PRINTED: 03/14/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345247	B. WING			1	C
NAME OF P	ROVIDER OR SUPPLIER	010211	1	STREET ADDRESS, CIT	TY, STATE, ZIP CODE	02/	18/2022
	UIDOINO OFNITED			581 NC HIGHWAY 16	SOUTH		
VALLEYN	IURSING CENTER			TAYLORSVILLE, NO	28681		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CC	DER'S PLAN OF CORRECTION PRRECTIVE ACTION SHOULD B FERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		E	00			
F 000	complaint investigation through 2/18/22. The compliance with the research Prepared INITIAL COMMENTS An unannounced one complaint investigation	requirement CFR 483.73, Iness. Event ID# LG2K11. site recertification and on was conducted on 2/14/22 o complaint allegations were ont substantiated.	F	00			
F 684 SS=J	J. CFR 483.25 at tag F J. The tags F 684 and F Substandard Quality Immediate Jeopardy removed on 2/17/22. conducted. Quality of Care CFR(s): 483.25 § 483.25 Quality of ca Quality of care is a fu applies to all treatmet facility residents. Bas assessment of a resident residents receive accordance with profe practice, the compreh care plan, and the residents.	began on 10/31/21 and was An extended survey was are Indamental principle that Int and care provided to It is deed on the comprehensive Ident, the facility must ensure It is treatment and care in It is essional standards of Inensive person-centered	F	84			3/11/22
I ABORATORY		SUPPLIER REPRESENTATIVE'S SIGNATURE			ITLE		(X6) DATE

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 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.

Electronically Signed

03/11/2022

NAME OF PROVIDER OR SUPPLIER VALLEY NURSING CENTER VALLEY NURSING CENTER SITERET ADDRESS, CITY, STATE, ZIP CODE SSI NO HIGHWAY 16 SOUTH TAYLORSVILLE, IN CARD REFORMS THE PROPERTY AND THE PROVIDERS PLAN OF CORRECTION (FACHO DEFORMS THAT SITE RESCRICTION FY ISLA (FACHO DEFORMS THE ADDRESS PLAN OF CORRECTION CONTROLL) DEFORMS THE PROPERTY OF THE PROPERTY AND THE PROPERTY OF THE PROPETY OF THE PROPETY OF THE PROPETY OF THE PRO	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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		345247	B. WING _		02	/18/2022	
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VALLEY N	URSING CENTER			TAYLORSVILLE, NC 28681			
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F 684	Continued From page	ge 2	Fé	684			
F 684	6/29/15 with diagnovegetative state with severe osteoporosis. A physician's order Resident #1 was to anticoagulant- blood daily at bedtime. A quarterly Minimum assessment dated 0 #19 had a urinary catreatments including tracheostomy care anticoagulant. A review of a docum (NA) #1 dated 10/3 changing [Resident and bouncing. I courolled off the bed. [F#2] and I put a bed back into bed. We the document did not proposed to the sident #19 was to the sident #19 was to the sident #19 was to the sident's room. C.N. A review of a document dated 10/31/21 read resident's room. C.N. assistance getting rec.N.A. in getting into the sident with the sident in the sident in the sident's room. C.N. assistance getting rec.N.A. in getting into the sident in the sident's room. C.N. assistance getting into the sident in t	dmitted to the facility on sees that included a persistent in chronic ventilator usage and state and sees that included a persistent in chronic ventilator usage and sees that included a persistent in chronic ventilator usage and sees that included a persistent (and it thinner) 20mg (milligram) In Data Set (MDS) 19/10/21 indicated Resident at the persistent and received an and ventilator and received an and ventilator and received an and ventilator and received an and the persistent (and the persiste	F	Resident #19 to the shower her to the shower room and #1 completed a shower bed a large amount of bowel on Respiratory Therapist/NA#2 # 1 after resident #19 had be transferred back to the bed performed a head to toe as: Resident #19 after she was of the fall. Nurse #1 noticed resident had an abrasion to and her right forearm and the leg was positioned different very flexible at the top near. Then at approximately 6:45 came on shift and he and N assessed the resident toget. Physician on call was notified and gave new orders for an leg. Nurse #2 stated that due assessment and thereafter, remained at her baseline, in grimacing, or nonverbal sign were observed. Nurse #2 in resident seleg while awaiting report. X-ray report received fractures of right tibia and fi #2 reported the X-ray result Physician and the order was Resident #19 to be sent to the Emergency Room. EMS are approximately 6:00pm on 1 transport. Resident returned at 00:15 on 11/1/21. The fact Practitioner assessed and desident on the morning of 10 on 11/1/2021 the DON sus	Nurse Aide rause she had her. 2 notified Nurse seen Nurse #1 sessment of made aware d that the her abdomen hat her right ly and was her knee. am Nurse #2 surse #1 ther. The red at 6:59am X-ray of right ring the Resident #19 of facial has of pain nobilized the red that X-ray in the red indicating bula. Nurse is to the received for the CVMC rived at 0/31/2021 to d to this facility cility Nurse revaluated this 11/1/21.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
						(С
		345247	B. WING _			02/	18/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				58	81 NC HIGHWAY 16 SOUTH		
VALLEY	IURSING CENTER			T	AYLORSVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	4 Continued From page 3		F 6	584			
F 684	RT/NA #2 on 10/31/2 #19 was sitting on the in between the bed at Resident #19 was cover the floor and Recatheter was lying on #19. NA #1 stated he Resident #19 back in NA #1 had already re #1 just needed help to back to bed. After Reshower, NA #1 comm #3 that the catheter n RT/NA #2 wrote after alerted the nurse abo and notified her that the replaced. At that time unaware of the fall.	1 read, in part, "Resident e floor/leaned up against bed and the wall air conditioner. Wered in BM; BM was all sident #19's fully inflated the floor under Resident just needed help getting the bed. RT/NA #2 believed ported to the nurse and NA or transfer Resident #19 sident #19 returned from the lented to RT/NA #2 and NA eeded to be replaced. This conversation, he ut what he had observed he catheter needed to be	F€	584	terminated from employment on 11/3/2021 due to not immediately notify the nurse of the fall and for moving the resident prior to her being assessed by the Nurse. # 2 - Address how the facility will idention other residents having the potential to laffected by the same deficient practice. Beginning on 11/1/2021, the DON begareviewing and monitoring all fall incider All fall incidents are monitored to ensur immediate nurse notification and assessment before the resident was moved. As of 3/11/22 all falls incidents have been in compliance with timely nunotification and assessment prior to the resident being moved. # 3 - Address what measures will be put	fy oe ; an nts. re	
	Resident #19 was on NA #1 to move her from #2 stated that he assume reported the fall to Number about it on his way be a was five to ten minute #1 to transfer Resident There were no writter #3 provided by the factor of the fac	the floor prior to assisting om the floor to bed. RT/NA umed NA #1 had already urse #1 but stated he told her ack to his unit. He stated it as after he had assisted NA ant #19 back to the bed. In statements written by NA cility. #3 on 02/16/22 at 7:15 PM hilliar with Resident #19 and 00 Hall on the night of stated she was approached nce by NA #1 when he was			into place or systemic changes made to ensure that the deficient practice will not recur; On 11/1/21 the DON provided in-service training for all Certified Nursing Assistation immediately notifying a Nurse upon observation of any resident experiencing fall and that the nurse is to assess the resident before the resident is moved. On 11/1/21 the DON began reviewing a falls that occur to determine if a nurse on notified immediately of the fall and the nurse performed an assessment prior to the resident being moved. All fall incidents have been in compliance with requirement of immediate nurse notification and nurse assessment of the	e nts ng a all was	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345247	B. WING			1) 18/2022	
NAME OF PI	ROVIDER OR SUPPLIER			S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	10/2022	
				58	81 NC HIGHWAY 16 SOUTH			
VALLEY N	IURSING CENTER				AYLORSVILLE, NC 28681			
(X4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 684	Continued From page	e 4	F	684				
		. NA #3 said RT/NA #2			resident.			
		omy care and ensured			On 2/16/22, the DON implemented fac	ility		
		operly attached to the			wide in-service training for all staff			
	I -	eft the room to alert the			(dietary, housekeeping, activities,			
		w the catheter needed to be			maintenance, Social Workers, Therapy	/		
		ed she did not know that			staff, office staff, Licensed nursing staff			
	Nurse #1 was not ma				and Certified Nursing Assistance include			
		1 and did not alert Nurse #1			all agency staff on the Fall Protocol tha	-		
	herself.				includes:			
					Notifying a Licensed Nurse immediat	ely		
	An incident report dat	ted 10/31/21 at 5:50 AM			before moving the resident.	-		
	written by Nurse #1 re	ead, in part, "I assessed			Before the resident is moved, the			
	resident for injuries a	nd noted abrasions on right			Licensed Nurse shall perform an			
	forearm and left lowe	r abdomen. Also, right lower			assessment of the resident to determin	ie if		
	leg swelling just below	w the knee and some			any injury has occurred. If no obvious			
	discoloration noted. I	was not informed of fall until			injury is present, the resident should be	Э		
		bed and taken to shower			assisted back to the bed, chair, or			
		C.N.A. (NA#1) said he was			wheelchair using the appropriate transf	fer		
	changing her, and sh	e rolled off bed into floor."			device.			
	A	h. N			The Director of Nursing informed	1114.		
		n by Nurse #1 on 10/31/21 at esident #19 had noted			Nursing Supervisors of their responsible to continue this education / re-education	•		
					on all shifts for all staff.)TI		
	swelling to her right lo	ower extremity.			The Director of Nursing and / or her			
	An interview with Nur	se #1 on 2/15/21 at 1:42PM			designee will track which staff has bee	n		
		or Resident #19 on the night			educated by comparing educational ro			
		to 7:00 AM). Nurse #1			to the employee work schedule.			
	,	ade aware that Resident #19			Any Staff not working on 2/16/22 are			
		er shift while Resident #19			required to receive this education on the			
		ncontinence care by NA #1.			next scheduled workday. Staff will not			
	. .	/NA #2 making her aware			allowed to work until this education is			
		ter needed to be replaced,			completed.			
		he thought NA #1 told her			New educational material has been			
		he went to the room about			added to the New Hire Orientation pac	ket,		
	the catheter. Nurse #	1 explained NA #1 reported			new CNA clinical competencies, and th	ne		
	that Resident #19 beg	gan coughing and jerking			facility information that is provided to			
	after she was rolled o				Nursing Agency staff.			
		esident #19 came out of bed						
	because NA #1 was i	unable to catch her before			# 4 - Indicate how the facility plans to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345247	B. WING		C 02/18/ 2	2022
NAME OF P	ROVIDER OR SUPPLIER	0.02.11	 	STREET ADDRESS, CITY, STATE, ZIP CODE	02/10/2	2022
NAME OF T	NOVIDER OR SOLT LIER					
VALLEY N	URSING CENTER			581 NC HIGHWAY 16 SOUTH		
				TAYLORSVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE CO	(X5) OMPLETION DATE
F 684	Continued From page 5		F 68	4		
	she came off the bed	and landed on the floor.		monitor its performance to make	sure that	
	Nurse #1 found Resid	lent #19 bathed and back in		solutions are sustained; and Inclu		
	bed when she arrived	at the room to assess her.		when corrective action will be con		
	She had abrasions to	her abdomen and right				
	forearm as well as sw	velling in her right lower		The Director of Nursing and/or he	r	
	extremity. Nurse #1 of	described Resident #19's		designee will continue to monitor	all fall	
	right lower extremity t	o be "more flexible and		incident reports to determine if a	nurse	
	different." Nurse #1 st	tated she did not notify the		was notified immediately of the fa	ll and	
	provider at the time of	f her assessment but		the nurse performed an assessme		
	-	ities along to the oncoming		to the resident being moved. The		
		e #2). Nurse #1 indicated		who completes the incident report		
	she was busy finishin	=		interviewed to assure that they we		
	·	provider at the end of her		immediately notified of the incider		
		not assess Resident #19 to		that the resident was assessed pr		
	have sustained major	injuries.		being moved. The fall incident m	-	
				with staff interviews will be record		
		ritten by Nurse #2 and dated		newly implemented audit sheet tit		
		ndicated Resident #19 was		Incident Monitoring". This monito		
		osterior (AP) and lateral		was implemented 3/1/22 and will		
	x-ray of the right lowe	•		for a minimum of six (6) months.	incident	
		se #2 on 2/15/21 at 4:45 PM				
	revealed he arrived to			The results of these audits will be		
		M. He stated Nurse #1		reported monthly to the Quality As		
	•	Resident #19 had fallen out		Performance Improvement comm	-	
		he shift and the staff had not		the Director of Nursing. The resul		
	T	r until after she was placed		reviewed and discussed. The Qu	-	
		e #2 explained that he and		Assurance Committee will assess		
		sident #19's room to assess		modify the action plan as needed		
		er right leg was positioned		ensure continued compliance with	1	
		very "flexible" at the top, was abnormal for Resident		immediate nurse notification and assessment of the resident prior t		
		that during the assessment		moving after a fall incident.		
		ent #19 remained at her		moving after a fall littlucit.		
	baseline with no visib					
		in that he could recall. He				
		d to the nurse's station and				
		and obtained new orders.				
		nift the portable x-rays were				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	IPLE CONSTR	(X3) DATE SURVEY COMPLETED			
		345247	B. WING			C 02/18/2022	
	ROVIDER OR SUPPLIER			581 NC HI	DDRESS, CITY, STATE, ZIP CODE IGHWAY 16 SOUTH SVILLE, NC 28681	1 02/	10/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE
F 684	A review of x-ray rep in -house company a 10/31/21 confirmed a tibia and fibula. According to an Emedated 10/31/21, Resiste ER after a traumileg. Per the report, it Resident #19 fell dur she was dropped dur to the shower stretch splinted because she candidate and ordere and subsequently dison 11/1/21. During an interview of (DON) on 2/15/22 at documentation titled #19-10/31/21 5:50 A 11/2/21 was provided	d in fractures to her tibia and le. orts from both the contracted and the hospital dated acute fractures to the right ergency Room (ER) report ident #19 was transported to atic injury of the right lower was unable to determine if ring incontinence care or if ring a transfer from the bed her. Resident #19 was a was not a surgical ed to be non-weight bearing scharged back to the facility	F	584	DETIGIENCY)		
	reeducated on position position." The DON fall in the facility, who on the floor, a staff in notify a nurse prior to also explained she direceived a shower by Nurse #1. The DON	cility nurses and NAs were oning a resident in lateral reported that following any en a resident was found to be nember should immediately o moving a resident. She etermined Resident #19 had efore assessed for injury by stated she did not think NA ag related to the fall but was					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345247	B. WING_			C
	ROVIDER OR SUPPLIER URSING CENTER	340241		STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	<u> </u>	02/18/2022
(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 CORRECT (CEACH CORRECTIVE ACTION SHOOTH CROSS-REFERENCED TO THE APPLICATION OF THE APPLIC	OULD BE	(X5) COMPLETION DATE
F 684	12:00 PM revealed of notify the nurse if a murse should assess the resident is move. An interview with the PM revealed he expendanges in condition Physician stated he an accident. The Administrator was Jeopardy on 2/16/22. The facility provided of Identify those recipare likely to suffer, a because of the none Resident # 19 slid of incontinent care at a Aide (NA) #1 request Therapist/Nurse Aide under the resident's transferred her back Therapist/NA#2 ensiairway was patent, we tracheostomy tube was being ventilated the room. Nurse Aide transferred Resident and took her to the separation of the sep	dministrator on 2/16/22 at each expected all staff to resident had a fall and a state resident for injury before d to ensure safety. Physician on 2/17/22 at 2:01 rected to be contacted with all is to include a fall. The thought this occurrence was as notified of the Immediate at 12:11 PM. The following IJ removal plan. The following IJ removal plan. The bed to the floor during proximately 5:50a. Nurse at the help from Respiratory are all and to the bed. Respiratory are that the resident's rentilator circuit and appropriately before leaving at #1 and Nurse Aide #3 then at #19 to the shower stretcher who wer because she had a large	F 6	84		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7. BOILD	_		Ι ,	C
		345247	B. WING				-
NAME OF D		343241	5		TREET ADDRESS CITY STATE 71D CODE	02/	18/2022
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY N	URSING CENTER				81 NC HIGHWAY 16 SOUTH		
				Т	TAYLORSVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page fall. Nurse #1 notice abrasion to her abdo and that her right leg and was very "flexib Then at approximate shift and he and Nur together. The Physic 6:59am and gave ne leg. Nurse #2 stated and thereafter, Residual page of pain were observed to the page of pain were observed tibia and fibula. Nur results to the Physic received for Resider Emergency Room. 6:00pm on 10/31/20 returned to this facility Nurse Practitic evaluated this reside On 11/1/2021 the Do incident investigation subsequently termin 11/3/2021 due to not nurse of the fall and to her being assessed To identify any other affected; beginning of began reviewing and All fall incidents are immediate nurse not	de that the resident had an omen and her right forearm g was positioned "differently" le" at the top near her knee. Lety 6:45am Nurse #2 came on se #1 assessed the resident cian on call was notified at lew orders for an X-ray of right that during the assessment dent #19 remained at her rimacing, or nonverbal signs led. Nurse #2 immobilized the lawaiting the x-ray report. It indicating fractures of right less #2 reported the X-ray lian and the order was let #19 to be sent to the CVMC lems arrived at approximately let to transport. Resident lety at 00:15 on 11/1/21. The lioner assessed and lent on the morning of 11/1/21. On suspended NA#1 while an an was conducted. NA#1 was lated from employment on the immediately notifying the for moving the resident prior led by the Nurse. I resident who may have been lon 11/21/2021, the DON dimonitoring all fall incidents.		684	DEFICIENCY)		
	nurse notification an -Specify the action the process or system fa	peen in compliance with d assessment. he entity will take to alter the ailure to prevent a serious hm occurring or recurring, and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345247	B. WING_			C 2/18/2022
	ROVIDER OR SUPPLIER URSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681		211012022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	for all Certified Nursin notifying a Nurse upo	ne complete I provided in-service training ng Assistants on immediately	F 6	84		
	to assess the resider moved. On 11/1/21 the DON occur to determine if immediately of the fa an assessment prior All fall incidents have requirement of immenurse assessment of On 2/16/22, the DON	began reviewing all falls that a nurse was notified and the nurse performed to the resident being moved. been in compliance with diate nurse notification and the resident.				
	Workers, Therapy stanursing staff and Cerincluding all agency sincludes: "Notifying a Licenbefore moving the residual standard s	ies, maintenance, Social aff, office staff, Licensed tified Nursing Assistance staff on the Fall Protocol that sed Nurse immediately sident. ent is moved, the Licensed				
	resident to determine If no obvious injury is be assisted back to the using the appropriate "The Director of N Supervisors of their reducation / re-educati "The Director of N will track which staff to comparing education work schedule. "Any Staff not wo to receive this education	if any injury has occurred. present, the resident should ne bed, chair, or wheelchair				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION 3		(X3) DATE SURVEY COMPLETED	
		345247	B. WING			C 02/18/2022
	ROVIDER OR SUPPLIER URSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681		2110/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	Continued From page 10		F 68	34		
	the New Hire Oriental clinical check off list, that is provided to Nu Alleged IJ removal da A credible allegation	material has been added to tion packet, new CNA and the facility information ursing Agency staff. ate: 2/17/22 validation for quality of care				
	review included Residual plan. Notable revision #19's transfer status person draw sheet or plan which are availa in-service training recinclude nursing, hous dietary, activities, and serviced on notification changes in a residentiand staff were not to	facility on 02/17/22. Record dent #19's Kardex and care as were as follows: Resident has been updated to 2-n both the Kardex and care ble to all nursing staff. The cords reflected all staff to bekeeping, maintenance, diadministrative staff were in on of a nurse with any the condition to include a fall move a resident without a and direction to do so.				
	validated.	val date of 2/17/22 was				
	CFR(s): 483.25(d)(1) §483.25(d) Accidents The facility must ensu §483.25(d)(1) The re- as free of accident has §483.25(d)(2)Each re- supervision and assis accidents.		F 6	39		3/11/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDI	_			С
		345247	B. WING _				/18/2022
NAME OF PI	ROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				58	81 NC HIGHWAY 16 SOUTH		
VALLEY N	IURSING CENTER			T.	AYLORSVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
			+		22.10.2.10		
F 689	Continued From page 11 Based on record review and staff interview, the facility failed to provide incontinence care			689	# 1 - Address how corrective action w be accomplished for those residents	ill	
	according to an estable who was on a ventila	oblished plan to Resident #19 tor and in a persistent rse Aide #1 (NA #1) lost			found to have been affected by the deficient practice:		
	process of providing	19 when he was in the incontinent care to Resident ugh and bounce on the air			Transfer status for Resident #19 was evaluated by the Physical Therapist Doctor of Physical Therapy for patient		
	#19 from falling out o	s unable to prevent Resident of bed. NA#1 did not of a nurse. Prior to a nursing			safety and mobility 2/17/2022. Therapi determined resident is dependent on functional mobility and would benefit	st	
	transferred Resident	for injury, nurse aides #19 three times, from the the bed to the shower			utilizing a draw sheet for lateral transfe with total assistance from 2+ staff. Kardex and Care Plan was updated to		
	stretcher and then from	om the shower stretcher to sfers were performed by two of the mechanical lift. This			person assist for incontinence care on 2/16/2022.		
		esident #19). Resident #19 gency room and diagnosed			# 2 - Address how the facility will iden other residents having the potential to affected by the same deficient practice	be	
	The immediate jeopa	rdy began on 10/31/21 when			On November 1, 2021 Director of Nurs implemented in-service training for all	ing	
	Resident #19 fell from incontinence care an The immediate jeopa 02/17/22 when the fa	d sustained acute fractures. Irdy was removed on			Nursing staff on Safe Positioning of Resident when Turning and Providing Incontinence Care Independently. In service covered positioning a resident	in	
	implemented a credib jeopardy removal. Th	ole allegation of immediate ne facility remained out of			lateral position, using proper body mechanics, assure residents face is no	ot	
	(an isolated situation potential for more that	er scope and severity of a D with no actual harm with an minimal harm that is not			obstructed. Use supporting devices. The education is covered in orientation and was used as a refresher to remind the	i	
	, , ,	to ensure education was in systems put into place were			nursing staff to be cognizant of the residents position on the bed during incontinent care and required no		
	Findings included:				additional steps for implementation. On February 16, 2022, Director of Nursing, MDS RNS, and Nursing		
	Pecident #10 was ad	mitted to the facility on			Supervisors reviewed all other residen	t⊓e	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		345247	B. WING _			02/	18/2022	
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
VALLEYA	UDOING CENTED			581 NC HIGHWAY 16 SOUTH				
VALLEY N	URSING CENTER			T	AYLORSVILLE, NC 28681			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 689	vegetative state with severe osteoporosis. A physician's order da	es that included a persistent chronic ventilator usage and ated 8/1/19 indicated	F	689	residing in the facility to determine thos who needed two person assistance wit incontinence care and those residents who required a mechanical lift for transfers. The MDS nurses then review each Resident⊡s Kardex (tool used in	h /ed		
	Resident #1 was to receive Xarelto (an anticoagulant- blood thinner) 20mg (milligram) daily at bedtime. A quarterly Minimum Data Set (MDS) dated 09/10/21 indicated Resident #19 required physical assistance from two or more persons with bed mobility, transfers, and toileting. She had a urinary catheter and was always incontinent of bowel. She received special respiratory treatments including oxygen, suctioning, tracheostomy care and was on a ventilator. She				electronic health record to inform staff of care requirements) and made changes where necessary to provide information	of n to		
					staff on amount of assistance needed f safe transfer of resident, the mobility status of a resident and the required number of staff to provide safe toileting/incontinence care to a residen while in bed. This was completed on 2/16/2022.			
	anticoagulant medica A self-care deficit car	e plan revised on 1/24/22			# 3 - Address what measures will be purinto place or systemic changes made to ensure that the deficient practice will no recur;	0		
	indicated Resident #19 was dependent for transfers and incontinence care with rounds and as needed. The care plan did not indicate how many staff should provide incontinence care or how to transfer the resident. According to the DON, on 2/15/22 at 5:00 PM, most ventilator residents in a vegetative state are transferred using a mechanical lift which required the assistance of 2 staff members. NA #1's statement read, "while I was changing Resident #19, she "started coughing and bouncing. I couldn't catch her before she rolled off the bed." RT/NA #2 and I put a bed pad under her and lifted her back into bed. We then took her to the bath."				All resident falls are reviewed in Mornir Standup meetings. The Director of Nursing presents the review of falls to t clinical team. Clinical team consists of DON, MDS Nurse, Wound Care Nurse	he		
					Nursing Supervisors, Administration, Director of Rehab, Social Worker, Director of Respiratory Therapy, Root cause of why the fall occurred is investigated by DON and shared with all disciplines			
					participating in the review. Interventions are put in place to keep the resident from having a recurring fall. MDS Nurse add interventions to the care plan which populates the Kardex. Nursing Supervisors inform hall staff of any updates in plan of care. Previous	m		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION					
			A. BOILDII			C				
		345247	B. WING _			0,	_			
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02	LITOIZOZZ			
				58	B1 NC HIGHWAY 16 SOUTH					
VALLEY N	URSING CENTER			T	AYLORSVILLE, NC 28681					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)			
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE			
F 689	Continued From pag	ge 13	F	589						
		contact NA #1 were made			implemented interventions are reviewe	d				
	without success.				at our monthly At Risk meetings to determine effectiveness. If the					
	A review of a docum	nent written by RT/NA#2			intervention does not work and a reside	ent				
		l, in part, "walking past			has a repeat fall, root cause is evaluate					
		I.A (NA #1) asked for			again and additional interventions put i					
		esident in bed. Assisted			place or previous interventions remove					
		bed. Resident covered in			Interventions are updated in the care p	ON ON DATE ON DATE ON DATE ON COMPLETION DATE				
	BM (bowel moveme	nt). C.N.A took resident to			immediately after the meeting and staf	f	C 02/18/2022 (X5) COMPLETION DATE Int d int d int s he for			
	shower. "				notified by Nursing Supervisors. CNA					
					have access to both the care plan and	the				
		witness statement signed by			Kardex.					
		21 read, in part, "Resident #1								
	_	oor/leaned up against bed in			On February 16, 2022, the Director of					
		d the wall air conditioner. overed in BM. Resident #19's			Nursing implemented in-services for al	i				
	*** *	r was lying on the floor under			Nursing Staff including Agency on Locating Required Staff Assistance for					
	_	1 stated he just needed help			Toileting and Incontinence Care. Any					
		back in the bed. RT/NA #2			nursing staff or agency nursing staff					
		I already conversed with the			reporting to work after this date will					
		st needed help to transfer			receive this in-service prior to working.					
		o bed. NA #3 ' s assistance			Information included:					
	was requested to he	elp clean Resident #19 and								
	she was taken to the	e shower room for bathing.			Locating information in electronic					
		er this conversation, he			Kardex which indicates residents need					
		nared what he had observed			number of staff required to provide safe	Э				
		the catheter needed to be			toileting/incontinence care .					
		ne, he learned she was			Use the correct number of staff wher	l				
	unaware of the fall.				providing care. Informing supervisor if additional state	f is				
	An interview with R1	T/NA #2 on 02/15/22 at 3:53			needed to provide incontinence care to					
		alled the events surrounding			resident safely.					
		Resident #19 on 10/31/21.			Use correct equipment/assistance					
		was walking by Resident			devices for lifting and/or transfers					
	#19's room and NA	#1 was in the hallway and			according to the assessment and care					
	-	nsfer Resident #19 from the			plan of the resident.					
		noticed Resident #19 lying			Reviewed location of Care Plan and					
		ight side with her catheter no			Kardex within the Electronic Records.					
	longer intact. RT/NA	x#2 explained that he and NA								

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			X3) DATE SURVEY COMPLETED			
			A. BOILD	The Bolesmo		C				
		345247	B. WING				-			
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	, ,,				
				581 NC HIGHWAY 16 SOUTH						
VALLEY N	URSING CENTER			Т	AYLORSVILLE, NC 28681					
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)			
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE			
F 689	Continued From page	e 14	F	689						
	#1 placed a cloth inco				New educational material has been ad	ded				
		ted her up to the bed. RT/NA			to the New Hire Orientation packet for	acu				
		IA #1 left the room to retrieve			Nursing and Nurse Aide staff, Agency					
		NA #1 stated he would			staff, as well as the Clinical version.					
	·	dent #19's catheter because			Kardex Information					
	it had come out durin	g the fall. When NA#1			Care Plan Information					
	returned to the room	with the shower stretcher,								
	NA#3 entered the roo	om and she assisted NA #1					COMPLETED C 02/18/2022 TE COMPLETION DATE ed at es d. es d. es file ss			
		from the bed to the shower			# 4 - Indicate how the facility plans to	ZIP CODE N OF CORRECTION EACTION SHOULD BE OTO THE APPROPRIATE DIENCY) rial has been added ation packet for the staff, Agency nical version. In facility plans to the to make sure that the digit and Include dates will be completed. It is implemented new the sand sold and should be diened at the care the c				
	_	oth bed pad used to lift her			monitor its performance to make sure t	DEF CORRECTION CTION SHOULD BE OF THE APPROPRIATE INCY) All has been added on packet for staff, Agency cal version. Cility plans to to make sure that and Include dates ill be completed. Implemented new and include dates istance with 1/22. The DON observe the care is (3) residents istance with 1/20 (2) residents istance with 1/20 (2) residents istance with 1/20 (2) residents incompleted incomplete inco				
		#2 stated he left the room			solutions are sustained; and Include da					
		and he stopped and told			when corrective action will be complete	ea.				
		ncident because he knew the			The Director of Nursing implemented a	0147				
	_	er intact. RT/NA #2 stated 9 was transferred using a			The Director of Nursing implemented n audit tool titled Transfers and	ew				
	mechanical lift and tw				Incontinence Care on 3/1/22. The DO	N				
		for some reason they were			and/or her designee will observe the ca					
		d not use the lift. RT/NA #2			provided to at least three (3) residents					
		ed NA #1 had already			requiring two person assistance with					
		urse #1 but stated he told her			incontinence care and two (2) residents	5				
	about it on his way ba	ack to his unit which he			requiring a mechanical lift for transfer to	0				
	stated was five to ten	minutes after he had			assure compliance. These observation	าร				
	assisted NA #1 to tra	nsfer Resident #19 back to			will be done weekly for four weeks, the	n				
	the bed.				every other week for two months, and	_				
					then monthly for two months for a total					
		n statements written by NA			6 months of performance monitoring. T					
	#3 provided by the fa	cility.			results will be recorded on the audit too					
	An intonvious with NA	#3 on 02/16/22 at 7:15 PM			titled Transfers and Incontinence Care					
		niliar with Resident #19 and			Results will be reported to the Quality					
		600 Hall on the night of			Assurance Performance Improvement					
	_	cated she was approached			committee by the Director of Nursing					
		ance by NA #1 when he was			monthly for review and discussion. The	е				
	enroute to retrieve a	•			Quality Assurance Committee will asse					
	Resident #19 after sh	ne had a large BM and			and modify the action plan as needed t					
	needed to be bathed.	NA #3 reported she			ensure continued compliance.					
		to Resident #19's room								
	where she found Res	sident #19 lying in the bed								
	with her catheter lying	g on the floor near the bed.								

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		345247	B. WING _			C 02/18/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681		52.11012022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	Resident #19 from the shower stretcher using and NA #1 took Residependently. Appropriater, when NA #1 refrom the shower root transfer Resident #1 the resident 's bed with pad. NA #3 vocalize #19's transfer status 2-person physical as never transferred Remechanical lift and a incontinence pad for An interview with NA revealed she was facared for her often. In have 2-person assiss mobility, but there with provide incontinence only one person if of other residents. An interview with Nu AM indicated staff with 2-person physical as Resident #19 and min 2-person physical as toileting.	and NA #1 transferred ne resident 's bed to the ng a cloth incontinence pad ident #19 to the shower room oximately 20-30 minutes eturned with Resident #19 m, she assisted NA #1 to 9 from shower stretcher to via a clean cloth incontinence d she was aware Resident was a mechanical lift with esistance, but stated staff esident #19 using a allways used a cloth	F	689		
	written by Nurse #1 resident for injuries a forearm and left low leg swelling just belodiscoloration noted.	read, in part, "I assessed and noted abrasions on right er abdomen. Also, right lower bw the knee and some I was not informed of fall until n bed and taken to shower				

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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BI E APPROPRIA		(X5) COMPLETION DATE
F 689	A nurses' note writter 7:00 AM indicated Reswelling to her right le An interview with Nur revealed she cared for 10/30/21 (7:00 PM indicated she was mand fallen earlier in hwas being provided in Nurse #1 explained Nurse #1 explained Nurse #1 explained Nurse during incompand on her side during incompand to catch her band landed on the flor Resident was found when she assessed to have abrasions to	C.N.A. said he was e rolled off bed into floor." In by Nurse #1 on 10/31/21 at esident #19 had noted ower extremity. It is se #1 on 2/15/21 at 1:42PM or Resident #1 on the night to 7:00 AM). Nurse #1 ade aware that Resident #19 er shift while Resident #19 noontinence care by NA #1. IA #1 reported Resident #19 jerking after she was rolled	F	DEFICIENCY;			
	right lower extremity flexible and different. Resident #19 was de the mechanical lift. N #19 was injured and physician before the approximately 1 hour A physician's order w 10/31/21 at 6:59 AM to have an anterior/prx-ray of the right lower An interview with Nur	pendent for transfers using urse #1 did not feel Resident did not feel contacting the end of her shift which was later was warranted. ritten by Nurse #2 and dated indicated Resident #19 was osterior (AP) and lateral					

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(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	he and Nurse #1 we assess her. He state positioned "different the top, near her kn Resident #19. Nurse assessment and the remained at her bas grimacing or nonver recall. Nurse #2 state dependent for trans mechanical lift and a safety. He elaborate have been lifted using she fell from her bear and the safety. He elaborate have been lifted using the fell from her bear and subsequently. According to an Emdated 10/31/21, Resident #19 fell dushe was dropped dushe was dropped dushe was dropped dushe shower stretch splinted and ordered and subsequently don 11/1/21. During an interview (DON) on 2/15/22 and documentation titled [Resident #19] 10/3 DON on 11/2/21, was the DON investigated.	AM. Nurse #2 explained that ent to Resident #19's room to ed that her right leg was tly" and was very "flexible" at ee, which was abnormal for e #2 stated that during the ereafter Resident #19 seline with no visible facial rbal signs of pain that he could ted Resident #19 was fers using a total body 2 staff physical assistance for ed Resident #19 should not ng an incontinence pad after	F	589			

_ ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` '	PLE CONSTRUCTION G	· ,	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 689	fall was due to the air the resident's cought indicated "in an abur concern for our reside and NAs were reeduresident in lateral pothat following any fall resident was found to member should immember should immet o moving a resident assessed not to have be transferred based method. Once the resafety established, the party, and the DON simmediately for furth The DON verbalized investigation Resider incorrectly using the An interview with the Administrator, and A 12:00 PM revealed enotify the nurse if a restated they did not be wouldn't fit on that si #19 fell, but later ack to have been moved the mechanical lift. The Administrator was Jeopardy on 2/16/22. The facility provided.	ing and the root cause of the r mattress' slick surface and ing. The document further idance of caution and ent safety, all facility nurses cated on positioning a sition." The DON reported I in the facility, when a be on the floor, a staff rediately notify a nurse prior. Once the resident was an injury, the resident may on their current transfer resident is transferred and in physician, responsible should be notified er orders and investigation. She discovered during her int #19 was transferred incorrect transfer method. DON, Assistant deministrator on 2/16/22 at each expected all staff to resident had a fall. They relieve the mechanical lift does of the bed where Resident inowledged the bed was able to allow for transfer using as notified of the Immediate at 12:11 PM. The solution of the Immediate at 12:11 PM. The solution of the Immediate at 12:11 PM.	F 68	39			

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F 689	a Certified Nursing A	ovided incontinence care by ssistant (CNA) on 10/31/21.	F	889			
	and began bouncing the Certified Nursing resident, she rolled for resident required 2 a care 1 time in the 7 conformation the reside providing incontinent the Kardex file. It is un opposite side was up #19 was rolled away requires 2 person as Kardex and Care Platassist for incontinent. Transfer status for R by the Physical Therapy for patient's	esident had a coughing spell around on the bed. Before Assistant #1 could reach the rom the bed. MDS indicated ssist to provide incontinence day look back period. ent required 2 assists when be care was not available on unknown if the side rail on the poor down. Per CNA Resident from him. Resident #19 sist for incontinence care. In was updated to 2 person be care on 2/16/2022. esident #19 was evaluated apist Doctor of Physical afety and mobility 2/17/2022. It resident is dependent on					
	functional mobility ardraw sheet for lateral assistance from 2+ s. This deficient practical residents residing incontinent and required. On November 1, 202 implemented in-servistaff on Safe Position Turning and Providin Independently. In servisident in lateral posmechanics, assure resident Use suppositional control of the service obstructed. Use suppositional control of the service of the se	and would benefit utilizing a I transfers with total staff. e has the potential to affect within the facility who are ire assistance with care. If Director of Nursing ice training for all Nursing ning of Resident when g Incontinence Care rvice covered positioning a sition, using proper body esidents face is not					

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F 689	cognizant of reside incontinent care an for implementation. On February 16, 20 RNS and Nursing Stresident's residing those who needed incontinence care arequired a mechan nurses then review (tool used in the elestaff of care require where necessary to on amount of assis of resident, the molthe required number toileting/incontinent	mind the nursing staff to be nts position on the bed during d required no additional steps 222, Director of Nursing, MDS Supervisors reviewed all other in the facility to determine two person assistance with and those residents who ical lift for transfers. The MDS ed each Resident's "Kardex" ectronic health record to inform ements) and made changes o provide information to staff tance needed for safe transfer bility status of a resident and er of staff to provide safe ce care to a resident while in inpleted on 2/16/2022.	F 68	9		
	process or system adverse outcome from the action will all resident falls are meetings. The Director of Rehab, Respiratory Therap occurred is investig	the entity will take to alter the failure to prevent a serious from occurring or recurring, and I be complete. The reviewed in Morning Standup ector of Nursing presents the eclinical team. Clinical team IDS Nurse, Wound Care pervisors, Administration, Social Worker, Director of by, Root cause of why the fall pated by the DON and shared coarticipating in the review.				

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F 689	from having a recuri interventions to the Kardex. Nursing Su any updates in plan implemented interventions are upimmediately after the care plan and the Conference of the work after this daprior to work after this daprior to working. Locating in which indicates resirequired to provide care. Use the coproviding and the casessment and the assessment and the Reviewed Kardex within the Elicitation interventions are upimmediately after the Nursing Supervisors the care plan and the Conference of the care plan and the Conference of the care including Agency or Assistance for Toiled Any nursing staff or to work after this daprior to working. Locating in which indicates resirequired to provide care. Use the coproviding care. Informing some devices for lifting and the assessment and the assessment and the conference of the conference	t in place to keep the resident ring fall. MDS Nurse adds care plan which populates the pervisors inform hall staff of of care. Previous entions are reviewed at our eetings to determine intervention does not work a repeat fall, root cause is a additional interventions put interventions removed. dated in the care plan e meeting and staff notified by c. CNA's have access to both e Kardex. 22 the Director of Nursing vices for all Nursing Staff Locating Required Staff ting and Incontinence Care. agency nursing staff reporting the will receive this in-service formation in electronic Kardex dents need for number of staff safe toileting/incontinence rrect number of staff when supervisor if additional staff is incontinence care to resident at equipment/assistance d/or transfers according to a care plan of the resident. location of Care Plan and	F	389		

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F 689	Nurse Aide staff as Kardex Inf Care Plan Alleged IJ removal 17, 2022 A credible allegatio prevent accidents w 02/17/22. Record re Kardex and care pl follows: Resident # updated to 2- perso Kardex and care pl nursing staff. The ir reflected all staff to housekeeping, mai and administrative notification of a nur resident's condition not to move a resid assessment and di observed to perforr appropriate turning residents were tran physical assistance lift.	on packet for Nursing and well as the Clinical version . formation Information date: Requested for February on validation for supervision to was conducted in the facility on eview included Resident #19's an. Notable revisions were as 19's transfer status has been on draw sheet on both the an which are available to all n-service training records	F	589			