STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	C 04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR NURSING AND REHAB	902 BERKSHIRE ROAD SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 4/16/24 through 4/19/24. The following intakes were investigated: NC00216049, NC00215827 and NC00210482. Intakes NC00215827 and NC00216049 resulted in immediate jeopardy. 3 of the 6 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity (J) CFR 483.25 at tag F689 at a scope and severity (J) The tags F600 and F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 3/04/24 and was removed on 4/19/24. A partial extended survey was conducted.	F 000		
F 600 SS=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-	F 600		5/9/24

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

Electronically Signed | 05/07/2024

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F 600	Continued From page 1 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews with staff, Nurse Practitioner, Medical Examiner and Physician, the facility failed to protect a resident's right to be free from neglect for 1 of 3 sampled residents reviewed for neglect (Resident #1). On 3/4/24, Nursing Assistant (NA) #1 disregarded Resident #1's physician orders and plan of care for the assessed need of 2 person assistance with Activities of Daily Living (ADL) care and provided care to the resident without assistance. During care, NA # left the resident positioned on his right side with the bed at waist height and turned his back to get a washcloth. Resident #1 rolled off the bed, landing face down on the tile floor. Resident #1 was transferred to the emergency room where a Computerized Tomography (CT) scan revealed a closed fracture of the left distal femur (a break of the thigh bone just above the knee) and a small skin tear to the left elbow. Resident #1 was on a blood thinning medication and he had multiple medical comorbidities making him vulnerable and at high risk for injury. The death certificate dated 3/31/24 listed the cause of death as complications of a left femur fracture. Immediate jeopardy began on 3/4/24 when NA #1 neglected to provide Resident #1 with the necessary care and services required to provide care safely. The immediate jeopardy was removed on 4/19/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains	F 600	Resident # 1 noted as discharged. All residents receiving ADL care with concentration on residents with orders and care plans for 2 person assist with ADLs (Activities of Daily Living) identified as residents having the potential to be affected by injury during ADL care. Residents with orders and care plans for 2 person assist with ADLs were identified through audit entitled "2 person ADL care order Audit" completed by Director of Nursing 4/17/2024. Audit was completed by reviewing all active residents' current orders and care plans to ascertain all residents at risk for injury during ADL care with concentration on 2 person ADL care orders. Results of audit identifying residents with 2 person assist with ADL care was reviewed by facility Quality Assurance Committee (Physician services, Administrator, Director of Nursing, Quality Assurance Coordinator, Rehab Manager, Staff Development Coordinator, Social Worker, Environmental Services Director) on 4/18/2024 and results ensured to be communicated clearly in facility software to all nursing staff (Nurses and Nurse Aide 1). Software communication noted to populate in ADL documentation grid for all nurses and nurse aides and is populated through the ADL care plan once any orders are received and are documented	

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F 600	Continued From page 2 out of compliance at a lower level and severity of "D" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place were effective. The findings included: This tag is cross-referenced to: F689: Based on observation, record review, staff, Nurse Practitioner, Medical Examiner and Physician interviews, the facility failed to provide Activities of Daily Living (ADL) care safely to a dependent resident for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #1). On 3/4/24 Nursing Assistant (NA #1) began providing care to Resident #1 when he left the resident positioned on his right side with the bed at waist height and turned his back to get a washcloth. Resident #1 rolled off the bed, landing face down on the tile floor. Resident #1 was transferred to the emergency room where a Computerized Tomography (CT) scan revealed a closed fracture of the left distal femur (a break of the thigh bone just above the knee) and a small skin tear to the left elbow. Resident #1 was on a blood thinning medication and he had multiple medical comorbidities making him vulnerable and at high risk for injury. The death certificate dated 3/31/24 listed the cause of death as complications of a left femur fracture. Review of the Initial Allegation Report dated 4/18/24 revealed the facility's Director of Nursing (DON) became aware of Resident #1's allegation of resident neglect from the State Survey Agency.	F 600	by care planning nurse. Current care plan and communication was validated by Quality Assurance Committee by 4/18/24. Resident #1 had injury reported via Initial Allegation Report by Director of Nursing to Health Care Personnel Investigation 4/18/2024 and Investigation Report completed by Director of Nursing to Health Care Personnel Investigation 4/19/24 as instructed by NCDHHS. Director of Nursing also notified injury to Adult Protective Services on 4/18/24 as instructed by NCDHHS. Audits entitled "2 Person ADL Care Audit" to include physician orders, care planning and staff observation were completed by Quality Assurance Coordinator on 4/18/2024 and shall continue to be completed monthly X 1 quarter and quarterly thereafter to ensure ongoing compliance with expectations with 2 person ADL care orders. Results of these audits shall be reviewed quarterly by the Quality Assurance Committee beginning with the next scheduled Quarterly Quality Assurance Committee meeting May 14th, 2024. The Quality Assurance Committee noted to adopt on 4/18/24 new "2 Person assist with ADL Care Icon" to be placed at foot of bed for any "Residents at Risk" as to improve process, in order to more clearly identify "Residents at Risk" with 2 person ADL care ordered. Quality Assurance committee ensured accuracy of audit, as well as communication through facility software and new icon and all nursing staff received education by Staff Development Coordinator or their	

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F 600	Continued From page 3 The alleged incident occurred on 3/04/24 at 2:50 PM. The resident received a bath and the aide turned away from the bed to retrieve cloth and resident rolled from bed resulting in fall. The Investigation Report dated 4/19/24 completed by the DON for the neglect allegation related to Resident #1 documented the accused staff member (NA #1) was noted to be aware of 2 person ADL care requirement, however, the NA felt he could provide care independently because he had worked with the resident for over a year. A fall occurred during care as a result of care plan not being followed. The report indicated Resident #1 sustained serious bodily injury and the allegation was substantiated. The Administrator and Director of Nursing (DON) were notified of Immediate Jeopardy on 4/17/24 at 5:51 PM. The facility provided the following credible allegation of Immediate Jeopardy removal: Identify those recipients who have suffered, or are likely to surer, a serious adverse outcome as a result of the noncompliance Resident # 1 noted to have received activities of daily living (ADL) care by NA #1 on 3-4-24. While receiving care, NA#1 noted to be providing care independently with Resident # 1 on his right side with bed at waist height. During care, it is noted that resident had a fall from the bed while NA#1 turned from care to retrieve bath cloth. Resident noted to have 2 person ADL (activities of daily living) ordered. Resident was noted to be sent to ER and returned with left leg injury. Resident	F 600	designee, regarding all residents currently at risk. Education encompassed all residents receiving ADL care and included instruction on safety with ADL care to include gathering supplies and equipment, ensuring proper positioning in bed to provide safety, awareness of bed height and leaving residents in a safe position with call light in place. Education also included current list of all "Residents at Risk," with 2 person ADL care and where their orders and care plan may be identified in facility software, care plan awareness through new Icon and expectations regarding 2 person assist with ADL care. Residents / responsible party were contacted by Resident Services Coordinator by 4/18/2024 to ensure permission to place Icon as to avoid any dignity issues and documented acceptance. "2 Person assist with ADL Icon" was placed at foot of bed for all "Residents at Risk" by Quality Assurance Coordinator by 4/18/2024. Additionally, all staff received education on facility policy for Resident Abuse and Neglect to include policy entitled "Resident Abuse Prohibition Policy and Procedures" with concentration on residents at higher risk for falls during ADL care requiring 2 people and to report to the Administrator / Director of Nursing, any witnessed abuse or neglect for these residents not meeting facility expectations. Education was completed by 4/19/24 and documented on "In-service Training Report."	

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F 600	Continued From page 4	F 600		

remained in facility until new onset of facial drooping noted and was sent to ER 3/18/24 where he was discovered to have renal stones leading to sepsis whereupon resident aspirated and became unresponsive leading to a hospice admission at a local Hospice House instead of returning to facility for hospice care. NA #1 noted to be out of work indefinitely since 3/8/2024 with no expected return to work date.

All residents receiving ADL care with concentration on residents with orders and care plans for 2 person assist with ADLs (Activities of Daily Living) identified as "Recipients at Risk" for neglect. Residents with orders and care plans for 2 person assist with ADLs shall be identified through audit entitled "2 person ADL care order Audit" completed by Director of Nursing no later than 4/17/2024. Audit shall be completed by reviewing all active residents' current orders and care plans to ascertain all "Recipients at Risk" for neglect. Entity shall complete facility wide audit of "Residents at Risk", no later than 4/17/2024. Results of audit identifying residents with 2 person assist with ADL care, shall be reviewed by facility Quality Assurance Committee (Physician services, Administrator, Director of Nursing, Quality Assurance Coordinator, Rehab Manager, Staff Development Coordinator, Social Worker, Environmental Services Director) on 4/18/2024 and results ensured to be communicated clearly in facility software to all nursing staff (Nurses and Nurse Aide 1). Software communication noted to populate in ADL documentation grid for all nurses and nurse aides and is populated through the ADL care plan once any orders are received and is documented by care planning nurse. Current care plan and communication shall be validated by Quality Assurance Committee by 4/18/24.

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F 600	Continued From page 5	F 600		

Resident #1 shall have neglect reported via Initial Allegation Report by Director of Nursing to Health Care Personnel Investigation 4/18/2024. Director of Nursing shall also notify neglect to adult protective services on 4/18/24. Audits entitled "2 Person ADL Care Audit" to include physician orders, care planning and staff observation shall be completed by Quality Assurance Coordinator on 4/18/2024.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring, and when the action will be complete:

The Quality Assurance Committee shall also adopt new "2 Person assist with ADL Care Icon" to be placed at foot of bed for any "Residents at Risk" as to improve process, in order to more clearly identify "Residents at Risk" with 2 person ADL care ordered. Once Committee has ensured accuracy of audit, as well as communication through facility software and new icon, all nursing staff shall receive education by Staff Development Coordinator or their designee, regarding all residents currently at risk. Education to encompass all residents receiving ADL care will include instruction on safety with ADL care to include gathering supplies and equipment, ensuring proper positioning in bed to provide safety, awareness of bed height and leaving residents in a safe position with call light in place. Education shall also include current list of all "Residents at Risk," with 2 person ADL care and where their orders and care plan, may be identified in facility software, care plan awareness through new Icon and expectations regarding 2 person assist with ADL care. Residents / responsible party shall also be contacted by

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F 600	Continued From page 6	F 600		

Resident Services Coordinator by 4/18/2024 to ensure permission to place Icon as to avoid any dignity issues and documented acceptance. Additionally, all staff shall receive education on facility policy for Resident Abuse and Neglect to include policy entitled "Resident Abuse Prohibition Policy and Procedures" with concentration on residents at higher risk for falls during ADL care requiring 2 people and to report to the Administrator / Director of Nursing, any witnessed abuse or neglect of care for these residents not meeting facility expectations. Education shall be completed and all efforts to encompass entire staff present 4/18/2024. Any staff not present 4/18/2024 shall have attempts made to complete education by phone no later than 4/18/2024 with messages left for any not spoken to, to contact facility as soon as possible for education, as to prevent future serious adverse outcomes from occurring. Education shall be documented on "In-service Training Report." Staff Development Coordinator shall notify nursing supervisor of any nursing staff on the schedule who have not received in-servicing so that education may be delegated and completed for any nursing staff that may enter facility after 4/18/24. "2 Person assist with ADL Icon" shall be placed at foot of bed for all "Residents at Risk" by Quality Assurance Coordinator by 4/18/2024. Audits entitled "2 Person ADL Care Audit" shall be completed by Quality Assurance Coordinator 4/18/2024 monitoring for compliance of education completed as to ensure prevention on possible neglect.
Alleged Immediate Jeopardy Removal Date: 4/19/24

Onsite validation of the immediate jeopardy

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F 600	Continued From page 7 removal plan was conducted on 4/19/24. The validation included staff interviews, observation, and record review. Inservice sign in sheets and staff interviews verified in-services were completed on the Abuse and Neglect Policy and Procedure with a concentration on residents at higher risk for falls during ADL care. Staff verified their understanding of neglect and the importance of providing residents with their assessed level of assistance. Additionally, staff revealed during education they had the opportunity to ask questions on resident Abuse and Neglect. Evidence of audits were reviewed for Abuse and Neglect and identifying "Residents at Risk". Resident interviews were conducted with no issues identified. Observation of ADL care revealed staff provided the necessary assistance to meet the resident's assessed needs. The immediate jeopardy removal date of 4/19/24 was validated.	F 600		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, Nurse Practitioner, Medical Examiner and Physician interviews, the facility failed to provide Activities of Daily Living (ADL) care safely to a dependent resident for 1 of 3 residents reviewed	F 689	Resident # 1 noted as discharged. All residents receiving ADL care with concentration on residents with orders and care plans for 2 person assist with ADLs (Activities of Daily Living) identified	5/9/24

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F 689	Continued From page 8 for supervision to prevent accidents (Resident #1). On 3/4/24 Nursing Assistant (NA #1) began providing care to Resident #1 when he left the resident positioned on his right side with the bed at waist height and turned his back to get a washcloth. Resident #1 rolled off the bed, landing face down on the tile floor. Resident #1 was transferred to the emergency room where a Computerized Tomography (CT) scan revealed a closed fracture of the left distal femur (a break of the thigh bone just above the knee) and a small skin tear to the left elbow. Resident #1 was on a blood thinning medication and he had multiple medical comorbidities making him vulnerable and at high risk for injury. The death certificate dated 3/31/24 listed the cause of death as complications of a left femur fracture. Immediate jeopardy began on 3/4/24 when NA #1 failed to provide care safely to Resident #1. The immediate jeopardy was removed on 4/19/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower level and severity of "D" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place were effective. The findings included: Resident #1 was admitted to the facility on 10/24/22 with diagnoses that included, chronic atrial fibrillation (a type of irregular heartbeat that causes the heart to beat too quickly), heart failure, diabetes mellitus, peripheral artery disease (a condition in which narrowed arteries reduce blood flow to the arms or legs), and obesity.	F 689	as residents having the potential to be affected by accidents during ADL care. Residents with orders and care plans for 2 person assist with ADLs were identified through audit entitled "2 person ADL care order Audit" completed by Director of Nursing 4/17/2024. Audit was completed by reviewing all active residents' current orders and care plans to ascertain all residents at risk for accidents during ADL care with concentration on 2 person ADL care orders. Results of audit identifying residents with 2 person assist with ADL care was reviewed by facility Quality Assurance Committee (Physician services, Administrator, Director of Nursing, Quality Assurance Coordinator, Rehab Manager, Staff Development Coordinator, Social Worker, Environmental Services Director) on 4/18/2024 and results ensured to be communicated clearly in facility software to all nursing staff (Nurses and Nurse Aide 1). Software communication noted to populate in ADL documentation grid for all nurses and nurse aides and is populated through the ADL care plan once any orders are received and is documented by care planning nurse. Current care plan and communication was validated by Quality Assurance Committee by 4/18/24. Resident #1 had injury reported via Initial Allegation Report by Director of Nursing to Health Care Personnel Investigation 4/18/2024 and Investigation Report completed by Director of Nursing to Health Care Personnel Investigation 4/19/24 as instructed by NCDHHS. Director of Nursing also notified injury to	

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F 689	Continued From page 9 Resident #1's quarterly Minimum Data Set dated 12/19/23 revealed he was cognitively intact. He was assessed as dependent with bed mobility, incontinence care and bathing. Resident #1 was not coded for any falls since the prior assessment. The MDS indicated the resident's weight as 325 pounds and he was coded for receiving an anticoagulant. A review of the active physician orders for March 2024 included the following orders: - Two person assist with ADL care (order start date 11/01/22). - Eliquis (anticoagulant) 5 milligrams twice daily Resident #1's care plan initiated on 10/24/22 and reviewed on 12/20/23 revealed he was at risk for falls related to impaired mobility, multiple comorbidities, and continuous oxygen (02). Interventions initiated on 11/01/22 included two people assisting with care. An interview was conducted with NA #2 on 4/16/24 at 2:29 PM. She indicated Resident #1 was a two person assist as he was a heavy-set man, and she always had another NA to help her provide his care. NA #2 revealed she would check in the FYI (for your information) section of the computer to see what care a resident needed. An interview on 4/17/24 at 1:09 PM was conducted with NA #3. She revealed Resident #1 was a 2 person assist with ADL care. NA #3 indicated she looked in the computer to see what type of care a resident needed. On 4/17/24 at 1:25 PM the Director of Nursing (DON) stated Resident #1 had extension bars on	F 689	Adult Protective Services on 4/18/24 as instructed by NCDHHS. Audits entitled "2 Person ADL Care Audit" to include physician orders, care planning and staff observation were completed by Quality Assurance Coordinator on 4/18/2024 and shall continue to be completed monthly X 1 quarter and quarterly thereafter to ensure ongoing compliance with expectations with 2 person ADL care orders. Results of these audits shall be reviewed quarterly by the Quality Assurance Committee beginning with the next scheduled Quarterly Quality Assurance Committee meeting May 14th, 2024. The Quality Assurance Committee noted to adopt on 4/18/24 new "2 Person assist with ADL Care Icon" to be placed at foot of bed for any "Residents at Risk" as to improve process, in order to more clearly identify "Residents at Risk" with 2 person ADL care ordered. Quality Assurance committee ensured accuracy of audit, as well as communication through facility software and new icon and all nursing staff received education by Staff Development Coordinator or their designee, regarding all residents currently at risk. Education encompassed all residents receiving ADL care and included instruction on safety with ADL care to include gathering supplies and equipment, ensuring proper positioning in bed to provide safety, awareness of bed height and leaving residents in a safe position with call light in place. Education also included current list of all "Residents at Risk," with 2 person ADL care and where	

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F 689	Continued From page 10 his bed that extended the bed frame out 8 inches on either side of the bed and a larger mattress to fit the bed frame. The Nurse note dated 3/4/24 completed by Nurse #1 revealed NA# 1 called nursing staff to Resident #1's room at 2:50 PM. Resident #1 was noted laying on his side undressed on the floor with the bed in the high position. NA #1 stated he was turning Resident #1, and he kept on rolling off the bed onto the floor. The Supervisor was notified and on assessment Resident #1 was noted to have blood upon inspection but could not locate the source due to his positioning. The note documented Resident #1 was on a blood thinner. EMS (Emergency Medical Service) were notified, and Medical Doctor notified. Order was obtained to send Resident #1 to (name of hospital) for evaluation. The Fall Incident/Accident Report initiated on 3/4/24 and signed completed on 3/4/24 by Unit Manager Nurse was reviewed. The report revealed while care was being provided Resident #1 was turned to face the door, the NA turned his back to get a cloth and Resident #1 landed face down on the floor. NA #1 was interviewed by phone on 4/16/24 at 5:29 PM. NA #1 indicated on 3/4/24 he positioned Resident #1 on his right side in the middle of bed. He indicated he (NA #1) turned to the tray table to grab a washcloth. He indicated while he was turned away from the bed he looked in the mirror in the room and saw the resident move his leg and he roll off the bed face first onto the floor. NA #1 indicated he was aware Resident #1 was a two person assist according to the care plan. When asked why he provided care without	F 689	their orders and care plan may be identified in facility software, care plan awareness through new Icon and expectations regarding 2 person assist with ADL care. Residents / responsible party were contacted by Resident Services Coordinator by 4/18/2024 to ensure permission to place Icon as to avoid any dignity issues and documented acceptance. "2 Person assist with ADL Icon" was placed at foot of bed for all "Residents at Risk" by Quality Assurance Coordinator by 4/18/2024. Education was completed by 4/19/24 and documented on "In-service Training Report."	

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another staff member's assistance on 3/4/24 he indicated there was a lot going on that day, it was close to shift change, he worked with Resident #1 daily, and thought he could provide incontinence care alone. NA #1 indicated Resident #1 was able to assist with his turning and repositioning in bed.

A follow up interview with NA #1 was conducted by phone on 4/17/24 at 4:10 PM. He revealed on 3/4/24 the bed was at waist height when the resident rolled onto the floor. NA #1 stated Resident #1 did not hit his head when he fell.

In a phone interview on 4/16/24 at 1:12 PM Nurse #1 stated that when she arrived in Resident #1's room on 3/4/24, she found Resident #1 on the floor lying between Bed A and Bed B. He was on his side and she observed some blood but she could not tell where it was coming from, and she wanted to send Resident #1 out for evaluation in case of head injury as he was receiving a blood thinner. She revealed Resident #1 was a larger man and required two persons for assistance with his ADL care.

The Unit Manager Nurse was interviewed on 4/17/23 at 9:31 AM. The Unit Manager Nurse revealed when she arrived at Resident #1's room on 3/4/24, the resident was on the floor face down with slight weight on his left side. She indicated NA #1 worked with the resident daily and the resident was a two person assist as he was a heavy man. She reported Resident #1 fell onto the tile floor. The Unit Manager Nurse called 911, the hospital to notify them they had a fall resident and the RP (responsible person). She stated that EMS arrived at the facility within 5 minutes of her call.

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Review of the Emergency Room (ER) report dated 3/4/24 revealed upon arrival at 4:09 PM EMS reported an obese, chronically ill-appearing, but awake, alert, Glasgow Coma Scale (a scale used to objectively describe the extent of impaired consciousness) of 15 (a score of 15 means you are fully awake, responsive and have no problems with thinking ability or memory). A Computerized Tomography (CT) scan was conducted in the ER of Resident #1's left lower extremity and revealed a comminuted non-displaced fracture of distal femoral meta-epiphysis (rounded long end portion of the bone) with fracture line extending to the lateral femoral condyle (a break in the lower part of a bone) with extension to posterior lateral femoral condyle. The resident was assessed by orthopedics and the fracture was non-operative. He was splinted at bedside and returned to the facility on 3/5/24.

Review of the physician progress note dated 3/11/24 documented Resident #1 was sent out to the ER on 3/04/24 following a fall from bed while being adjusted in bed. He was noted with some bleeding and concerned for a head injury as on Eliquis. CT scan revealed a closed fracture of the left distal femur. The orthopedist was consulted, determined the fracture was nonoperative and the resident was splinted at bedside. Post splint x-ray showed stable positioning and the resident was cleared to discharge to the facility.

Review of the nurse notes dated 3/17/24 documented the resident was complaining of chest pain at 10:30 AM. The Supervisor was notified of the resident's cardiac history (chronic atrial fibrillation), 911 was called, and the resident was transported to the ER by EMS for evaluation

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and treatment.

Review of the physician progress note dated 3/18/24 documented Resident #1 was sent out to the ER on 3/17/24 for concern of acute chest pain. A complete blood count showed no leukocytosis (high white blood cell count may indicate an infection or inflammation in the body). Cardiac tests were unremarkable, (for heart proteins leaking into the blood) and the resident was discharged back to the facility.

Review of the nurse note dated 3/18/24 at 11:46 AM indicated the resident was seen by Nurse Practitioner #1 for follow up of chest pain. Resident #1 was noted to have right sided facial droop, a fixed pupil and acute disorientation. Resident #1 was sent to the ER for evaluation and treatment.

Review of the Emergency Room report dated 3/18/24 at 12:44 PM revealed Resident #1 presented as a prehospital code stroke due to a change in mental status. The resident was afebrile, chronically ill-appearing and had a left lower extremity in a splint due to recent fracture. An EKG (electrocardiogram) revealed atrial fibrillation with premature atrial contraction (PVC is associated with an increased risk of atrial fibrillation) and a chest x-ray revealed pulmonary venous congestion with hypoventilatory changes (breathing that is too shallow or slow to meet the needs of the body).

Review of the Discharge Summary dated 3/29/24 revealed Resident #1 was reviewed by the Tele-neurologist for suspected stroke. The stroke was ruled out and suggested probable acute metabolic encephalopathy (metabolic

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encephalopathy occurs when problems with your metabolism cause brain dysfunction). He was treated with antibiotics for a complicated UTI (urinary tract infection that carries a higher risk of treatment failure and typically require longer antibiotic courses) and aspiration pneumonia (occurs when food or liquid is breathed into the airways or lungs instead of being swallowed). The Discharge Summary documented that due to Resident #1's age related debility and poor improvement the family decided on comfort measures. Resident #1 was discharged from the hospital on 3/29/24 to an inpatient hospice facility.

Review of Resident #1's death certificate dated 3/31/24 listed the cause of death as complications of a left femur fracture.

An interview was conducted with the Medical Examiner (ME) on 4/17/24 at 12:39 PM. She indicated she had reviewed Resident #1's medical history after she received the body for autopsy which revealed he fractured his ankle 3 years prior. The Medical Examiner indicated after a fall or broken bone patients were never the same and the femur fracture precipitated a decline in the body. The ME indicated Resident #1 was not a young man, had many comorbidities and determined the cause of death was due to blunt force trauma to the femur.

The Nurse Practitioner was interviewed by phone on 4/16/24 at 3:24 PM. He revealed Resident #1 had a history of atrial fibrillation, was on a blood thinner, and after his fall on 3/4/24 the facility sent Resident #1 out immediately to evaluate for head injury (individuals taking a blood thinner are at higher risk of brain bleeding, following a head injury). The Nurse Practitioner indicated the

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resident was diagnosed with a femur fracture, received a soft cast in the ER and returned to the facility that same day. He indicated on 3/17/24 Resident #1, was sent to the ER for a complaint of chest pains, where a cardiac evaluation was unremarkable for heart proteins leaking into the blood, and the resident returned to the facility. The Nurse Practitioner revealed he followed up with Resident #1 on 3/18/24 and sent him back to the ER for a facial droop and slurred speech. He stated within a two-week period, Resident #1 had no further falls, had two hospital visits and with his contributing comorbidities he did not see how the fracture could have contributed to his death.

A phone interview was conducted with the Medical Doctor on 4/17/24 at 2:47 PM. He indicated during Resident #1's hospital stay on 3/18/24, he was diagnosed with an UTI (urinary tract infection), an acute kidney injury, renal stones, and during that hospital stay he had an infection that overwhelmed his system and had an acute aspiration event. The MD indicated Resident #1's infection, UTI, and renal stones would have occurred regardless of the fall, and the hospital record highlighted the aspiration pneumonia as a contributing factor. The Medical Doctor indicated he saw no connection between his fall/fracture and expiration.

The Director of Nursing (DON) was interviewed on 4/17/24 at 5:00 PM. The DON revealed staff were trained to look in the computer for resident care needs and NA #1 should have followed their policies and procedures. He indicated Resident #1 was care planned and documented in the computer for a two person assist with ADL care and any residents requiring extensive assistance with ADL's staff should use 2-person assistance

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with care.

The Administrator and DON were notified of Immediate Jeopardy on 4/17/24 at 5:51 PM.

The facility provided the following credible allegation of Immediate Jeopardy removal:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

· Resident # 1 noted to have received Activities of Daily Living (ADL) care by NA #1 on 3-4-24. While receiving care, NA #1 noted to be providing care independently with Resident #1 on his right side with bed at waist height. During care, it is noted that resident had a fall from the bed while NA #1 turned from care to retrieve bath cloth. Resident noted to have 2 person ADL (activities of daily living) ordered. Resident was noted to be sent to Emergency Room (ER) and returned with left leg injury. Resident remained in facility until new onset of facial drooping noted and was sent to ER 3/18/24 where he was discovered to have renal stones leading to sepsis whereupon resident aspirated and became unresponsive leading to a hospice admission at a local Hospice House instead of returning to facility for hospice care. NA #1 noted to be out of work indefinitely since 3/8/2024 with no expected return to work date.

All residents receiving ADL care with concentration on residents with orders and care plans for 2 person assist with ADLs (Activities of Daily Living) identified as "Recipients at Risk" for accidents and failure to provide safe care. Residents with orders and care plans for 2 person

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assist with ADLs shall be identified through audit entitled "2 person ADL care order Audit" completed by Director of Nursing no later than 4/17/2024. Audit shall be completed by reviewing all active residents' current orders and care plans to ascertain all "Recipients at Risk" for accidents and failure to provide safe care. Entity shall complete facility wide audit of "Residents at Risk", no later than 4/17/2024. Results of audit identifying residents with 2 person assist with ADL care, shall be reviewed by facility Quality Assurance Committee (Physician services, Administrator, Director of Nursing, Quality Assurance Coordinator, Rehab Manager, Staff Development Coordinator, Social Worker, Environmental Services Director) on 4/18/2024 and results ensured to be communicated clearly in facility software to all nursing staff (Nurses and Nurse Aide 1). Software communication noted to populate in ADL documentation grid for all nurses and nurse aides and is populated through the ADL care plan once any orders are received and is documented by care planning nurse. Current care plan and communication shall be validated by Quality Assurance Committee by 4/18/24.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

· The Quality Assurance Committee shall also adopt new "2 Person assist with ADL Care Icon" to be placed at foot of bed for any "Residents at Risk" as to improve process, in order to more clearly identify "Residents at Risk" with 2 person ADL care ordered. Once Committee has ensured accuracy of audit, as well as communication through facility software and new icon, all nursing

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F 689	Continued From page 18 staff shall receive education by Staff Development Coordinator or their designee, regarding all residents currently at risk. Education to encompass all residents receiving ADL care will include instruction on safety with ADL care to include gathering supplies and equipment, ensuring proper positioning in bed to provide safety, awareness of bed height and leaving residents in a safe position with call light in place. Education shall also include current list of all "Residents at Risk," with 2 person ADL care and where their orders and care plan may be identified in facility software, care plan awareness through new Icon and expectations regarding 2 person assist with ADL care. Residents / responsible party shall also be contacted by Resident Services Coordinator by 4/18/2024, to ensure permission to place Icon as to avoid any dignity issues and documented acceptance. Education shall be completed and all efforts to encompass entire staff present 4/18/2024. Any staff not present 4/18/2024 shall have attempts made to complete education by phone no later than 4/18/2024 with messages left for any not spoken to, to contact facility as soon as possible for education, as to prevent future serious adverse outcomes from occurring. Education shall be documented on "In-service Training Report." Staff Development Coordinator shall notify nursing supervisor of any nursing staff on the schedule who have not received in-servicing so that education may be delegated and completed for any nursing staff that may enter facility after 4/18/24. Staff Development Coordinator shall additionally add lesson plan to Orientation packet to encompass all new hires as well. "2 Person assist with ADL Icon" shall be placed at foot of bed for all "Residents at Risk" by Quality Assurance Coordinator by 4/18/2024.	F 689		

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F 689	Continued From page 19 Alleged Immediate Jeopardy Removal Date: 4/19/24. Onsite validation of the immediate jeopardy removal plan was conducted on 4/19/24. The validation included staff interviews, observation, and record review. Inservice sign in sheets and staff interviews verified in-services were completed on 2- person assist with ADL care. Education was confirmed for facility nursing staff. Observation of staff providing 2-person assistance with ADL care revealed no issues. Evidence of audits were reviewed for 2 person ADL care and the current list of identified "Residents at Risk." Resident interviews were conducted with no issues identified. The immediate jeopardy removal date of 4/19/24 was validated.	F 689		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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F 580	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; (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, staff and family interviews, the facility failed to notify the residents (Resident #1) Responsible Party (RP) when resident was sent to the hospital for chest pain for 1 of 3 sampled residents reviewed for notification. Findings included: Resident #1 was admitted to the facility on 10/24/22 with diagnoses that included chronic atrial fibrillation, and heart failure. Review of the quarterly Minimum Data Set dated 12/19/23 revealed Resident #1 was cognitively intact. He was assessed as dependent on 2 or more staff for assistance with bed mobility.

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

The above isolated deficiencies pose no actual harm to the residents

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Review of Resident#1's face sheet in his medical record listed Resident # 1's son as his responsible person (RP).

Review of the Nursing progress note dated 3/17/24 documented the resident was complaining of chest pain at 10:30 AM. On assessment Resident # 1's vital signs were taken, skin was noted warm, and dry to the touch. The Supervisor was notified of the residents' cardiac history, (chronic atrial fibrillation) 911 was called and the resident was transported to the hospital ER (emergency room) via stretcher by EMS for evaluation and treatment.

An interview on 4/18/24 at 2:30 PM the Unit Manager Nurse revealed she usually called Resident # 1's son with any changes, but she did not call on 3/17/24, as she was getting the resident ready to send out.

An interview on 4/18/24 at 3:28 PM the admissions coordinator revealed at one time Resident#1's wife acted as Resident #1's RP. She requested staff to call her son with any ER visits during the night.

An interview on 4/17/24 at 1:12 PM Nurse #1 revealed on 3/17/24 Resident #1 complained of chest pain and vital signs revealed a blood pressure of 184/96. She stated she called the physician for the order to send Resident # 1 out, called 911 and thought that another nurse or the unit manager would assist her by calling the family. Nurse #1 reported that she did not call the RP on 3/17/24 to notify him Resident #1 was sent to the ER for chest pain.

Nurse #3 did not respond to attempts to contact her via telephone for an interview.

Review of resident #1's record there was no documentation or evidence in Resident #1's medical record, his RP was notified of his transfer to the ER on 3/17/24.

An interview on 4/19/24 at 11:30 AM the Director of Nursing reported the 2 nurses working with Resident #1 on 3/17/24 each thought the other nurse was calling the family to notify that resident was being sent to the ER and neither nurse did.