 screamed. They paused the bed bath and called him (Nurse # 1). Resident # 1's left knee was swollen. Resident # 1 had not fallen, and he was not screaming. He (Nurse # 1) called the Night Shift Supervisor (Nurse # 2) and asked him to come look at the resident's leg. While they	F0684		

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F0684 SS = SQC-J	Continued from page 31 waited for Nurse # 2, the Nurse Aides asked him (Nurse # 1) for help to transfer Resident # 1 from the bed to the wheelchair. The two Nurse Aides used the sit-to-stand lift to transfer Resident # 1 from the bed to the wheelchair. He (Nurse # 1) had never received training on the mechanical lifts and did not use them. He helped by guiding Resident # 1's feet on the sit-to stand lift platform as they transferred him. Once Resident # 1 was in the wheelchair, Nurse # 2 arrived. Nurse # 2 thought the resident's knee might possibly be dislocated. It was not an emergency. Nurse # 2 asked him (Nurse # 1) to give Resident # 1 some Tylenol and tell the oncoming dayshift Nurse about the issue. Nurse # 1 had other blood work to draw and medications to give to other residents at that time. Nurse # 2 told him (Nurse # 1) to then continue his other work, and that he (Nurse # 2) would make a notation in the resident's record and also pass along to the dayshift nursing supervisor to follow up about the resident's swollen knee. He (Nurse # 1) then administered acetaminophen to Resident # 1 and continued with his work. The relief nurse for him was Nurse # 3. When Nurse # 3 came on duty, he reported to Nurse # 3 about Resident # 1's left knee pain and told him to make sure the dayshift Nursing Supervisor (Nurse # 4) knew about the issue and there was follow up. Nurse # 2 (the Night Shift Nursing Supervisor) was interviewed on 7/17/25 at 7:30 AM and reported the following information. On the morning of 7/3/25 near the end of the night shift, Nurse # 1 called him and asked him to come over. Nurse # 1 had not given a reason. When he entered the room, Nurse #1 was in the room and two other staff members. Resident # 1 was seated in his wheelchair. He (Nurse # 2) asked them "what's up?" and they said they wanted him (Nurse # 2) to look at Resident # 1's knee. They reported Resident # 1 was screaming when they got him in the wheelchair. They did not report any fall or any type of trauma. At the time he (Nurse # 2) entered the room, the resident was not screaming. He (Nurse # 2) assessed Resident # 1's knee, checked pulses, and checked for a Homan's sign (a way of flexing the ankle to check for a blood clot). The resident did not say ouch when this was being done. The left knee did look as if it was approximately 3 to 4 cm (centimeters) larger than the right knee. He also noted Resident # 1 looked "mal-aligned" in his wheelchair. Resident # 1 seemed twisted at the waist. He (Nurse # 2) asked the staff members how Resident # 1 got up and they reported they had used the sit-to-stand lift to place him in the wheelchair and that was "how they do it." Given that there was no fall or trauma reported, and no deviation noted from his assessment, he thought something	F0684		

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F0684 SS = SQC-J	Continued from page 32 pathological might be causing the swelling. It was nearly shift change, and he instructed Nurse # 1 to look and see if the resident could receive anything for pain. He further instructed Nurse # 1 to document about the issue and report to his (Nurse # 1's) relief nurse that was about to come on duty. He (Nurse # 2) in turn planned to report to the oncoming dayshift Nursing Supervisor, which he did. NA # 3 was interviewed on 7/17/25 at 11:35 AM and reported the following information. She had arrived to work on 7/3/25 at 6:40 AM. She was not assigned to Resident # 1 but had to go by his room as she arrived to his unit where she was assigned. From the hallway she could see into Resident # 1's room that he was up in the wheelchair, and he was hollering "hurt-hurt" over and over again. He could be heard from the hallway. Nurse # 1 was seated near his room looking into the room. She asked Nurse # 1 what was wrong with Resident # 1 and Nurse # 1 replied the resident was hurting, he (Nurse # 1) had given Resident # 1 some acetaminophen, and the resident would be okay. She had not cared for Resident 1 that day, but she knew eventually he quietened down and could not be heard in the hallway. NA # 4 was interviewed on 7/16/25 at 3:35 PM and reported the following information. She had been assigned to care for Resident # 1 on the 7/3/25 shift from 7:00 AM to 3:00 PM. When she arrived at work, Resident # 1 was already up in the wheelchair, and he could be heard in the hallway as he yelled from his room. When asked what was wrong, he would just say, "My leg, my hip." He could not tell her what else was wrong. He would just yell those words, and he would not allow her to touch him all day. When she would try to touch or care for him, he would say, "no, no, no" over and over. He quietened down some but before she left at 3:00 PM she could again hear him hollering. This was new for him. He did not routinely yell. She had asked NA # 2 before NA # 2 had left work at 7:00 AM what was wrong with him, and NA # 2 had said she did not know. She (NA # 4) told both Nurse # 3, who was caring for him on the dayshift on 7/3/25 and she told Nurse # 4 (the Nursing dayshift Supervisor.). Restorative Aide # 1 was interviewed on 7/17/25 at 10:10 AM and reported the following information. She had arrived at 8:00 AM and before she even entered Resident # 1's unit, she could hear Resident # 1 "screaming to the top of his lungs in distress." He was screaming "pain-help-help." He did not want to be touched and did not want to go to restorative dining for breakfast. He always went to restorative so that	F0684		

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F0684 SS = SQC-J	Continued from page 33 was unusual for him. At the time he was in his wheelchair and still in his pajamas. She had immediately informed Nurse # 4 (the dayshift Nursing Supervisor.) She left the room and checked back around 12:15 PM for restorative lunch. At lunch he still did not want to go to restorative dining or come out of his room. His speech was slurred but he would say “no.” He was not yelling at lunch, and she brought his tray to his room. He ate a little bit. The first notation in Resident # 1s narrative nursing notes for the date of 7/3/25 was documented at 9:02 AM. The Facility Care Plan Nurse documented at this time, “This writer heard resident hollering out. Housekeeping staff reported he had been hollering for about 30 minutes. This writer went to check on resident. When asked what was wrong, he stated ‘you being in here, don’t touch me.’ Resident was sitting at bedside table with breakfast in front of him. He refuses to attend restorative dining and also refused going to dining room or allowing this writer to assist him with meal. Asked if they (as written) is anything I could do and he stated ‘no.’ Floor nurse and supervisor are aware.” The Facility’s Care Plan Nurse was interviewed on 7/16/25 at 3:18 PM and reported the following information. Her office is on the hallway where Resident # 1 resided. When she arrived to work on the morning of 7/3/25 she could hear from the hallway “hollering” from his room. A housekeeping staff member reported he had been hollering like that for about 30 minutes. He had never done anything like that before. One of the restorative Nurse Aides reported Resident # 1 would not go to restorative dining. She checked on Resident # 1 and he would not allow for anyone to help him. Nurse # 3 was the dayshift Nurse on duty at the time, and he reported Resident # 1 had received Tylenol around 6:30 AM that morning and he (Nurse # 3) had told the day shift Nursing Supervisor (Nurse # 4). She (the Facility Care Plan Nurse) had a meeting that morning and left the unit. Approximately an hour and half later she noted Resident # 1 was quiet at that point. Nurse # 3 was interviewed on 7/18/25 at 11:04 AM and reported the following information. He worked from 7:00 AM to 7:00 PM on 7/3/25. When he arrived at work, Nurse # 1 reported Resident # 1 had some pain in his left knee. Nurse # 1 said, “Let’s see him.” They both went into Resident # 1’s room. Both his knees looked the same but one of his knees was more tender when palpated. When the knee was touched, he would scream out in pain but say no words. He (Nurse # 3) asked Nurse # 1 when this had happened and Nurse # 1 reported when Resident # 1 was being transferred from the bed to	F0684		

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F0684 SS = SQC-J	Continued from page 34 the chair. Nurse # 1 did not report any type of fall. Nurse # 1 reported he had given Resident # 1 some acetaminophen around 6:30 AM. They continued on report about other residents. While he was giving morning medications, he could hear Resident # 1 from the hallway yelling and screaming. He went to the room, and the restorative aide was in the room trying to take Resident # 1 to breakfast. He seemed to be in pain and wanted to be left alone. He instructed the restorative aide to leave the resident alone and he spoke to the dayshift Nursing Supervisor (Nurse # 4). He asked Nurse # 4 if Resident # 1 had been in the facility supervisor's report at shift change, and she reported that he had. He (Nurse # 3) told Nurse # 4 that the resident needed something more for pain than acetaminophen. She (Nurse # 4) went to check the resident and he continued giving out medications. Later that day, Nurse # 4 told him (Nurse # 3) that she had contacted the provider and lab work and an x-ray were ordered. He (Nurse # 3) was not aware if the x-ray was to be done stat or routine. During morning medication pass, Resident # 1 refused to take medications. Later he checked back with him a second time, and he did take his morning medications. His yelling in pain seemed to stop after around 10:00 AM. He did not know NA # 4 was unable to touch him or care for him all dayshift. The resident did eat lunch and dinner that day. At the end of his shift he reported off at 7:00 PM to Nurse # 1 again. He let Nurse # 1 know that the x-ray still had not been done. Following the nursing note on 7/3/25 at 9:02 AM, the next nursing note was entered on 7/3/25 at 12:45 PM. At this time Nurse # 4 (the day shift Nursing Supervisor) documented the following. "Resident presenting with left knee pain, swelling, warmth. No redness noted. No open areas noted. Afebrile. Received orders from [the provider's secure messaging application for communication] for Stat (right away) CBC (complete blood count), CMP (comprehensive metabolic panel), D Dimer (lab to detect a blood clot), Uric Acid level (lab to detect gout), 2 view x-ray of left knee, and venous doppler of LLE (left lower extremity). Resident has refused blood work X 2 attempts at this time. Notified [Provider through the facility's secure electronic messaging app] and will continue to attempt." Record review revealed the details of the electronic communication between Nurse # 4 and the on-call NP (Nurse Practitioner) through the facility's secure electronic messaging system. The record of communication was documented as follows: On 7/3/25 at 10:25 AM Nurse # 4 notified the on-call NP that	F0684		

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F0684 SS = SQC-J	Continued from page 35 Resident # 1's left knee and above was swollen and warm with no redness noted and there had been no fall or injury. Nurse # 4 also noted to the on-call NP she was attaching a picture and that Resident # 1 was complaining of pain and "won't let anyone do anything with him due to the pain." The on- call NP responded electronically at 10:56 AM on 7/3/25 to draw stat blood work, obtain a 2 view x-ray of his left knee and a venous doppler of his left lower extremity. The on-call NP also responded electronically that the resident should be monitored for any acute changes and that there should be follow up with the primary provider. On 7/3/25 at 12:42 PM there was an electronic message sent to the on-call provider again through the secure electronic messaging app noting that Resident # 1 was refusing blood work at that time, the staff would continue to attempt, and they were not sure if Resident # 1 was going to allow the x-ray and doppler but they would let the x-ray company attempt it. The on-call provider responded electronically on 7/3/25 at 12:45 PM and instructed electronically to attempt the x-ray and doppler and notify the provider if he refused the doppler and x-ray. Nurse # 4 (the day shift Nursing Supervisor) was interviewed on 7/16/25 at 3:29 PM and reported the following information. Around 7:55 AM, Nurse # 3 had asked her to look at Resident # 1's knee because he was having some pain and the night shift Nurse had already given him Tylenol. At the time she looked at Resident # 1's knee, he was not in distress or yelling. She saw no signs of a fracture. The area above his knee was swollen and warm. Usually the resident was "nonchalant" about things and on that day he indicated it hurt a little. The facility has a means of communication where they can electronically communicate with a provider via way of a secure messaging system. They can send a message and upload pictures if needed. She communicated with the provider through this system and sent a picture of his knee. She received orders back. One of the orders was for a x-ray. She entered the order. Through the facility's system when it is entered as an order then it is automatically sent electronically to the x-ray company that completes the facility's x-rays. She also called the x-ray company. She was on duty on 7/4/25 and nothing was mentioned about Resident # 1. She was off on 7/5/25. On 7/23/25 at 2:00 PM the Administrator reported both the x-ray and blood work were ordered stat (right away). NA # 5 was interviewed on 7/16/25 at 4:05 PM and reported the following information. He cared for	F0684		

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F0684 SS = SQC-J	Continued from page 36 Resident # 1 on 7/3/25 during the 3:00 to 11:00 PM shift. In report, he had received information that the resident had been yelling and agitated. Between the hours of 3:00 to 4:00 PM he obtained help and placed Resident # 1 back in bed with the total mechanical lift. He was not yelling and did not seem in pain during the transfer with the total mechanical lift. The resident was soiled and in need of incontinent care. They had to turn him to provide the care and he did have pain with turning in the bed and would yell out. They were gentle. He let Nurse # 3 know about the pain with turning. After Resident # 1 was still in bed, the resident was calm. Nurse # 1 had again cared for Resident # 1 on the shift which began at 7:00 PM and ended at 7:00 AM on 7/4/25. Nurse # 1 was interviewed on 7/18/25 at 3:44 PM and reported the following information. According to Nurse # 1 Resident # 1 was in bed and did not complain of pain during his shift. Nurse # 1 reported that Nurse # 3 had told him that the x-ray company had been in and done the x-ray before he (Nurse #1) arrived to work at 7:00 PM. Review of Resident # 1's MAR (Medication Administration Record) revealed no documented pain medication on 7/3/25 and 7/4/25. Review of the MAR revealed nurses documented "0" for pain on both the day and night twelve hour shifts for 7/3/25 and 7/4/25. Record review revealed no narrative nursing notes for the date of 7/4/25. Nurse # 6 was assigned to care for Resident # 1 on 7/4/25 from 7:00 AM to 7:00 PM. Nurse # 6 was interviewed on 7/16/25 at 4:15 PM and reported the following information. She was helping an orienting nurse (Nurse # 5) on 7/4/25. She (Nurse # 6) arrived to work a few minutes late and Nurse # 5 (the orienting nurse) had already received nursing report from Nurse # 1. Nurse # 5 reported to her (Nurse # 6) that Nurse # 1 said everyone was fine. She did not know anything had been wrong with Resident # 1's leg. She had not assessed Resident # 1's leg on 7/4/25 or done follow up since it was not brought to her attention there was a problem. Nurse # 5 was interviewed on 7/17/25 at 6:35 AM and again on 7/21/25 at 9:39 AM and reported the following information. She had been orienting as a new nurse to the facility on 7/4/25. Nurse # 1 had not reported Resident # 1 was having pain in his leg and she had not looked at Resident # 1's leg. She did know Resident # 1 was due for an ultrasound and a x-ray. That part was in	F0684		

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F0684 SS = SQC-J	Continued from page 37 report. She was aware the x-ray company came in to do a test on 7/4/25. She was still new and did not know all the protocols, was working in orientation with Nurse # 6, and thought that they would have done both tests at the same time. Resident # 1 seemed okay on 7/4/25. NA # 4 was interviewed on 7/18/25 at 10:03 AM. NA # 4 had been assigned to Resident # 1 on 7/4/25 from 7:00 AM to 3:00 PM. NA # 4 reported the following information. On 7/4/25 “hollered now and again” on 7/4/25 but not as badly as he had on 7/3/25. He was up in the chair when she came on duty and he would not allow her to lay him down and provide incontinent care or other care during her dayshift. He would tell her “no” and to get away. She did not recall the specific nurse she spoke to on 7/4/25 but reported she had told a nurse he refused care still. NA # 7 was interviewed on 7/16/25 at 3:50 PM. NA # 7 had been assigned to Resident # 1 on 7/4/25 from 3:00 PM to 11:00 PM shift. NA # 7 reported the following information. Resident # 1 was up in the chair when she arrived to work. She and NA # 8 used the total mechanical lift to place him back in bed and he tolerated the transfer okay. A person from the x-ray company came to do the ultrasound on her shift. Resident # 1 did not “whimper” when she turned and changed him, and she did not notice bruising or anything wrong. NA # 8 was interviewed on 7/16/25 at 3:55 PM and reported she assisted NA # 7 in transferring Resident # 1 back to bed on the evening shift on 7/4/25. NA # 8 reported Resident # 1 “did good” and did not flinch or holler. Nurse # 1 was interviewed on 7/19/25 at 3:44 PM and reported the following information about his shift which began at 7:00 PM on 7/4/25 and ended at 7:00 AM on 7/5/25. The resident was not in pain that night. He (Nurse # 1) received the ultrasound report on his shift and saw they had not done any x-ray. He placed the ultrasound report in the medical provider’s box for review. He passed along in shift report at 7:00 AM on 7/5/25 to Nurse # 5 (the orienting nurse) that the ultrasound (used to detect blood clots) had been done, but an x-ray was supposed to have been done and for her (Nurse # 5) to tell one of the supervising nurses (Nurse # 8) on day shift. NA # 2 was interviewed on 7/17/25 at 2:05 PM. NA # 2 had cared for Resident # 1 on the shift which began at 11:00 PM on 7/4/25 and ended at 7:00 AM on 7/5/25. NA # 2 reported the following information. Resident # 1 was	F0684		

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F0684 SS = SQC-J	Continued from page 38 in bed when she came on duty. His thigh was swollen. He was not yelling or in pain. She knew to be careful and not turn him too much since his thigh was swollen. Near the end of the shift, she bathed him but did not get him out of bed because of the swelling. She explained this to the day shift Nurse Aide (NA # 9) who came on duty after her. NA # 9 was interviewed on 7/17/25 at 11:45 AM and reported the following information. She had cared for Resident # 1 from 7:00 AM to 11:00 AM (a partial shift). When she came on duty she noted that Resident # 1 was still in bed and this was unusual because he was normally assisted up out of bed by night shift. She talked to NA # 2 about why the resident was still in bed and NA # 2 said because his leg was swollen. She looked at Resident # 1's leg and his knee was swollen. She told him good morning and he did not complain of pain while lying in the bed. Later that morning, Resident # 1's family came to visit and wanted him up out of bed. She (NA #9), Restorative Aide #2, and Nurse # 5 helped get Resident # 1 out of bed while using the total care mechanical lift. When they would turn him to get him ready to get up and out of the bed, he would say "Ah-my leg." Once in the chair, he did not complain. Restorative Aide # 2 was interviewed on 7/18/25 at 10:12 AM and reported the following information. Prior to helping NA #9 on 7/5/25, she had helped Resident # 1 with restorative dining on 7/4/25. During that time, the resident had pants on and she could not see his knee. He told her, "you know I broke my foot?" At the time Resident # 1 said the comment, he had bunny boots (used for protection of his heels) and long pants on so that his leg was not visible. He was "in and out with his thoughts" and she mentioned his comment to Nurse # 6 at some point during the day, who said they did an ultrasound. He did not seem in pain when he made the comment to her on 7/4/25. On 7/5/25 she assisted NA # 9 in getting Resident # 1 out of bed with the total mechanical lift. At that time his knee was red and hot to the touch. Nurse # 5 checked it when they got him up. They were extra careful because they did not know what was going on with his leg. If they touched his knee then he would make a noise and if you did not touch it then he was okay. On 7/5/25 during restorative dining at lunch, he would not eat. She (Restorative Aide # 2) asked him why he was not eating and he replied because he hurt. She asked him where he hurt and he reported his leg and his "butt." Later after lunch and before 3:00 PM she helped NA # 10 put him back to bed with the total mechanical lift and he did okay. He did not yell out during the transfer back to	F0684		

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F0684 SS = SQC-J	Continued from page 39 bed. There was a definite difference in his two legs by visibly looking at them and she was careful. In addition to talking to Nurse # 5 about his knee, she reported the concern to Nurse # 7 and Nurse # 7 looked into it further. Resident # 1 ‘s Responsible Party (Family Member # 1) was interviewed on 7/18/25 at 11:31 AM along with Resident # 1’s second emergency contact relative (Family Member # 2) who was listed on his chart. (The two were on speaker phone together). They reported the following information. Neither had been informed about any fall or problems with the resident’s knee and knew nothing about any orders that had been given on 7/3/25. Family Member # 1 arrived on 7/5/25 and did not understand why the resident was in bed and therefore asked that they get him out of bed. Family Member # 1 stood outside while the NAs transferred Resident # 1. From the hallway she could hear Resident # 1 yelling as they got him out of bed. His knees had “marks” on them and were swollen. She talked to Nurse # 5 who told her she did not know anything. As she left, she showed someone at the front desk the pictures she had taken and her concern. Shortly after she arrived home, the facility called to tell her that they were sending Resident # 1 to the hospital. Record review revealed the first nursing narrative note on 7/5/25 was entered at 1:54 PM by Nurse # 7 who documented, “writer contacted mobile x-ray to obtain xray results; xray not performed. Order was refaxed and verbally requested STAT x-ray to L (left) knee.” Review of Resident # 1’s record revealed documentation of an electronic message sent to the on-call Physician Assistant by Nurse # 7 on 7/5/25 at 4:15 PM through their secure app. Nurse # 7 communicated that they did not have a hard copy of the x-ray result but the technician stated she did not feel comfortable doing any more bone x-rays because the femur bone appeared fractured and unstable, and that a picture was being uploaded to the on-call provider. Nurse # 7 further noted she was sending the resident to the hospital. The on-call Physician Assistant responded electronically at 4:17 PM on 7/5/25 that the bone looked fractured and displaced and to notify the provider when the resident returned/ follow up with the primary physician. On 7/5/25 at 4:16 PM Nurse # 9 documented on the MAR she administered 650 mg of acetaminophen per an as needed order. This was the only documented acetaminophen that date (7/5/25). On 7/5/25 at 4:32 PM Nurse # 7 made a notation in the	F0684		

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F0684 SS = SQC-J	Continued from page 40 nursing narrative notes she had been called to the resident's room by the x-ray technician, and that there was a concern the resident's femur was broken. The X-ray technician did not feel comfortable further moving the resident. Attempts were made to notify the RP. On 7/5/25 at 4:32 PM Nurse # 7 noted 911 was called. On 7/5/25 at 4:39 PM Nurse # 7 noted the resident was transferred to the hospital. According to staffing sheets, Nurse # 7 was assigned to care for Resident # 1 on 7/5/25 from 7:00 AM to 3:00 PM. Nurse # 7 was interviewed on 7/17/25 at 3:51 PM and reported the following information. On that day she was in charge of still training Nurse # 5 (the orientee nurse) on Resident # 1's unit. Nurse # 5 had already been orienting for five or six weeks at that time and said she was okay with the assignment which included Resident # 1. She (Nurse # 7) also shared responsibility with supervising the whole facility that day with another Supervisor Nurse (Nurse # 8). Nurse # 5 (the orientee Nurse) had gotten report at shift change on Resident # 1's unit. She (Nurse # 7) had gotten supervisor's shift change report and there was nothing in supervisor's report about Resident # 1 having a problem. She was in a dining room at lunch helping assist with feeding residents when there was a phone call from the front desk saying that Resident # 1s family was wanting to show something to one of the supervisors. At the time, she was assisting with feeding residents and asked the front desk to call the other supervising nurse (Nurse # 8). She later asked Nurse # 8 what the family wanted and was told that the family had taken pictures of Resident # 1's leg and wanted to show them to someone. She (Nurse # 7) went to Resident # 1's medical record and reviewed the record. She saw at that point that the resident was supposed to have had an x-ray done on 7/3/25 and there were no results. She called the X-ray company and they said they had not received the order, and it had not been done. The x-ray company planned to come that day right away. After looking at the medical record and calling x-ray she went to look at Resident # 1 and saw his leg had "minor bruises" and was swollen. He was not able to report what had happened. As a nurse she had seen fractured legs before, and from looking at Resident # 1's leg she would not have thought the resident's leg was fractured just by looking at it. The X-ray company came that afternoon and did the x-ray. The technician alerted them that she could see the initial film was showing his leg was broken and that the technician did not feel comfortable moving him any further to continue. The physician was called, and the resident	F0684		

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F0684 SS = SQC-J	Continued from page 41 was transferred out to the hospital. Prior to transport the resident was lying in bed and did not show outward signs of hurting while lying still. He was watching television. Nurse # 8 was interviewed on 7/18/25 at 9:07 AM and reported the following information. She was sharing supervisor duties with Nurse # 7 on 7/5/25. On 7/5/25 she was also responsible for medication administration as well. The day prior she had been working and although she had not been responsible for Resident # 1 on that date, she had observed when taking another resident to a July 4th party in the facility, that Resident # 1 was at the party, and he appeared as if he was participating and having a good time. On 7/5/25 she had not known anything about a x-ray needing to be done on Resident # 1's leg or a problem with his leg. A x-ray technician called her and was at the facility that afternoon doing an x-ray. She (Nurse # 8) was in another part of the facility at the time when the x-ray technician called from Resident # 1's unit. The x-ray technician reported she could tell the resident's leg was fractured and did not feel comfortable continuing with the x-ray. At that time Nurse # 9 had taken over the resident's care at 3:00 PM on 7/5/25. Nurse # 9 gave Resident # 1 some acetaminophen and she (Nurse # 8) helped with transfer paperwork, and they had the resident sent to the hospital. A manager for the provider of x-ray services at the facility was interviewed on 7/18/25 at 10:38 AM and reported the following information. Their records showed they never received a fax on 7/3/25 for an x-ray of the resident's leg. They had no record of a call about a needed x-ray or a fax until the date of 7/5/25 at 1:51 PM when their records showed Nurse # 7 called them. They did have record of an ultrasound order being faxed to them on 7/3/25 at 11:27 AM. The xray company had been in talks with the facility's corporate office about setting up a bidirectional interface with the facility's electronic order interface. Then when an order was placed in the computer, the order would automatically come to them. This had not yet been approved. There was a way that the facility could send orders currently through their order system, but it relied on going through a fax phone line system which could at times fail. It was not an integrated system with the x-ray company's system. They had told the facility they should always call as well as fax an order and they were to send the order and the resident's face sheet. With stat requests for diagnostic test, they could be there within an hour or two. For all other tests, they could give an estimated arrival time to the nurse who called in the order.	F0684		

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F0684 SS = SQC-J	Continued from page 42 There were four different ways to communicate with them (fax, email, phone call-in's, and through a portal). The x-ray company manager reported with faxes that were not integrated with their system the facility must always call to ensure the order comes through because a fax through a phone can fail. Review of hospital records for Resident # 1's hospital stay of 7/5/25 through 7/10/25 revealed the following information. The initial ED (Emergency Department) assessment documentation included a diagram of the front and back of a human body where skin areas could be marked. There was a notation that the resident had extensive swelling, bruising and deformity to the distal femur. There was nothing noted on the skin diagram or accompanying notations below the diagram depicting a problem with the resident's buttocks or sacrum. Hospital x-rays were done and showed Resident # 1 had a comminuted displaced fracture at the distal femoral shaft. (A comminuted fracture is one in which the bone breaks in three or more places and the femur is a leg bone). Labs were done and the resident's hemoglobin was 7.5. (normal range for men 13.5 to 17.5). A CT (computerized tomography) scan showed that the fractured bones were in close proximity to the proximal popliteal and distal superficial femoral arteries in the resident's leg with no definite evidence of injury to the blood vessels. Diagnostic test also showed the resident had a large bladder stone and blood in his urine. The resident received blood. A x-ray of the left shoulder, which was done while hospitalized, showed findings "most likely compatible with complete rotator cuff tear." (The rotator cuff is a group of four tendons and muscles that stabilize and rotate the shoulder joint. These tendons connect the muscles to the bones of the shoulder, which allows stability of the shoulder joint). A discussion was held with Resident # 1's RP who was documented as saying that the resident had always wanted everything done for him and she wanted to talk to other family members before making a final decision about surgery. An orthopedic consult was obtained and the orthopedic recommended the resident's leg be placed in a left knee immobilizer and that surgery would be planned. Review of the orthopedic surgeon's note revealed surgery was done on 7/8/25 and it was more for comfort as opposed to fixation of the fracture. According to the orthopedic surgeon's note, the bone had not come through the skin until they took him to surgery and then the bone did so. The orthopedic surgeon noted the resident was in terrible pain. The surgeon also noted Resident # 1 had buttock wounds and debriding them would not improve his quality of life. Review of Resident # 1's hospital discharge summary, dated	F0684		

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F0684 SS = SQC-J	Continued from page 43 7/10/25, revealed Resident # 1 was discharged for comfort care. The discharging physician noted that the resident had experienced a complicated hospital course and prior to being taken to surgery he had developed fevers. The physician noted, “Initially fevers were considered to be reactive after urine and blood cultures were negative. On skin review patient noted to have several pressure related injuries including unstageable ischial ulcer. “ The resident’s prognosis was discussed with the family before discharge and the resident was made comfort care.” A hospital nursing note on the day of hospital discharge (7/10/25) noted Resident # 1 had wounds to his sacrum and ischium but he could not tolerate being turned long enough to change the dressings although premedicated with Dilaudid (a narcotic pain medication) on the day of discharge. Resident # 1’s facility record was reviewed for information regarding the status of Resident # 1’s wounds prior to his fracture and hospitalization revealing a 5/29/25 order for a medicated cream and a protective dressing to the sacrum and ischium. According to the facility’s wound Nurse Practitioner’s notes, Resident # 1 had an area of moisture associated skin damage to the ischium that had been treated and healed on 6/17/25 and no further problems to the resident’s buttocks and sacrum were noted on that date by the Wound NP. The facility’s Wound Care Nurse and Administrator were interviewed on 7/21/25 at 10:34 AM regarding the status of Resident # 1’s wounds prior to his fracture and transfer to the hospital. The facility Wound Care Nurse reported the resident did have an open area on his ischium which was healed on 6/17/25 and a protective cream (the medicated cream) and a protective dressing were continued for prevention to both his sacrum and ischium areas. The Facility Treatment nurse reported she had changed Resident # 1’s dressings on 7/4/25 and at that time he had no marginal areas that were problematic or concerning and that the cream and dressings were still preventative. A review of hospice records revealed Resident # 1 expired on 7/20/25 at 9:42 PM while under hospice care at a hospice facility. The resident’s body was signed over to the medical examiner. During the interview on 7/18/25 at 11:31 AM with Family Member # 1 and Family Member # 2, Family Member # 2 reported the following information. They had not yet learned what had happened but from talking to the	F0684		

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F0684 SS = SQC-J	Continued from page 44 hospital physician they suspected Resident # 1 had been dropped somehow on the floor, and Resident # 1 had reported to them (her and Family Member # 1) that he had been dropped when they asked him. According to Family Member # 2, the hospital physician had indicated the rotator cuff tear could have occurred when he was picked up from the floor. Resident # 1's facility physician, who serves as the facility medical director, was interviewed on 7/18/25 at 1:40 PM and again on 7/22/25 at 2:35 PM and reported the following information. She was out of town during the interim of 7/3/25 through 7/5/25 and the regular NP, who was routinely in the facility five days per week, was also not there. For her or other providers, if the staff had reported that the resident had fallen and was yelling loudly enough to be heard in the hallway about his leg, then she or an on-call provider would have instructed the staff to get the x-ray, stabilize his leg, and not move him until the results were known. Without the x-ray, it would have been hard to tell what was wrong with the resident. The facility staff had not reported the fall and they had delayed in getting the x-ray. The physician reported in general an undiagnosed comminuted fracture femur fracture is associated with a difficult surgery and with poor healing. The physician further reported prior to the fracture, the resident did have multiple diagnoses and anyone could die unexpectedly at any moment, but Resident # 1's death was not expected to be imminent before he sustained the fracture. The physician felt the fracture had contributed to the resident's death which was earlier than expected. The medical director was interviewed about the resident's torn rotator cuff and reported that with normal aging some tears can also occur. The physician also reported as medical director, the Administrator had been in contact with her (the physician) and the facility had done a corrective action plan. The Administrator was interviewed on 7/16/25 at 3:00 PM and again on 7/17/25 at 6:00 PM revealing the following information. Initially she was informed about the fracture when it was identified on 7/5/25 and started an investigation. At the time, no one had reported a fall or trauma, and therefore her investigation was centered on an injury of unknown origin. Multiple staff were interviewed, which included NA # 1, NA # 2, and Nurse # 1. None of these three reported a fall, but she was able to determine through her investigation that the resident started having knee pain when they were caring for him and knew something had happened. The facility was equipped with hall cameras, and she viewed the camera footage while doing the investigation. She	F0684		

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F0684 SS = SQC-J	Continued from page 45 saw that NA # 1 and NA # 2 went into Resident # 1's room on 7/3/25 with a sit-to-stand lift at 6:02 AM. This was not the correct lift for the resident. Written care guides were placed on the back of residents' closet doors at the time. Resident # 1's care guide had correctly noted that he needed a total mechanical lift. On the video after NA # 1 and NA # 2 were in the room, she could see Nurse # 1 enter the room. NA # 1 and NA # 2 were still in the room at the time. Soon after he went in, one of them came out and obtained a vital sign machine and they were in the room for awhile. None of these three staff members had reported the fall to Nurse # 2 (the Night Shift Nursing Supervisor) or to the physician. They all maintained that he had not fallen. She did suspend them during the investigation for using the wrong type of lift when it was established they had done so and further questioned them. On 7/14/25 Nurse Aide # 1 was honest and explained Resident # 1 had fallen and there had been a plan not to disclose the fall. Following the incident the facility had developed a corrective action plan as part of their quality assurance program. The Administrator also reported during her investigation it was recognized that there was a delay in getting the x-ray and treatment for the resident, and they had also done a corrective action plan for that as well. The Administrator was informed of Immediate Jeopardy on 7/22/25 at 12:45 PM and presented the following corrective action plan. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility failed to ensure nursing staff effectively communicated amongst themselves to ensure staff who care for Resident#1 were aware of a fall with obvious injury that occurred on 7/3/25 between 6:00AM and 7:00AM for a severely cognitively impaired and dependent resident. A comprehensive assessment was not completed prior to moving Resident #1 after the fall. The failure to communicate ongoing assessment, monitoring, treatment, and follow up when an ordered x-ray was not completed. Nursing staff who were unaware of the fall continue to transfer, reposition and provide care for the resident without professional stabilization of his leg despite indicators of problems with the resident leg. The investigation began 7/5/25 when the Administrator was informed by Nurse #8 there was a fracture of unknown origin on Resident #1. The Administrator was informed by Nurse #8 the resident complained of left	F0684		

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F0684 SS = SQC-J	Continued from page 46 knee pain on the morning of 7/3/25 to NA #1 and NA #2 who were providing care to him. NA #1 and NA #2 notified Nurse #1 to come to the resident's room. Nurse #1 was informed by both NA #1 and NA #2 that the resident complained of pain in his left knee while they were giving him a bed bath. Resident #1 was unable to state how the fracture occurred when asked by Nurse #8 on 7/5/25. Nurse #1, NA #1 and NA #2 were interviewed by the Administrator on 7/8/25 stating Nurse #1 assessed the resident in bed on 7/3/25 and determined both resident's knees did not look the same. Nurse #1 called Nurse #2 to assess the resident's left knee. Nurse #2 entered the room and assessed the resident while the resident was in the chair. During an interview with NA # 1 on 7/14/25 by the Administrator, NA #1 stated the resident had fallen to the floor from sitting on the side of the bed on 7/3/25. NA #1 stated NA #2 and Nurse #1 assisted her in getting Resident #1 up from the floor and placing him in chair. Nurse #2 entered the room to find the resident in the chair. Nurse #2 noted no pain on palpation, but possible kneecap deviation in size. Nurse #3, the 7AM -7PM charge nurse for Resident #1 requested Nurse #4, the 7AM to 3PM supervisor to assess resident's knees. The left knee was noted to be swollen above the kneecap. The resident was administered Tylenol the morning of 7/3/25 by Nurse # 1 due to complaints of pain. Notification of Resident #1 experiencing knee pain was entered in the Medical Provider electronic software by Nurse # 4 at 10:26 AM on 7/3/25. Orders were received for immediate lab work, ultrasound and Xray at 10:56 AM on 7/3/25. Nurse #4 gave a copy of faxed orders to Nurse #3. Resident # 1 refused lab work ordered on 7/3/35. The Medical Provider was notified on 7/3/25 at 12:42 PM of the resident's refusal. No new orders were given. The on-call provider responded electronically on 7/3/25 at 12:45 PM and instructed electronically to attempt the x-ray and doppler and notify the provider if he refused the doppler and x-ray. The Ultrasound was negative on 7/4/25. The Xray was obtained on 7/5/25 and was positive for acute fracture of the left distal femur with osteopenia. The resident was transported to the hospital on 7/5/25 for positive acute fracture of left femur. Nurse #1 failed to report Resident # 1's fall to the Medical Provider immediately after the fall.	F0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345560	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/28/2025

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F0684 SS = SQC-J	Continued from page 47 Nurse #1 and Nurse #2 failed to document Resident #1's assessment in the medical record. Both Nurse #1 and Nurse #2 documented written statements regarding Resident # 1's complaints of left knee pain during the investigation, but not at the time of their assessment. Nurse #3 and Nurse # 4 failed to give written report from shift to shift and inform the oncoming nurse of an immediate Xray order for 7/3/25 causing X-ray to be delayed until 7/5/25. Nurse #1, NA #1 and NA #2 wrote statements on 7/7/25 that indicated they used the sit to stand lift to transfer Resident #1, but Resident #1 did not fall. NA #1 and NA #2 wrote statements again on 7/9/25 that indicated they used the standup lift, but denied the resident fell. They stated Resident #1 only complained about left leg pain during his morning care and that he did not fall. On 7/14/25 NA #1 stated to the Administrator and Director of Health Services that Resident #1 did fall from the side of the bed to the floor on his knee on 7/3/25. NA #1 stated they were attempting to use the Sit to Stand Lift with the lift sling clipped around the resident's waist, but not to the lift. The resident slipped from the side of the bed. NA #1 and NA #2 called Nurse #1 into the room. NA #1 stated Nurse #1 entered the room and assessed the resident, noting something was wrong with the resident's knee. Nurse #1 helped NA #1 and NA #2 lift the resident from the floor and into the chair. NA #1 was terminated on 7/14/25 for failure to report a fall. Nurse #1 had originally written in his 7/7/25 statement, when he walked in the room on 7/3/25, the resident was in bed, and he requested NA #1 and NA #2 move Resident #1 to the chair so he could be assessed by Nurse #2. Nurse #1 stated to Human Resource Manager on 7/14/25 that Resident #1 did not fall on 7/3/25. He was terminated on 7/14/25 for failure to report a fall. NA #2 was questioned again on 7/14/25 by the Administrator. She continued to state that Resident #1 did not fall on 7/3/25. NA # 2 was terminated on 7/14/25 for failure to report a fall. It was determined by NA #1's statement on 7/14/25 that Resident #1 fell from the bed to the floor. Address how the facility will identify other residents having the potential to be affected by the same	F0684		

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F0684 SS = SQC-J	Continued from page 48 deficient practice: All residents have the potential to suffer a serious outcome as a result of this non-compliance. The Director of Health Services completed a Radiology audit to identify other radiology reports that were not obtained as ordered on 7/5/25 that expanded from 6/1/25 to 7/4/25. There was no additional findings on the radiology report. The Quality Assurance Nurse (QA Nurse), Director of Health Services (DHS), Assistant Director of Nursing (ADON), wound nurse and Infection Control Nurse completed a 100% body audit related to skin and potential signs of new fractures with no new findings. The audit started on 7/8/25 and completed 7/8/25. The Quality Assurance Nurse (QA Nurse), Director of Health Services (DHS), Assistant Director of Nursing (ADON), wound nurse and Infection Control Nurse completed a 100% resident pain assessment. There were no new finding that required notifying the Medical Provider. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: All staff in all departments were in-service by the DHS, ADHS and QA Nurse on immediate reporting of Resident Events and Accidents to their supervisor beginning 7/14/25 and completed 7/14/25. Any staff who did not receive the education by 7/14/25 will be educated prior to working on the floor. All nurses were inserviced on reporting resident changes in condition, to include falls, and that it is crucial to report any change in resident condition to a healthcare provider immediately face to face or via electronic notification system. The inservice was started 7/8/25 and was completed 7/11/25. All Nurses were re-educated on Pain Management policy by the DHS, QA nurse, DHS, and ADHS. The Inservice was started on 7/8/25 and completed on 7/11/25. This in-service was done as a precaution as the facility was not aware how the injury occurred until 7/14/25. All Nurses were re-educated on documentation of assessment notes and medication administration by the DHS and nurse managers beginning 7/7/25 and completed on 7/11/25.	F0684		

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F0684 SS = SQC-J	Continued from page 49 All Nurses, therapy and NAs were re-educated by the DHS, QA nurse, and ADHS regarding: 1) changes in condition referring to a noticeable shift in a resident's physical or mental health status to include sudden changes in vital signs, altered mental status, change in eating habits, unusual pain or new onset of pain this includes any signs and symptoms of increasing pain, falls, difficulty breathing, unexpected weight gain or loss and any new skin issues (open areas, skin tears, redness, bruising and rashes); 2) the use of the Stop and Watch Tool (Stop and Watch forms are for any staff member to utilize and report to Nurse Manager, DHS, or ADHS any observed changes in residents and serve as a first indication of a change in condition and should be given attention; and 3) resident profiles (a resident profile is the care guide that NAs and the Nurses can access electronically and includes how to care for resident). Additionally, all nurses and NAs were educated to check the resident profile regularly for any changes and updates to resident care. The in-service was started on 7/8/25 and completed on 7/11/25. All nurses were educated by the QA nurse on use of the 24-hour sheet /shift report. 24-hour sheet is a summary of all activity within the nursing dept. It includes any change in condition, family and or provider communication, follow up on any orders and results from the orders. The inservice was started on 7/7/25 and completed on 7/14/25 All nurses were educated by the QA nurse on use of the Supervisor Rounding Sheet/shift to shift report. The shift report is a communication tool that is used between the nurse ending his/her shift to communicate information to the oncoming nurse. This information includes any change in condition, provider changes, outstanding x ray/labs and pending results. This tool is signed by the nurse at the end of their shift along with oncoming nurse. The in-service was started on 7/7/25 and completed 7/11/25. All nurses were in-serviced by the DHS, ADHS, QA Nurse on the Xray company process for completing x-ray and ultrasound orders. Nurses will continue to input orders electronically and will follow up with a phone call to ensure that the company has received the electronic order. The facility nurse is to contact the Xray company within two hours if the Xray company has not arrived to obtain the order Radiology test. This inservice was started 7/10/25 and completed 7/14/25. All inservices given in this plan of correction will be	F0684		

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F0684 SS = SQC-J	Continued from page 50 incorporated into the new hire the orientation effective 7/15/25. Staff will not work after 7/14/25 until they have been inserviced on all applicable in services. The QA Nurse is providing inservices and obtain signatures on all newly hired staff. The QA Nurse is tracking education and the DHS, ADHS, and nurse manager are providing all of the education after 7/14/25. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The decision to monitor and take to QA was made on 7/10/25. The DHS or Supervisor will print the Facility Activity Report (FAR BOOK) and EMAR and supervisor shift to shift report 5 days per week for use during the clinical meeting to audit pain management, documentation of assessments and medication administration. The results of the audits will be reviewed by the QA nurse 5 x per week x 4 weeks and two x per week x 4 weeks, then weekly x 4 weeks. The results of the audits will be reviewed by QA nurse weekly x 12 weeks. The results will be submitted to the Executive QA committee monthly x 3. This team includes the Director of Health Services, Assistant Director of Health Services, Administrator, Quality Assurance Nurse and Wound Nurse. The Medical Director will attend no less than once quarterly. The DHS or nurse manager will use the Shift to Shift Report Tool to audit the Charge Nurse Shift Report. The audit tool will determine if effective reports are given shift to shift and nurse signatures are present to validate reports are given. The tool will be used 5 x per week x 4 weeks and two x per week x 4 weeks, then weekly x 4 weeks. The results of the audits will be reviewed by the QA nurse weekly x 12 weeks. The results will be submitted to the Executive QA committee monthly x 3. The DHS or nurse manager will use the Supervisor Shift to Shift Report Audit tool to audit change of shift report to each other. The audit tool will determine if effective reports are being used shift to shift and nurse signatures are present to validate reports are given and outstanding issues are moved forward for resolution. The tool will be used 5 x per week x 4 weeks and two x per week x 4 weeks, then weekly x 4 weeks. The results of the audits will be reviewed by the QA nurse weekly x 12 weeks. The results will be submitted to the Executive QA committee monthly x 3.	F0684		

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F0684 SS = SQC-J	Continued from page 51 The DHS or Nurse Manager will use the 24 Hour Report audit tool to ensure changes in condition are addressed by the nurse. The DHS and nurse managers will use the Facility Activity Report to ensure the physician, resident representative, Situation Background Appearance Review Form, care plan and IDT team related to a change in condition are all updated. The audit tool will be used 5 x per week x 4 weeks and 2 x per week x 4 weeks, then weekly x 4 weeks. The results of the audits will be reviewed by the QA nurse weekly x 12 weeks. The results will be submitted to the Executive QA committee monthly x 3. The DHS or Nurse Manager will use the Radiology report from the electronic medical records system to follow up on Xray orders. The radiology report will be used 5 x per week x 12 weeks. The results of the audits will be reviewed by the QA nurse weekly x 12 weeks. The results will be submitted to the Executive QA committee monthly x 3. The facility alleges an immediate jeopardy removal date and compliance date of 7/15/25. The facility's corrective action plan was validated by the following measures: On 7/16/25 from 9:50 AM through 11:55 AM multiple residents were interviewed regarding the care they received at the facility and residents reported they were pleased with care and services. There were no residents who reported medical conditions or pain issues that were not being addressed by the nursing staff. A family member of a cognitively impaired, dependent resident was interviewed on 7/16/25 at 5:00 PM and reporting she was pleased and referred to the nursing staff as "perfect." A current resident, who required assessment and monitoring related to end of life needs, was placed on the sample. Interviews and record review revealed monitoring, assessment, and care were being provided per this additionally sampled resident's plan of care. Interviews with nursing staff revealed communication amongst direct care staff and supervising nurses was occurring for this additionally sampled resident. On 7/17/25 and 7/18/25 the facility presented audits per their corrective action plan and documentation of inservices per their corrective action plan with sign in sheets.	F0684		

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F0684 SS = SQC-J	Continued from page 52 Beginning on 7/16/25 staff members from different shifts were interviewed and reported they had attended inservice training and reported they were inserviced regarding communication (not waiting to communicate) and making sure there was follow up for residents when they noted something was wrong. Staff were able to report how to find resident care information to know residents' needs and the plan of care which was to be followed. The facility's corrective action plan was validated with an Immediate Jeopardy removal date and compliance date of 7/15/25.	F0684		
F0689 SS = SQC-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 interviews with staff, and physician the facility failed to provide the necessary supervision to prevent accidents and provide care in a safe manner for a severely cognitively impaired resident totally dependent on staff for care and required a total mechanical lift for transfers. On 7/3/25 between 6:00 AM and 7:00 AM Nurse Aide #1 and Nurse Aide #2 were preparing to use a sit-to stand mechanical lift to transfer Resident # 1 from the bed to the chair. On 7/3/25 while seated on the side of the bed, the resident slid to the floor on his knees and was crying on the floor. The resident was manually lifted from the floor to the bed following the fall. NA #1 reported Nurse #1, who was the supervising nurse for NA # 1 and NA # 2, then helped them transfer Resident # 1 from the bed to the wheelchair with the sit-to-stand lift. On 7/5/25 Resident # 1 was hospitalized and identified to have a comminuted fracture (broken in three or more pieces) of the femur (thigh bone). A diagnostic test showed the fractured bones in close proximity to the resident's leg arteries. The resident	F0689	"Past Noncompliance - no plan of correction required"	

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F0689 SS = SQC-J	Continued from page 53 underwent surgery for stabilization purposes, was placed on hospice care, and expired on 7/20/25. Resident # 1's physician reported that prior to Resident # 1's fall and fracture, his death was not expected to be imminent. This was for one of three sampled residents reviewed for falls (Resident #1). The findings included: Record review revealed Resident # 1 was admitted to the facility on 2/7/22. Resident # 1's diagnoses included a history of stroke with left hemiplegia and hemiparesis, Parkinson's disease, chronic obstructive pulmonary disease, and muscle weakness. Review of an occupational therapy evaluation, dated 4/4/25, revealed the following information. The resident had balance problems and was assessed to need maximum assistance from staff to sit on the side of the bed. The resident was not assessed to have pain that interfered with his functional activity. He had impaired range of motion to his left shoulder, elbow/forearm, wrist, hand, thumb, and fingers. He also had impaired strength in his left shoulder, elbow/forearm, and wrist. He had problems with fine and gross motor coordination, strength, and attention. Resident # 1's quarterly Minimum Data Set Assessment, dated 5/6/25, coded Resident # 1 as severely cognitively impaired and as being totally dependent on staff for hygiene, bathing, dressing, turning in the bed, sitting up from a lying position, and transferring. He was not ambulatory and was assessed to be dependent on staff for wheelchair mobility. On 7/17/25 at 9:15 AM the Administrator provided a copy of Resident # 1's Nurse Aide care guide. According to the Administrator care guides were placed on the back of all residents' closet doors for the Nurse Aides to access. A review of Resident # 1's care guide revealed a notation it had been updated on 2/12/25 to reflect the resident was a total mechanical lift. The facility's Rehabilitation Director was interviewed on 7/17/25 at 3:50 PM and reported the following information regarding Resident # 1's physical capabilities and the types of lifts that the facility used. Resident # 1 had been experiencing a Parkinson's decline over the time he had resided at the facility. He had contracture of his hips, knees, ankles, and upper body and also suffered from tightness and rigidity from his Parkinson's disease. Resident # 1 would also hold his arms close into his body from the rigidity. He required a total mechanical lift for	F0689		

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F0689 SS = SQC-J	Continued from page 54 transfers. He could not bear weight. In order to utilize a sit- to- stand lift, an individual had to be able to bear a portion of their weight, and also be able to reach and hold onto the bars of the sit-to-stand mechanical lift. Also, with a sit-to-stand lift, a resident needed to be able to move smoothly up as the lift raised an individual from a seated position to a standing position prior to letting the individual down into a chair. Resident # 1's Parkinson's could cause sudden rigidity as the lift was moving him. A sit-to-stand lift was not an appropriate device for him. Review of physician orders revealed an order, dated 12/18/24, for 650 milligrams of acetaminophen every four hours as needed for pain. Review of nursing notes for Resident #1 revealed no nursing narrative notes for the shift which began on 7/2/25 at 11:00 PM and ended at 7:00 AM. Nurse Aide (NA) # 1 was interviewed on 7/16/25 at 4:21 PM and again on 7/18/25 at 8:31 AM and reported the following information about the events of the shift which began on 7/2/25 at 11:00 PM and ended at 7:00 AM on 7/3/25. She had not been working at the facility very long and had recently completed orientation as a new facility Nurse Aide. She had been working as a team with NA # 2 on the shift which began on 7/2/25 at 11:00 PM and ended at 7:00 AM on 7/3/25. It was her first night working with Resident # 1. She and NA # 2 had entered the room around "6 something" in the morning to get Resident # 1 out of the bed. They were preparing to transfer Resident # 1 with the sit-to-stand lift. They had placed the sling on the resident, and he was sitting on the side of the bed. Before they started to mechanically lift Resident # 1 up in the sling, he slid from the side of the bed onto the floor and landed on his knees. While on the floor Resident # 1 was crying and she could tell there was something wrong, and he had hurt his knee. She and NA # 2 manually lifted Resident # 1 back into the bed and NA # 2 called Nurse # 1 into the room. Nurse # 1 came into the room and said it looked like his knee was dislocated. When interviewed about whether Nurse # 1 knew that Resident # 1 had fallen, NA # 1 reported he knew. When asked if they had told Nurse # 1 the resident had fallen, NA # 1 reported she could not recall if verbally she told him but that he knew something had happened. When asked how Nurse # 1 knew, NA # 1 reiterated without explaining further that Nurse # 1 knew Resident # 1 had fallen. According to NA # 1, Nurse # 1 and NA # 2 wanted her (NA # 1) to not disclose that Resident # 1 had actually fallen. After Nurse # 1 checked Resident # 1, Nurse # 1	F0689		

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F0689 SS = SQC-J	Continued from page 55 helped her and NA # 2 use the sit-to-stand lift and transfer Resident # 1 from the bed to the chair. After Resident # 1 was in the wheelchair, the Night Shift Supervisor (Nurse # 2) came to also check Resident # 1's leg. While in the wheelchair, Resident # 1 was still having some pain, but he was no longer crying. NA # 1 reported she had not known the resident was not supposed to use the sit- to- stand lift. She felt very badly about what had happened, but "right was right" and "wrong was wrong," and she told the truth when she was further questioned about the incident by administrative staff members days later after the fall. NA # 1 was further interviewed about why the sit-to-stand lift was used and further reported the following information. She did not recall being the one to get the lift. If she had known, she would not have intentionally used the wrong lift. In training she had been told the information was in the computer, but she did not recall being shown how to access the information. NA # 1 said, "Maybe I should have known, but I didn't." NA # 2 was interviewed on 7/17/25 at 2:05 PM. According to NA # 2, Resident # 1 had never fallen and she and NA # 1 just noticed his knee was giving him pain. NA # 2 reported the following information about caring for Resident # 1 on the shift which began at 11:00 PM on 7/2/25 and ended on 7/3/25 at 7:00 AM. Near the end of the shift she and NA # 1 were bathing Resident # 1. When they got to his knee, he would "holler oh-oh" indicating his knee hurt. She called out from the room for Nurse # 1 to come into the room. Nurse # 1 entered and did an assessment. Nurse # 1 then called the Night Supervisor (Nurse # 2). Before Nurse # 2 arrived, they asked Nurse # 1 to help them get Resident # 1 up to the wheelchair. They used a sit-to- stand lift. This was the lift that NA # 2 reported she always used as did other Nurse Aides. She had been caring for Resident # 1 about a year, and she was just doing what other people did. Nurse # 1 helped by making sure Resident # 1's leg did not touch up against the part of the lift as they transferred him and they gently put him in the chair. Nurse # 2 then came into the room and commented Resident # 1's knee might be dislocated. Nurse # 1 gave Resident # 1 some acetaminophen and then she and Nurse # 1 placed Resident # 1 back in bed. When she left Resident # 1 was okay. NA # 2 was interviewed about whether she knew what was on Resident # 1's care guide on his door and she said she did not know. She had looked at his care guide one time when she was training. Nurse # 1 was interviewed on 7/17/25 at 12:10 PM and on 7/18/25 at 4:37 PM and reported the following	F0689		

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F0689 SS = SQC-J	Continued from page 56 information. He had cared for Resident # 1 from 7:00 PM on 7/2/25 until 7:00 AM on 7/3/25. When he arrived at the first of his shift, Resident # 1 had no form of complaint. Around 6:30 AM NA # 2 called him into the room by verbally calling out from the room. NA # 1 and NA # 2 said they were giving Resident # 1 a bed bath and when they touched his knee, Resident # 1 screamed. They paused the bed bath and called him (Nurse # 1). Resident # 1's left knee was swollen. Resident # 1 had not fallen, and he was not screaming. He (Nurse # 1) called the Night Shift Supervisor (Nurse # 2) and asked him to come look at the resident's leg. While they waited for Nurse # 2, the Nurse Aides asked him (Nurse # 1) for help putting Resident # 1 in the wheelchair. The two nurse aides used the sit-to-stand lift to transfer Resident # 1 from the bed to the wheelchair. He (Nurse # 1) had never received training on the mechanical lifts and did not use them. He helped by guiding Resident # 1's feet on the sit-to stand lift platform as they transferred him. Once Resident # 1 was in the wheelchair, Nurse # 2 arrived. Nurse # 2 thought the resident's knee might possibly be dislocated. Nurse # 2 asked him (Nurse # 1) to give Resident # 1 some acetaminophen and tell the oncoming dayshift Nurse about the issue. Nurse # 1 had other blood work to draw and medications to give to other residents at that time. Nurse # 2 told him (Nurse # 1) to then continue his work, and that he (Nurse # 2) would make a notation and pass along to the dayshift nursing supervisor as well to follow up about the resident's swollen knee. He (Nurse # 1) then administered acetaminophen to Resident # 1 and continued with his work. The relief nurse for him was Nurse # 3. When Nurse # 3 came on duty, he reported to Nurse # 3 about Resident # 1's left knee pain and told him to make sure the dayshift Nursing Supervisor (Nurse # 4) knew about the issue and there was follow up. Nurse # 2 (the Night Shift Nursing Supervisor) was interviewed on 7/17/25 at 7:30 AM and reported the following information. On the morning of 7/3/25 near the end of the night shift, Nurse # 1 called him and asked him to come over. Nurse # 1 had not given a reason. When he entered the room, Nurse #1 was in the room and two other staff members. Resident # 1 was seated in his wheelchair. He (Nurse # 2) asked them "what's up?" and they said they wanted him (Nurse # 2) to look at Resident # 1's knee. They reported Resident # 1 was screaming when they got him in the wheelchair. They did not report any fall or any type of trauma. At the time he (Nurse # 2) entered the room, the resident was not screaming. He (Nurse # 2) assessed Resident # 1's knee, checked pulses, and checked for a Homan's sign (a way of flexing the ankle to check for a blood	F0689		

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F0689 SS = SQC-J	Continued from page 57 clot). The resident did not say ouch when this was being done. The left knee did look as if it was approximately 3 to 4 cm (centimeters) larger than the right knee. He also noted Resident # 1 looked “mal-aligned” in his wheelchair. Resident # 1 seemed twisted at the waist. He (Nurse # 2) asked the staff members how Resident # 1 got up and they reported they had used the sit-to-stand lift to place him in the wheelchair and that was “how they do it.” It was nearly shift change, and he instructed Nurse # 1 to look and see if the resident could receive anything for pain. He further instructed Nurse # 1 to document about the issue and report to his (Nurse # 1’s) relief nurse that was about to come on duty. He (Nurse # 2) in turn planned to report to the oncoming dayshift Nursing Supervisor, which he did. Nurse # 2 was interviewed regarding what should have happened if the fall had been reported. Nurse # 2 reported a particular code is called over the intercom so that multiple staff members from different units would respond to help with assessment and care. Any resident that falls was supposed to be assessed for injuries and the environment was assessed at that time to see what contributed to the fall. The staff do a “fall huddle” to discuss if the resident is okay and what happened. Since Resident # 1’s fall was not reported, this was not done. The first notation in Resident # 1’s narrative nursing notes for the date of 7/3/25 was documented at 9:02 AM. The Facility Care Plan Nurse documented at this time, “This writer heard resident hollering out. Housekeeping staff reported he had been hollering for about 30 minutes. This writer went to check on resident. When asked what was wrong, he stated ‘you being in here, don’t touch me.’ Resident was sitting at bedside table with breakfast in front of him. He refuses to attend restorative dining and also refused going to dining room or allowing this writer to assist him with meal. Asked if they (as written) is anything I could do and he stated ‘no.’ Floor nurse and supervisor are aware.” Following the nursing note on 7/3/25 at 9:02 AM, the next nursing note was entered on 7/3/25 at 12:45 PM by Nurse # 4 (the day shift Nursing Supervisor) who noted Resident # 1’s knee was swollen, warm, and painful. Nurse # 4 further noted that labs, a x-ray of the left knee, and a venous doppler of the left lower extremity were ordered. Record review revealed documented details of the electronic communication between Nurse # 4 and the on-call NP (Nurse Practitioner) through the facility’s secure electronic messaging system. The record of	F0689		

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F0689 SS = SQC-J	Continued from page 58 communication was documented as follows: On 7/3/25 at 10:25 AM Nurse # 4 notified the on-call NP that Resident # 1's left knee and above was swollen and warm with no redness noted and there had been no fall or injury. The on call NP responded electronically at 10:56 AM on 7/3/25 to draw stat blood work, obtain a 2 view x-ray of his left knee and a venous doppler of his left lower extremity. The on-call provider responded electronically on 7/3/25 at 12:45 PM and instructed electronically to attempt the x-ray and doppler and notify the provider if he refused the doppler and x-ray. Nurse # 4 (the day shift Nursing Supervisor) was interviewed on 7/16/25 at 3:29 PM and reported the following information. Around 7:55 AM, on 7/3/25 Nurse # 3 had asked her to look at Resident # 1's knee because he was having some pain and the night shift Nurse had already given him acetaminophen. At the time she looked at Resident # 1's knee, he was not in distress or yelling. She saw no signs of a fracture. The area above his knee was swollen and warm. Usually the resident was "nonchalant" about things and on that day he indicated it hurt a little. The facility has a means of communication where they can electronically communicate with a provider via way of a secure messaging system. They can send a message and upload pictures if needed. She communicated with the provider through this system and sent a picture of his knee. She received orders back. One of the orders was for a x-ray. She entered the order. Through the facility's system when it is entered as an order then it is automatically sent electronically to the x-ray company that does their x-rays. She also called the x-ray company. She was on duty on 7/4/25 and nothing was mentioned about Resident # 1. She was off on 7/5/25. NA # 5 was interviewed on 7/16/25 at 4:05 PM and reported the following information. He cared for Resident # 1 on 7/3/25 during the 3:00 to 11:00 PM shift. During his shift he had transferred the resident back to bed on 7/3/25 with assistance and a total care mechanical lift. Record review revealed no narrative nursing notes for the date of 7/4/25. NA # 7 was interviewed on 7/16/25 at 3:50 PM. NA # 7 had been assigned to Resident # 1 on 7/4/25 from 3:00 PM to 11:00 PM shift. NA # 7 reported the following information. Resident # 1 was up in the chair when she arrived to work. She and NA # 8 used the total mechanical lift to place him back in bed and she turned and repositioned the resident during her shift.	F0689		

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F0689 SS = SQC-J	Continued from page 59 NA # 9 was interviewed on 7/17/25 at 11:45 AM and reported the following information. She had cared for Resident # 1 from 7:00 AM to 11:00 AM (a partial shift). When she came on duty she noted that Resident # 1 was still in bed and this was unusual because he was normally assisted up out of bed by night shift. She talked to NA # 2 about why the resident was still in bed and NA # 2 said because his leg was swollen. She looked at Resident # 1's leg and his knee was swollen. She told him good morning and he did not complain of pain while lying in the bed. Later that morning, Resident # 1's family came to visit and wanted him up out of bed. She (NA #9), Restorative Aide #2, and Nurse # 5 helped get Resident # 1 out of bed while using the total care mechanical lift. When they would turn him to get him ready to get up and out of the bed, he would say "Ah-my leg." Once in the chair, he did not complain. Record review revealed the first nursing narrative note on 7/5/25 was entered at 1:54 PM by Nurse # 7 who documented, "writer contacted mobile x-ray to obtain x-ray results; x-ray not performed. Order was refaxed and verbally requested STAT XR (x-ray) to L (left) knee." Review of Resident # 1's record revealed documentation of an electronic message sent to the on-call Physician Assistant by Nurse # 7 on 7/5/25 at 4:15 PM through their secure app. Nurse # 7 communicated that they did not have a hard copy of the x-ray result but the technician stated she did not feel comfortable doing any more bone x-rays because the femur bone appeared fractured and unstable, and that a picture was being uploaded to the on-call provider. Nurse # 7 further noted she was sending the resident to the hospital. The on-call Physician Assistant responded electronically at 4:17 PM on 7/5/25 that the bone looked fractured and displaced and to notify the provider when the resident returned/ follow up with the primary physician. On 7/5/25 at 4:16 PM Nurse # 9 documented on the MAR she administered 650 mg of acetaminophen per an as needed order. On 7/5/25 at 4:32 PM Nurse # 7 made a notation in the nursing narrative notes she had been called to the resident's room by the x-ray technician, and that there was a concern the resident's femur was broken. The X-ray technician did not feel comfortable further moving the resident. Attempts were made to notify the RP.	F0689		

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F0689 SS = SQC-J	Continued from page 60 On 7/5/25 at 4:32 PM Nurse # 7 noted 911 was called. On 7/5/25 at 4:39 PM Nurse # 7 noted the resident was transferred to the hospital. Review of hospital records for Resident # 1's hospital stay of 7/5/25 through 7/10/25 revealed the following information. There was a notation that the resident had extensive swelling, bruising and deformity to the distal femur. Hospital x-rays were done and showed Resident # 1 had a comminuted displaced fracture at the distal femoral shaft. (A comminuted fracture is one in which the bone breaks in three or more places and the femur is a leg bone). A CT (computerized tomography) scan showed that the fractured bones were in close proximity to the proximal popliteal and distal superficial femoral arteries in the resident's leg with no definite evidence of injury to the blood vessels. An x-ray of the left shoulder, which was done while hospitalized, showed findings "most likely compatible with complete rotator cuff tear." (The rotator cuff is a group of four tendons and muscles that stabilize and rotate the shoulder joint. These tendons connect the muscles to the bones of the shoulder, which allows stability of the shoulder joint). A discussion was held with Resident # 1's RP who was documented as saying that the resident had always wanted everything done for him and she wanted to talk to other family members before making a final decision about surgery. An orthopedic consult was obtained and the orthopedic recommended the resident's leg be placed in a left knee immobilizer and that surgery would be planned. Review of the orthopedic surgeon's note revealed surgery was done on 7/8/25 and it was more for comfort as opposed to fixation of the fracture. According to the orthopedic surgeon's note, the bone had not come through the skin until they took him to surgery and then the bone did so. The orthopedic surgeon noted the resident was in terrible pain. Review of Resident # 1's hospital discharge summary, dated 7/10/25, revealed Resident # 1 was discharged for comfort care. The discharging physician noted that the resident had experienced a complicated hospital course and prior to being taken to surgery he had developed fevers. The resident's prognosis was discussed with the family before discharge and the resident was made comfort care. A review of hospice records revealed Resident # 1 expired on 7/20/25 at 9:42 PM while under hospice care. Resident # 1's facility physician, who serves as the facility Medical Director, was interviewed on 7/18/25 at 1:40 PM and again on 7/22/25 at 2:35 PM and reported the following information. She was out of town when the	F0689		

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F0689 SS = SQC-J	Continued from page 61 on-call provider was contacted on 7/3/25. The facility staff had not reported the fall and they had delayed in getting the x-ray. For her or other providers, if the staff had reported that the resident had fallen and was yelling loudly enough to be heard in the hallway about his leg, then she or an on-call provider would have instructed the staff to get the x-ray, stabilize his leg, and not move him until the results were known. The physician reported in general an undiagnosed comminuted fracture femur fracture is associated with a difficult surgery and with poor healing. The physician further reported prior to the fracture, the resident did have multiple diagnoses and anyone could die unexpectedly at any moment, but Resident # 1's death was not expected to be imminent before he sustained the fracture. The physician felt the fracture had contributed to the resident's death which was earlier than expected. The medical director was interviewed about the resident's torn rotator cuff and reported that with normal aging some tears can also occur. As medical director, the Administrator had been in contact with her (the physician) and the facility had done a corrective action plan. The Administrator was interviewed on 7/16/25 at 3:00 PM and again on 7/17/25 at 6:00 PM revealing the following information. Initially she was informed about the fracture when it was identified on 7/5/25 and started an investigation. At the time, no one had reported a fall or trauma. Multiple staff were interviewed, which included NA # 1, NA # 2, and Nurse # 1. None of these three reported a fall, but she was able to determine through her investigation that the resident started having knee pain when they were caring for him. The facility was equipped with hall cameras, and she viewed the camera footage while doing the investigation. She saw that NA # 1 and NA # 2 went into Resident # 1's room on 7/3/25 with a sit-to-stand lift at 6:02 AM. This was not the correct lift for the resident. On the video after NA # 1 and NA # 2 were in the room, she could see Nurse # 1 enter the room. NA # 1 and NA # 2 were still in the room at the time. Soon after he went in, one of them came out and obtained a vital sign machine and they were in the room for awhile. None of these three staff members had reported the fall to Nurse # 2 (the Night Shift Nursing Supervisor) or to the physician. They all maintained that he had not fallen. She did suspend them during the investigation for using the wrong type of lift when it was established they had done so and further questioned them. On 7/14/25 Nurse Aide # 1 was honest and explained Resident # 1 had fallen and there had been a plan not to disclose the fall. Following the incident the facility had developed a corrective action plan as	F0689		

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F0689 SS = SQC-J	Continued from page 62 part of their quality assurance program. The Administrator was notified of immediate jeopardy on 7/23/25 at 2:01 PM. The Administrator presented the following corrective action plan. Identify how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The resident was assessed and care planned for use of a mechanical lift for transfers. Resident #1 was identified to have a comminuted fracture of his femur on 7/5/25 as a result the fall. The resident experienced pain as a result of the fall with fracture. He was hospitalized, underwent surgery, placed on hospice, and expired. During an interview with NA #1 on 7/14/25 by the Administrator, NA #1 stated the resident had fallen to the floor from sitting on the side of the bed on 7/3/25. NA #1 stated NA #2 and Nurse #1 assisted her in getting Resident #1 up from the floor and placing him in chair. Nurse #2 entered the room to find the resident in the chair. Nurse #1, NA #1 and NA #2 were terminated on 7/14/25. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to suffer a serious outcome because of noncompliance. The Quality Assurance Nurse (QA Nurse), Director of Health Services (DHS), Assistant Director of Nursing (ADON), wound nurse and Infection Control Nurse completed a 100% body audit related to skin and potential signs of new fractures with no new findings. The audit started on 7/8/25 and completed 7/8/25. The QA nurse completed an audit on all falls from 6/7/25 to 7/8/25. This audit also included notification of physician and/or physician extender – All falls during this time period were reviewed to ensure the medical provider was made aware of any falls or injuries. The audit was completed 7/8/25. The DHS and Senior Nurse consultant reviewed facility activity report in the electronic health records which includes change of conditions from 6/7/25 to 7/7/25. There were no significant changes in conditions for any resident that had not been reported to the medical	F0689		

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F0689 SS = SQC-J	Continued from page 63 provider. Address what measures will be put into place or systemic changes are made to ensure the deficient practice will not recur. All nurses, therapy and NAs were re-educated by the DHS, QA Nuse, and the ADHS regarding resident profiles (a resident profile is the care guide that NAs and the Nurses can access electronically and includes how to care for the resident). Additionally, all nurses and NAs were educated to check the resident profile regularly for any changes and updates to resident care. The in-service was started on 7/8/25 and completed on 7/11/25. All Nurses and NAs were in-service by the DHS, QA Nurse and the ADHS regarding proper mode of resident transfer and types of transfers and mechanical lifts. The in-service included a checklist with a visual demonstration. The inservice was started on 7/8/25 and completed on 7/11/25. All in-services given in this plan of correction will be incorporated into the new hire orientation effective 7/15/25. Staff will not work after 7/14/25 until they have been in-serviced on all applicable in-services. The QA Nurse will provide in-services and obtain signatures on all newly hired staff. The QA nurse is tracking education and the DHS, ADHS, and nurse managers are providing all the education after 7/14/25. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The decision to monitor and take to QAPI was made on 7/10/25. The DHS or Nurse Manager will use the Admission Readmission Tool to ensure new admissions have accurate lift assessments, resident profiles and care plans to ensure mode of transfer is in the resident profile. The results of the audits will be reviewed by the QA Nurse weekly x 12 weeks. The results will be submitted to the Executive QA Committee monthly x 3. This team includes the Director of Health Services, Assistant Director of Health Services, Administrator, Quality Assurance Nurse and Wound Nurse. The Medical Director will attend no less than once quarterly. The DHS or Nurse Manager will use the Mode of Transfer Audit Tool to ensure clinical staff are checking the resident profile to ensure they are using the proper mode of transfer for each resident. Staff will be	F0689		

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F0689 SS = SQC-J	Continued from page 64 observed using the correct mode of transfer for the residents. The staff will also be asked to show the auditor how to find the correct mode of transfer in the resident profile. The tool will be used 5 x per week x 4 weeks and two x per week x 4 weeks, then weekly x 4 weeks. The observational audits will be conducted on varied days of the weeks to include weekends and varied shifts. The results of the audits will be reviewed by the QA Nurse weekly x 12 weeks. The results will be submitted to the Executive QA Committee monthly x 3. The facility alleges an immediate jeopardy removal date and compliance date of 7/15/25. The facility's corrective action plan was validated by the following measures: On 7/16/25 beginning at 9:50 AM an initial tour of the facility was conducted. Multiple residents were interviewed regarding the care they received at the facility and residents reported they were pleased with care and services. There were no residents who reported problems with transfers or accidents. Staff were observed present and responding to residents' needs. There were no residents who were observed with extensive bruising which might signify a severe accident. A family member of a cognitively impaired and dependent resident was interviewed on 7/16/25 at 5:00 PM and reporting she was pleased and referred to the nursing staff as "perfect." On 7/17/25 and 7/18/25 the facility presented audits per their corrective action plan and documentation of in-services per their corrective action plan with sign in sheets. Staff members from different shifts were interviewed and reported they had attended in-service training. Staff members were able to voice where to find information regarding how a resident transferred and reported they had received training with the mechanical lifts. The facility's corrective action plan was validated with an Immediate Jeopardy removal date and compliance date of 7/15/25.	F0689		