STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345351	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SALUDA	501 ESSEOLA CIRCLE SALUDA, NC 28773

(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 The survey team entered the facility on 05/07/24 to conduct a complaint survey and exited on 05/08/24. The survey team returned to the facility on 05/16/24 to validate the credible allegations and exited on 05/16/24. Therefore, the exit date was changed to 05/16/24. Event ID# PSLW11. The following intakes were investigated: NC00214829 and NC00216543. Intake NC00216543 resulted in immediate jeopardy. Two (2) of the 3 complaint allegations resulted in deficiency. Past noncompliance was identified at: CFR 483.10 at tag F580 at a scope and severity (J) CFR 483.12 at tag F600 at a scope and severity (J) CFR 483.25 at tag F684 at a scope and severity (J) CFR 483.25 at tag F689 at a scope and severity (J) CFR 483.35 at tag F726 at a scope and severity (J) The tags F600, F684, and F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 04/24/24 and was removed on 05/04/24. A partial extended survey was conducted.	F 000		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident;	F 580		

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

Electronically Signed | 06/03/2024

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.

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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

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F 580	Continued From page 2 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, Nurse Practitioner (NP), and Medical Doctor (MD) interviews, the facility failed to notify the physician of a fall when they reported a change in condition to the physician for a severely cognitively impaired resident on blood thinner. In addition, the physician was not notified when there was a delay in a STAT (immediately without delay) x-ray order of the left hip for a resident with a decrease in range of motion in her left hip and pain. The STAT x-ray order was ordered on 4/25/24 at 12:48 PM and not obtained until 4/26/24 that showed an acute fracture of the left hip at the intertrochanteric region (the area near the hip joint). On 4/28/24 Resident #1 underwent surgery to repair the left hip fracture. On 5/1/24 Resident #1 was discharged from the hospital to hospice care and Resident #1 expired on 5/2/2024. This practice occurred for 1 of 3 residents reviewed for notification of change (Resident #1). Findings included: Resident #1 was admitted to the facility on 12/11/22 with a diagnosis that included Alzheimer's disease. The quarterly Minimum Data Set (MDS) dated 03/25/24 assessed Resident # with severe impairment in cognition.	F 580	Past noncompliance: no plan of correction required.	

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Record review of the Change in Condition document by Nurse #3 dated 04/25/24 revealed in part: Resident #1 was assessed due to a change in condition. Her vital signs were obtained and within normal limits. Resident #1 received anticoagulant medication and had no changes in mental or functional status. Resident #1 displayed signs/symptoms of pain and an order was received for a STAT (immediate) x-ray of the left hip for decrease range of motion and pain.

Record review of the physician's orders revealed in part:
Stat X-ray for left hip for decreased range of motion and pain dated 4/25/24 at 12:48 PM.

Record review of a progress note dated 4/26/24 at 10:56 AM written by the DON revealed in part: On 4/24/24 Agency NA #1 took Resident #1 to the shower. Was lowering Resident #1 to the toilet when her foot came off the sit to stand mechanical lift. NA #1stated that she lowered the resident to the floor. Agency NA #1 called for NA #2 to assist with Resident #1. On 4/25/24 staff NA #2 transferred Resident #1 to her chair and noted resident was unable to hold her foot up while being wheeled. After repositioning and making another attempt, NA #2 immediately notified the NP that something was wrong with Resident #1. NP ordered a STAT x-ray of the left hip related to decreased mobility and pain. Final results of x-ray were received on 4/26/24. Results noted an acute fracture of the left hip at the intertrochanteric region. NP notified of results and order received to transfer Resident #1 to the ER for further evaluation and treatment. Resident #1 had remained at her baseline. The Guardian was notified of the incident along with the order

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for transfer. Resident #1 was currently at the hospital.

A phone interview on 5/7/24 at 10:52 AM with NA #1 (agency) revealed that she was assigned to Resident #1 for a shower only on 4/24/24. NA #1 stated that she placed Resident #1 in the sit to stand lift and as she (NA #1) transferred Resident #1 to the toilet, Resident #1 was yelling in shock. She then transferred Resident #1 off the toilet with the sit to stand lift, Resident #1's foot slipped, and she lowered Resident #1 to the floor using the sling from the sit to stand mechanical lift. Once Resident #1 was lowered to the floor, NA #1 stated she stepped out into the hallway and called for help from NA #2. NA #1 stated she had not called a Nurse to assess Resident #1 because Resident #1 had not fallen. NA #1 stated after the shower she told Nurse #1 about the yelling but did not tell her about Resident #1's foot slipping and lowering her to the ground.

A phone interview on 5/7/24 at 12:22 PM with NA #2 revealed that on 4/24/24 she was in another resident's room when NA #1 came out into the hall and asked her to come into the shower room. When NA #2 entered the shower room, she saw Resident #1 sitting on her bottom on the floor. NA #2 stated that she did not get a nurse to assess Resident #1 because she was told Resident #1 slid down to the floor and she (NA #2) had not thought of that as a fall. NA #2 stated that if she thought Resident #1 had fallen harder, she would have gotten a nurse immediately. NA #2 revealed that she had received education on falls being defined as any descent (action of moving downward, dropping or falling) to the floor by a resident. She stated that she should have told her nurse and had her

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assess Resident #1 before she was moved. NA #2 stated that she did not tell the NP about the incident in the shower the previous day because she had not associated the foot drag with the shower room incident.

An interview on 5/7/23 at 12:06 PM with Nurse #1 revealed that neither NA #1 nor NA #2 had come to her and spoken about Resident #1 on 4/24/24.

A phone interview on 5/8/24 at 10:32 AM with Nurse #2 revealed he was Resident #1's assigned nurse on 4/24/24 and neither NA #1 nor NA #2 had mentioned anything to him about Resident #1's fall. Nurse #2 stated that during his interactions with Resident #1 on 4/24/24 she displayed no signs or symptoms of pain. Nurse #2 stated that his next shift was on 4/26/24 and he got report from the off going nurse (unable to identify) that they were waiting on a hip x-ray to be completed for Resident#1. The nurse did not state if he was aware the x-ray order was STAT and was delayed or that he contacted the physician regarding the delayed x-ray.

A phone interview on 5/7/24 at 12:54 PM with Nurse #3 revealed she was working on 4/25/24. She stated that Resident #1 was talking and seemed fine in the morning. Nurse #3 stated that around noon when NA #2 got Resident #1 up and put her in her wheelchair, NA #2 reported she noticed a decrease in range of motion in Resident #1's leg and informed the NP. The NP assessed Resident #1 and ordered a STAT x-ray. Nurse #3 stated that when she did not see the x-ray staff come during her shift, she did not notify anyone because it was not unusual for the x-ray company to take a while to arrive.

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An interview on 5/7/24 at 10:27 AM with the NP revealed on 4/25/24 when she was coming down the hallway, NA #2 stopped her and told her something was wrong with Resident #1's leg. She stated that NA #2 told her when she (NA #2) had provided care to Resident #1 she yelled, and her leg dragged when (NA #2) attempted to push her in the wheelchair. When she assessed Resident #1, she yelled and guarded her left leg upon examination. She ordered a STAT hip x-ray to the left hip for pain and decreased range of motion (ROM) but there was a delay from the x-ray company and the NP was not notified of the delay. The DON notified her on 4/26/24 of the x-ray results showing a fracture to the left hip and then she had the facility to send Resident #1 to the ER. She stated that had she known there was a delay in the x-ray she would have sent Resident #1 out to the ER sooner. The NP stated that NA #2 had not told her about the fall when she was alerted to Resident #1's pain on 4/25/24. The NP further revealed that had she known about Resident #1's fall she would have sent Resident #1 directly to the ER. The NP could not say for certain that the delay in care would have changed the outcome for Resident #1. She stated that when she ordered the STAT x-ray, she expected it to be completed in the evening of 04/25/24 after she had left for the day. She further revealed that if there was a delay in obtaining the STAT x-ray she expected to be informed of the delay via phone call. Resident #1 was taking antiplatelet medication.

An interview on 5/7/24 at 4:07 PM with the Director of Nursing (DON) revealed that on 4/24/24 NA #1 that had taken Resident #1 into the shower. Resident #1 slid down with the help from NA #1 who was from an agency. NA #1

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called NA #2 into the shower room and NA #2 asked if Resident #1 was ok. She stated that NA #1 and NA #2 moved Resident #1 back into her wheelchair without having a Nurse assess her. Then NA #2 left the shower room and neither NA #1 nor NA #2 told anyone. On 4/25/24 NA #2 was providing a bed bath to Resident #1 then she got Resident #1 up into her wheelchair to take her to the small dining room and as NA #2 started to push Resident #1 out of the room in her wheelchair she noticed Resident #1's foot dragging. NA #2 adjusted Resident #1's foot and noticed there was a problem. NA #2 got the NP and asked her to assess Resident #1. The NP assessed Resident #1 and ordered a STAT hip x-ray for increased pain and decreased ROM. NA #2 had said nothing about the fall on 4/24/24 at this point to anyone. On 4/26/24 in the morning meeting the DON was reviewing the orders from the previous day and she inquired about the x-ray order for Resident #1. The Unit Manager had told her there were no results and she would look into it. As the Unit Manager was looking into it and the x-ray unit company had arrived at the facility to take the x-ray for Resident #1. The x-ray results were given to the NP and the NP wanted to know how this happened. The DON stated that she was looking into what happened, the NP gave orders to send Resident #1 out to the ER for further evaluation and treatment. During the investigation on 4/26/24 when the DON interviewed NA #2, NA #2 then told the DON about Resident #1's fall in the shower room on 4/24/24. The DON further revealed that all STAT orders should be fulfilled within 2 hours and if they had not been the Nurse should notify the DON or the Provider and the that the order had not been completed and the RP that there had been a change in condition.

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An interview on 5/8/24 at 10:00 AM with the Medical Director revealed that the NP was notified first and then she called him immediately. The MD stated that the NP then ordered an x-ray for unknown pain and decreased range of motion. He stated that NA #1 and NA #2 should have informed the facility about the fall, and he would have wanted Resident #1 assessed before being moved. The MD stated that he did not feel that the delay in notification had altered Resident #1's outcome. He stated that he expected the facility to inform him about the delay in the STAT x-ray order. The MD stated that he probably would not have sent Resident #1 to the ER for a hip x-ray since they were coming the following morning, but that was a decision for the Provider to make not the staff. Resident #1 was taking antiplatelet medication.

An interview on 5/8/24 at 1:49 PM with the Administrator revealed he expected staff to communicate to the Provider and the RP if there was a delay in a STAT order.

The Administrator was notified of Immediate Jeopardy on 5/8/24 at 4:41 PM.

The facility provided the following corrective action plan for removal of Immediate Jeopardy with a completion date of 5/4/24.

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

The facility failed to notify the MD/NP and RP when Resident #1 fell on 4/24/24 and failed to

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notify the NP when there was a delay in a stat x-ray order on 4/25/24. C.N.A. #1 and C.N.A #2 failed to notify a Nurse/MD or NP when Resident #1 fell on 4/24/24 and failed to notify before moving Resident #1 off the floor. C.N.A. #2 informed the NP on 4/25/24 that Resident #1 was having issues with her foot dragging. C.N.A #2 did not notify the NP of the fall on 4/24/24. NP performed an assessment on Resident #1, no bruising or swelling was noted. NP ordered stat x-ray and changed scheduled Tylenol to three times daily for pain. Radiology contacted facility on 4/25/24 and notified the floor nurse that they would not be able to obtain the stat x-ray until 4/26/24. Floor nurse did not notify NP of delay in stat x-ray. Director of Nursing and/or designee re-educated floor nurse on 5/3/24 on proper notification of MD for any delay in stat orders. X-ray results revealed acute fracture of left hip on 4/26/24. Facility notified Nurse Practitioner and received orders to send resident to the hospital on 4/26/24 for evaluation and treatment.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.
Director of Nursing and/or designee completed education on 4/26/24 and on 5/3/24 with all licensed nurses and CNA's including agency staff on notification to MD/NP and RP of all incidents or falls and accidents. Director of Nursing and/or designee completed education on 4/26/24 and 5/3/24 with all licensed nurses including agency staff on notification to MD/NP on delay of stat x-rays orders. Interviews were conducted with communicative residents on 4/29/24, 5/2/24 and 5/3/24. These interviews were conducted to determine if any issues regarding care and services would be identified. No other issues

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were identified. Unit managers completed skin checks on all residents on 4/26/24. Skin checks were completed to ensure there were no signs of injury from an unreported fall, no negative findings were noted. On 4/26/24 Director of Nursing checked for any other stat x-ray orders and there were none.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

The Director of Nursing and/or their designee on 4/26/24 educated 100% C.N.A.'s and licensed nurses including agency staff on reporting of incidents and accidents and reporting protocols and change in condition to physician or nurse practitioner. New hires to the facility are educated with the onboarding procedures. On 5/2/24 through 5/3/24 Director of Nursing and/or their designee educated all C.N.A.s and licensed staff including agency staff on reporting of accidents and incidents. On 4/26/24 the Director of Nursing and/or their designee educated all licensed nurses including agency nurses on stat orders and procedures. This education included notification to physician or NP on a delay of stat orders or other changes of condition for the residents.

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

The facility made the decision to have an ad hoc QAPI committee meeting on 5/3/24 as a result of our investigation into the incident. It was the decision of the QAPI committee to begin monitoring of this deficient practice beginning on

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5/6/24 for a period of 12 weeks.

Director of Nursing and/or their designee will obtain copies of new and stat x-ray orders from NP. Director of Nursing and/or their designee will audit results daily for 12 weeks to ensure order for x-rays are completed as ordered. NP was notified of this process on 5/3/24.

Director of Nursing and/or their designee will audit change of condition and incident reports daily for 12 weeks to ensure physician notification of incidents/accidents and falls has been completed.

Director of Nursing and/or designee will have daily huddles with licensed nurses and C.N.A.'s at beginning and end of shift to discuss any change in condition or incidents that may have occurred throughout the shift in order to ensure proper notifications have been made. This is to ensure that MD/NP have been notified of any incidents.

Results of the audits will be presented monthly to the QAPI committee meeting by the Director of Nursing and/or their designee for review/revision as needed for three months.

Corrective action will be completed: May 4, 2024

The facility alleged a IJ removal date of 5/4/24.

The Corrective Action plan was validated on 5/16/24 and verified the facility implemented an acceptable corrective action plan on 5/04/24 as evidenced by facility documentation and staff interviews. Review of the in-service sign-in sheets dated 4/26/24, 5/2/24, and 5/3/24 revealed all staff/all departments received education staff

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F 580	Continued From page 12 notification of incidents and accidents and reporting protocols and change in condition to physician or nurse practitioner. Interviews with facility staff revealed they received in-service education regarding the facility's incident reporting protocol and were able to verbalize what to do when a resident had a fall and who to notify of the fall. Review of the facility's monitoring tools dated 4/26/24 through 5/16/24 revealed they were completed as outlined in the corrective action plan with no concerns identified.	F 580		
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- §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 staff, Nurse Practitioner, and Medical Doctor interviews, the facility failed to protect a resident's right to be free from neglect when staff disregarded Resident #1's plan of care and transferred the resident without the use of a total mechanical lift and two-person assistance.	F 600	Past noncompliance: no plan of correction required.	

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During the first transfer Resident #1 was assisted to the floor. The following day (4/25/24) the Nurse Practitioner was asked to assess Resident #1 due to her left foot dragging on the floor and x-ray results revealed an acute fracture of the left hip. On 4/28/24 Resident #1 underwent surgery to repair the left hip fracture. On 5/1/24 Resident #1 was discharged from the hospital to hospice care and Resident #1 expired on 5/2/2024.

Findings included:

This tag is crossed referred to F 689.

Based on observation, record review, and staff, Nurse Practitioner, and Medical Doctor interviews, the facility failed to safely transfer a resident from the toilet to the shower chair when one staff member used the sit to stand mechanical lift instead of the total mechanical lift resulting in the resident falling to the floor for 1 of 3 sampled residents reviewed for accidents (Resident #1). On 4/24/24 Nurse Aide (NA) #1 transferred Resident #1 independently using a sit to stand mechanical lift. Resident #1's care plan indicated the resident required use of a total mechanical lift with 2-person assistance. During the transfer from the toilet to the sit to stand mechanical lift, Resident #1's foot slipped, and NA #1 had to lower Resident #1 to the floor. NA #1 requested help from NA #2 and they both assisted Resident #1 off the floor without using a mechanical lift. Transfers continued without using the total mechanical lift and assistance from two people. On 4/25/24 NA #2 reported to the Nurse Practitioner (NP) that Resident #1's left foot dragged the floor when in a wheelchair and asked for her to assess the resident. NA #2 did not inform the NP of Resident #1's fall on 4/24/24.

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The NP assessed Resident #1 and ordered STAT (immediate) x-rays on 4/25/2024. On 4/26/24 STAT x-ray results for Resident #1 revealed an acute fracture of the left hip. The Director of Nursing (DON) notified the NP who ordered Resident #1 to be sent out to the hospital for further evaluation and treatment. On 4/28/24 Resident #1 underwent surgery to repair the left hip fracture. On 5/1/24 Resident #1 was discharged from the hospital to hospice care and Resident #1 expired on 5/2/2024.

The Administrator was notified of Immediate Jeopardy on 5/8/24 at 4:41 PM.

The facility provided the following corrective action plan with a completion date of 5/4/24.

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

The facility failed to transfer resident #1 in a safe manner which resulted in a left hip fracture. Resident #1 was supposed to be transferred using a total lift and was transferred by C.N.A #1 with a sit to stand when the fall occurred. C.N.A. # 1 requested help from C.N.A. # 2. Both C.N.A.'s transferred the resident from the floor to her chair without the use of the proper lift. X-ray was obtained on 4/26/24 which revealed fracture of left hip, facility notified Nurse Practitioner and orders were obtained to transfer resident to the hospital for further evaluation and treatment. Immediate investigation for Injury of Unknown Origin was initiated on 4/26/24. The Director of Nursing conducted an interview with C.N.A. #2 which confirmed that resident was on the floor in the shower room, and she assisted

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C.N.A #1 in returning resident to chair. CNA #1 is no longer permitted to work at the facility, CNA #2 has been terminated.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.
The Director of Nursing and/or designee completed interviews with communicative residents on 4/26/24, 5/2/24 and 5/3/24 regarding care and services provided to identify any other injury of unknown origin. No other issues were identified. Unit managers completed skin check on all residents on 4/26/24 to ensure there were no signs or symptoms of injury noted, no negative findings were noted. Current lift status was obtained from the therapy department. Unit managers cross-referenced the lift status to the Kardex and Care Plans.

3. Address what measure will be put into place or systemic changes made to ensure that the deficient practice will not recur.
The Director of Nursing and/or their designee on 4/29/24 educated 100% C.N.A.'s and licensed nurses on safe transfers, reporting of incidents and accidents and reporting protocols. Agency staff will be educated prior to the first shift working on proper lifts, facility policies, and reporting all incidents and changes in condition. New hires to the facility are educated with the onboarding procedures. On 5/2/24 through 5/3/24 Director of Nursing and/or their designee educated all C.N.A.s and licensed staff on lift competencies and transfers and proper use of the lift, with return demonstration by the licensed staff and C.N.A.'s, reporting of accidents and incidents, following the Kardex for proper transfers and change in condition. On 5/2/24

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through 5/3/24 the Director of Nursing and/or their designee educated all facility staff on abuse and neglect, definition of abuse/neglect and facility policy for reporting. Staff educated that facility has no tolerance for abuse/neglect and will result in immediate termination. Director of Nursing and/or their designee educated agency staff on abuse/neglect policy, reporting and consequences of abuse/neglect on 5/3/24. New staff will be educated upon hire by the Director of Nursing and/or their designee.

4. Indicate how the facility plans to monitor it performance to make sure that solutions are sustained.
The facility made the decision to have an ad hoc QAPI committee meeting on 5/3/24 as a result of our investigation into the incident. It was the decision of the QAPI committee to begin monitoring of this deficient practice beginning on 5/6/24 for a period of 12 weeks.

To monitor ongoing compliance the Director of Nursing and/or their designee will complete observations of five (5) residents per week for 12 weeks to ensure residents requiring assist utilizing lifts are receiving the proper transfer. Unit Mangers will select 5 residents weekly over the next 12 weeks that currently use a lift and compare therapy lift status to the current care plan and Kardex to ensure accuracy.

Administrator and/or their designee will audit five (5) random staff members weekly times 12 weeks to ensure that they understand the definition abuse/neglect and the reporting requirements for abuse/neglect.

The Social Services Director and/or their

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F 600	Continued From page 17 designee will interview 5 alert residents and 5 responsible parties per week for 12 weeks to ensure that no abuse/neglect is occurring. Results of the audits will be presented monthly to the QAPI committee meeting by the Director of Nursing and/or their designee for review/revision as needed for three months. Completion date: May 4, 2024 The facility alleged a IJ removal date of 5/4/24. The Corrective Action plan was validated on 5/16/24 and concluded the facility had implemented an acceptable corrective action plan on 5/4/24. Interviews with nursing staff, including agency staff, revealed the facility had provided education and training on use of mechanical lift transfers that included requiring two-person assistance for all transfers, using the proper lift, identifying a resident's lift status on the Kardex, and lift identifying tag on the door, and gait belt training. Additionally, agency staff along with all facility staff were educated on the facilities abuse/neglect policy, reporting and consequences of abuse/neglect on 5/3/24. Staff interviewed all verbalized they were observed performing a mechanical lift transfer after receiving re-education and received re-education regarding the facilities abuse and neglect policies. Review of the monitoring tools of mechanical lift transfers that began on 4/29/24 and continued weekly for the next 12 weeks were completed as outlined in the corrective action plan with no concerns identified.	F 600		
F 684 SS=J	Quality of Care CFR(s): 483.25	F 684		

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F 684	Continued From page 18 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and Medical Doctor (MD), Nurse Practitioner (NP) and staff interviews, the facility failed to assess Resident #1 by a nurse after a fall and prior to getting her off the floor. Additionally, the facility failed to ensure a STAT (immediate) order for x-ray was executed resulting in delayed care. On 4/24/24 Nurse Aide (NA) #1 transferred Resident #1 from her bed to the sit to stand lift and transported Resident #1 to the shower room. During a transfer in the shower room from the toilet to the sit-to-stand lift Resident #1's foot slipped and NA #1 had to lower Resident #1 to the floor. NA #1 called for assistance from NA #2. NA #1 and NA #2 did not notify the Nurse that Resident #1 had fallen. An assessment for injury was not completed by a Nurse prior to Resident #1 being moved. On 4/25/24 the NP placed a STAT order for left hip x-ray at 2:00 PM. The facility was made aware there was a delay in the STAT x-ray and did not inform the NP. The results of the x-ray were available on 4/26/24 at 11:38 AM when the Director of Nursing (DON) notified the NP of the results. The NP sent Resident #1 to the hospital. A change in condition report indicated Resident #1 suffered pain and the final x-ray noted a fracture of Resident #1's left hip. This	F 684	Past noncompliance: no plan of correction required.	

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deficient practice affected 1 of 3 residents.

Findings included:

Resident #1 was admitted to the facility on 12/11/22 with diagnoses that included Alzheimer's disease, mild protein-calorie malnutrition, cerebral infarction (a disruption of blood flow to the brain), severe vascular dementia, history of falling, unsteadiness on feet, abnormalities of gait and mobility, reduced mobility, and lack of coordination.

An Activity of Daily Living (ADL) care plan, last revised 03/08/24, revealed Resident #1 had an ADL self-care performance deficit related to mobility, weakness, pain, temporal sclerosis (scarring of the temporal lobe of the brain), polymyalgia rheumatica (an inflammatory disorder that causes muscle pain and stiffness). Included was an intervention that noted Resident #1 required a total mechanical lift with a sling and two-person assistance for all transfers.

The quarterly Minimum Data Set (MDS) dated 03/25/24 assessed Resident #1 with severe impairment in cognition and had no impairment of the upper and lower extremities. Resident #1 required total dependence on staff assistance with bed mobility (roll left and right), toilet transfers, and tub/shower transfers. Resident #1 took antiplatelet and hypoglycemic medications and had no previous falls.

A phone interview on 5/7/24 at 10:52 AM with NA #1 (agency) revealed that she was assigned to Resident #1 for a shower only on 4/24/24 and had worked at the facility for approximately one month. She stated she gathered her items and

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the sit to stand mechanical lift and went to Resident #1's room. NA #1 stated she transferred Resident #1 from her bed with the sit to stand lift proceeded to the shower room where she placed Resident #1 on the toilet. She then transferred Resident #1 off the toilet with the sit to stand lift, Resident #1's foot slipped, and she lowered Resident #1 to the floor using the sling from the sit to stand mechanical lift. Once Resident #1 was lowered to the floor, NA #1 stated she stepped out into the hallway and called for help from NA #2. NA #2 came to help NA #1. NA #1 explained what happened to NA #2 and NA #2 replied that Resident #1 yelled like that sometimes. NA #1 and NA #2 then performed a 2-person physical assist to get Resident #1 up off the floor to her wheelchair. NA #1 stated she had not called a Nurse to assess Resident #1 because NA #1 did not think lowering Resident #1 to the floor qualified as a fall. She stated after the shower she told Nurse #1 about the yelling but did not tell her about Resident #1's foot slipping and lowering her to the ground.

A phone interview on 5/7/24 at 12:22 PM with NA #2 revealed that on 4/24/24 she was in another resident's room when NA #1 came out into the hall and asked her to come into the shower room. When she entered the shower room, she saw Resident #1 sitting on her bottom on the floor. She asked NA #1 what happened, and NA #1 stated that Resident #1 slid out of the sit to stand mechanical lift. She asked NA #1 if Resident #1 was alright and NA #1 got on each side of Resident #1, grabbed her by the pants, placed their arms under Resident #1's arms, lifted her into a wheelchair and then NA #2 left the shower room. NA #2 stated that she did not get a nurse to assess Resident #1 because she was told

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Resident #1 slid down to the floor and she (NA #2) had not thought of that as a fall. She stated that if she thought Resident #1 had fallen harder, she would have gotten a nurse immediately. NA #2 revealed that she had received education on falls being defined as any descent (action of moving downward, dropping or falling) to the floor by a resident. She stated that she should have told her nurse and had her assess Resident #1 before she was moved. She stated that she did not tell the NP about the incident in the shower the previous day because she had not associated the foot drag with the shower room incident.

A phone interview on 5/8/24 at 10:32 AM with Nurse #2 revealed he was Resident #1's assigned nurse on 4/24/24 and neither NA #1 nor NA #2 had mentioned anything to him about Resident #1's fall. He stated that during his interactions with Resident #1 on 4/24/24 she displayed no signs or symptoms of pain in the day room and later on in resident #1's room. He stated that his next shift was on 4/26/24 and he got report from the off going nurse that they were waiting on a hip x-ray to be completed for Resident #1. When the x-ray results were received on 04/26/24 and revealed that Resident #1 had a hip fracture, she was sent out to the emergency room (ER).

An interview on 5/7/23 12:06 PM with Nurse #1 revealed that she was not involved in the incident related to Resident #1's fall on 04/24/24. She stated that she worked on 4/24/24, but she was not Resident #1's assigned nurse. She further revealed that neither NA #1 nor NA #2 had come to her and spoke to her about Resident #1.

A phone interview on 5/7/24 at 12:54 PM with

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Nurse #3 revealed she was not working on 4/24/24 the day of the incident but was working the day after the incident on 4/25/24. She stated first thing in the morning (4/25/24) she went into Resident #1's room and she was lying flat on her back. Resident #1's vital signs and they were fine. She stated that Resident #1 was talking, and she seemed fine. She stated that around noon when NA #2 got Resident #1 up and put her in her wheelchair, NA #2 reported she noticed a decrease in range of motion in Resident #1's leg and informed the NP. The NP immediately assessed Resident #1 and ordered an x-ray. She stated she received no mention in shift report the morning of 4/25/24 of Resident #1's fall in the shower room the previous day. She stated that Resident #1 had not displayed any signs or symptoms of pain like yelling, moaning, grimacing, or guarding. She stated she did not see the x-ray staff come during her shift.

Record review of the Change in Condition document by Nurse #3 dated 04/25/24 revealed in part: Resident #1 was assessed due to a change in condition. Her vital signs were obtained and within normal limits. Resident #1 received anticoagulant medication and had no changes in mental or functional status. Resident #1 displayed signs/symptoms of pain and an order was received for a STAT (immediate) x-ray of the left hip for decrease range of motion and pain.

An interview on 5/7/24 at 10:27 AM with the NP revealed on 4/25/24 when she was coming down the hallway, NA #2 stopped her and told her something was wrong with Resident #1's leg. She stated that NA #2 told her when she (NA #2) had provided care to Resident #1 she yelled, and

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her leg dragged when (NA #2) attempted to push her in the wheelchair. When she assessed Resident #1, she yelled and guarded her left leg upon examination. She stated that Resident #1 was normally up in her wheelchair with a very calm personality, and she was not herself that day. The NP observed no bruising when she did a skin check. She ordered a STAT hip x-ray to the left hip for pain and decreased range of motion (ROM) but there was a delay from the x-ray company and the NP was not notified of the delay. The DON notified her on 4/26/24 of the x-ray results showing a fracture to the left hip and then she had the facility to send Resident #1 to the ER. She stated that had she known there was a delay in the x-ray she would have sent Resident #1 out to the ER sooner. She stated that NA #2 helped NA #1 on 4/24/24 when Resident #1 had the fall in the shower. The NP stated that NA #2 had not told her about the fall when she was alerted to Resident #1's pain on 4/25/24. She further revealed that had she known about Resident #1's fall she would have sent Resident #1 directly to the ER. The NP could not say for certain that the delay in care would have changed the outcome for Resident #1. She stated that communication with falls was very great at this facility, and this seemed like an anomaly (something that deviates from what is standard, normal or expected). She stated that when she ordered the STAT x-ray, she expected it to be completed in the evening of 04/25/24 after she had left for the day. She further revealed that if there was a delay in obtaining the STAT x-ray she expected to be informed of the delay via phone call. She stated that when a STAT order was placed, for example in the morning, it should be completed by the time she left at 5 PM.

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Record review of the physician's orders revealed in part:
" Stat X-ray for left hip for decreased range of motion and pain dated 4/25/24 at 12:48 PM.
" Tylenol Oral Tablet 325 milligrams (MG) (Acetaminophen), give 650 mg by mouth three times a day for pain started on 4/25/2024.

Record review of the radiology report dated 4/26/24 at 11:28 AM revealed there was an acute fracture of left hip.

Record review of the medication administration record (MAR) for April 2024 revealed that the acetaminophen was documented as administered per the physician's order until Resident #1's discharge to the hospital.

Review of Resident #1's daily pain scale from 4/24/24 through 4/26/24 revealed her pain was documented as 0.

Record review of the shower sheets from March 2024 through April 2024 revealed skin assessments were completed with no concerns noted.

An interview on 5/7/24 at 4:07 PM with the DON revealed that on 4/24/24 NA #1 that had taken Resident #1 into the shower. Resident #1 slid down with the help NA #1 who was from an agency. NA #1 called NA #2 into the shower room and NA #2 asked if Resident #1 was okay. She stated that NA #1 and NA #2 moved Resident #1 back into her wheelchair without having a nurse assess her. Then NA #2 left the shower room and neither NA #1 or NA #2 told anyone. On 4/25/24 NA #2 was providing a bed bath to Resident #1 then she got Resident #1 up

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into her wheelchair to take her to the small dining room and as NA #2 started to push Resident #1 out of the room in her wheelchair she noticed Resident #1's foot dragging. NA #2 adjusted Resident #1's foot and noticed there was a problem. NA #2 got the NP and asked her to assess Resident #1. The NP assessed Resident #1 and ordered a STAT hip x-ray for increased pain and decreased ROM. NA #2 said nothing about the fall on 4/24/24 at this point to anyone. On 4/26/24 in the morning meeting the DON was reviewing the orders from the previous day and she inquired about the x-ray order for Resident #1. The Unit Manager told her there were no results and she would look into it. As the Unit Manager was looking into it, the x-ray unit company had arrived at the facility to take the x-ray for Resident #1. The x-ray results were given to the NP and the NP wanted to know how this delay happened. The DON stated that she was looking into what happened, the NP gave orders to send Resident #1 out to the ER for further evaluation and treatment. The DON then shared the information with the Administrator and an investigation began for an injury of unknown origin. During the investigation on 4/26/24, NA #2 told the DON about Resident #1's fall in the shower room on 4/24/24. The DON notified the NP and the Administrator and implemented risk tools. She further revealed that all STAT orders should be fulfilled within 2 hours and if they had not been the Nurse should notify the DON or the Provider that the order had not been completed.

Record review of a progress note dated 4/26/24 at 10:56 AM written by the DON revealed in part: On 4/24/24 Agency NA #1 took Resident #1 to the shower. Was lowering Resident #1 to the toilet when her foot came off the sit to stand

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mechanical lift. NA #1 stated that she lowered the resident to the floor. Agency NA #1 called for NA #2 to assist with Resident #1. On 4/25/24 staff NA #2 transferred Resident #1 to her chair and noted resident was unable to hold her foot up while being wheeled. After repositioning and making another attempt, NA #2 immediately notified the NP that something was wrong with Resident #1. NP ordered a STAT x-ray of the left hip related to decreased mobility and pain. Final results of x-ray were received on 4/26/24. Results noted an acute fracture of the left hip at the intertrochanteric region. NP notified of results and order received to transfer Resident #1 to the ER for further evaluation and treatment. Resident #1 had remained at her baseline. Resident #1 was currently at the hospital.

An interview on 5/8/24 at 10:00 AM with the Medical Director revealed that the NP was notified first and then she called him immediately. He stated that the NP then ordered an x-ray for unknown pain and decreased range of motion. He stated that NA #1 and NA #2 should have informed the facility about the fall, and he would have wanted Resident #1 assessed before being moved. He stated that he did not feel that the delay in care had altered Resident #1's outcome. He stated that he expected the facility to inform him about the delay in the STAT x-ray order. He stated that he probably would not have sent Resident #1 to the ER for a hip x-ray since they were coming the following morning, but that was a decision for the Provider to make not the staff. He further stated that STAT to him meant completing it the day it was ordered, roughly 4-6 hours. He stated if a resident was lowered to the ground, he expected them to be assessed before they were moved.

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An interview on 5/8/24 at 1:49 PM with the Administrator revealed that an x-ray was ordered on 4/25/24. On 4/26/24 the results of an x-ray revealed that Resident #1 had a leg fracture and that was when they had discovered something had happened. The DON and himself investigated the incident. During the first interview NA #2 revealed Resident #1 had a fall on 4/24/24. The NP ordered Resident #1 to be sent out to the hospital for further evaluation and treatment. He stated this was a very unusual incident because they pride themselves on thorough communication. They started staff education that Friday 4/26/24. He stated he expected staff to communicate to the Provider if there was a delay in a STAT order and he would have to defer to the Medical Director for an appropriate time frame for STAT orders.

The Administrator was notified of Immediate Jeopardy on 5/8/24 at 4:41 PM. The facility provided the following corrective action plan with a completion date of 5/4/24.

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

The facility failed to have resident assessed by a nurse after the fall and prior to getting her off the floor. The facility failed to report the fall and improper transfer the next day when CNA #2 reported the resident having issues with her foot dragging. On 4/25/24 Nurse Practitioner was notified by C.N.A. #2 that resident could not move her left foot. Nurse Practitioner performed an assessment on resident, no bruising or swelling was noted. Nurse Practitioner ordered stat x-ray

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and changed Tylenol order to three times daily for pain. Radiology contacted facility on 4/25/24 and notified the floor nurse that they would not be able to obtain the stat x-ray until 4/26/24. Floor nurse did not notify NP of delay in stat x-ray. Director of Nursing and/or designee re-educated floor nurse on 5/3/24 on proper notification to MD for any delay in stat orders. X-ray results revealed acute fracture of left hip on 4/26/24. Facility notified Nurse Practitioner and received orders to send resident to the hospital on 4/26/24 for evaluation and treatment. Immediate investigation for Injury of Unknown Origin was initiated on 4/26/24. Director of Nursing conducted an interview with C.N.A. #2 which revealed the incident on 4/24/24 and a conclusion on how the fracture occurred. C.N.A. #2 confirmed that resident was on the floor in the shower room and C.N.A #2 assisted C.N.A #1 in returning resident to chair. C.N.A #1 cannot return to the facility, CNA #2 has been terminated from the facility.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.
Director of Nursing and/or designee completed interviews with communicative residents on 5/2/24 and 5/3/24 regarding care and services provided to identify any unreported incidents or other injury of unknown origin. No other issues were identified by residents. Head to toe skin assessments were completed on all residents by Unit Managers on 4/26/24. This was done to ensure there were no signs or symptoms of injuries related to incidents not being reported. No negative findings were noted from residents.

The Director of Nursing checked for any other stat x-ray orders on 4/26/24 and there were none.

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3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

The Director of Nursing and/or their designee completed education of 100% C.N.A.'s and licensed nurses on 4/29/24 which included, safe transfers, reporting of incidents and accidents, and reporting protocols and change in condition. This includes having a licensed nurse assess a resident after all falls and/or incidents. Agency staff will be educated prior to first shift working on proper lifts, facility policies, and reporting all incidents and change in condition. New hires to the facility are educated with the onboarding procedures. On 5/2/24 through 5/3/24 the Director of Nursing and/or their designee educated all C.N.A.s and licensed staff on reporting of incidents and accidents and the definition of a fall. Agency staff were educated prior to taking an assignment. On 4/26/24 the Director of Nursing and/or their designee completed 100% education of all licensed nurses on stat orders. This education included notification to MD/NP if stat order has been delayed. Agency nurses are educated on STAT orders prior to first shift working.

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

The facility made the decision to have an ad hoc QAPI committee meeting on 5/3/24 as a result of our investigation into the incident. It was the decision of the QAPI committee to begin monitoring of this deficient practice beginning on 5/6/24 for a period of 12 weeks.

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Director of Nursing and/or their designee will obtain copies of new and stat x-ray orders daily from NP. Director of Nursing and/or their designee will audit results daily for 12 weeks to ensure orders for x-rays are completed as ordered. NP was notified of this process on 5/3/24.

Director of Nursing and/or their designee will randomly audit five (5) staff members weekly for 12 weeks to monitor knowledge of reporting of incidents, falls and what is considered a fall.

Results of the audits will be presented monthly to the QAPI committee meeting by the Director of Nursing and/or their designee for review/revision as needed for three months.

Corrective action will be completed: May 4, 2024

The facility alleged a IJ removal date of 5/4/24.

The Corrective Action plan was validated on 5/16/24 and concluded the facility implemented an acceptable corrective action plan on 5/04/24 as evidenced by facility documentation and staff interviews. Review of the in-service sign-in sheets dated 4/29/24 revealed all staff/all departments received education that a resident that had a fall must be assessed by the nurse and the MD/provider must be immediately notified. Interviews with facility staff revealed they received in-service education regarding the facility's fall protocol and were able to verbalize what to do when a resident had a fall and who to notify of the fall. Interviews with nurses revealed they received additional education on 4/29/24 regarding the change to the facility's fall protocol and verbalized

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F 684	Continued From page 31 they were to call the MD/provider immediately anytime a resident had a fall with or without injury and regardless if the resident was on anticoagulant medication. Review of the facility's monitoring tools dated 4/26/24 through 5/16/24 revealed they were completed as outlined in the corrective action plan with no concerns identified.	F 684		
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, and staff, Nurse Practitioner, and Medical Doctor interviews, the facility failed to safely transfer a resident from the toilet to the shower chair when one staff member used the sit to stand mechanical lift instead of the total mechanical lift resulting in the resident falling to the floor for 1 of 3 sampled residents reviewed for accidents (Resident #1). On 4/24/24 Nurse Aide (NA) #1 transferred Resident #1 independently using a sit to stand mechanical lift. Resident #1's care plan indicated the resident required use of a total mechanical lift with 2-person assistance. During the transfer from the toilet to the sit to stand mechanical lift, Resident #1's foot slipped, and NA #1 had to lower Resident #1 to the floor. NA #1 requested help from NA #2 and they both assisted Resident #1 off the floor without using a	F 689	Past noncompliance: no plan of correction required.	

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mechanical lift. Transfers continued without using the total mechanical lift and assistance from two people. On 4/25/24 NA #2 reported to the Nurse Practitioner (NP) that Resident #1's left foot dragged the floor when in a wheelchair and asked for her to assess the resident. NA #2 did not inform the NP of Resident #1's fall on 4/24/24. The NP assessed Resident #1 and ordered STAT (immediate) x-rays on 4/25/2024. On 4/26/24 STAT x-ray results for Resident #1 revealed an acute fracture of the left hip. The Director of Nursing (DON) notified the NP who ordered Resident #1 to be sent out to the hospital for further evaluation and treatment. On 4/28/24 Resident #1 underwent surgery to repair the left hip fracture. On 5/1/24 Resident #1 was discharged from the hospital to hospice care and Resident #1 expired on 5/2/2024.

Findings included:

Resident #1 was admitted to the facility on 12/11/22 with diagnoses that included Alzheimer's disease, mild protein-calorie malnutrition, cerebral infarction (a disruption of blood flow to the brain), severe vascular dementia, history of falling, unsteadiness on feet, abnormalities of gait and mobility, reduced mobility, and lack of coordination.

An Activity of Daily Living (ADL) care plan, last revised 03/08/24, revealed Resident #1 had an ADL self-care performance deficit related to mobility, weakness, pain, temporal sclerosis (scarring of the temporal lobe of the brain), polymyalgia rheumatica (an inflammatory disorder that causes muscle pain and stiffness). The care plan included an intervention that noted Resident #1 required a total mechanical lift with a

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sling and two-person assistance for all transfers.

The quarterly Minimum Data Set (MDS) dated 03/25/24 assessed Resident #1 with severe impairment in cognition and had no impairment of the upper and lower extremities. Resident #1 required total dependence on staff assistance with bed mobility (roll left and right), toilet transfers, and tub/shower transfers. Resident #1 used antiplatelet and hypoglycemic medications.

A phone interview on 5/7/24 at 10:52 AM with NA #1 (agency) revealed that she was assigned to Resident #1 for a shower only on 4/24/24 and had worked at the facility for approximately one month. She stated she gathered her items and the sit to stand mechanical lift and went to Resident #1's room. NA #1 stated she transferred Resident #1 from her bed with the sit to stand lift proceeded to the shower room where she placed Resident #1 on the toilet. She then transferred Resident #1 off the toilet with the sit to stand lift, Resident #1's foot slipped, and she lowered Resident #1 to the floor using the sling from the sit to stand mechanical lift. Once Resident #1 was lowered to the floor, NA #1 stated she stepped out into the hallway and called for help from NA #2. NA #2 came to help NA #1. NA # 1 explained what happened to NA #2 and NA #2 replied that Resident #1 yelled like that sometimes. NA #1 and NA #2 then performed a two-person manual lift to get Resident #1 up off the floor to her wheelchair. NA #1 stated she had not called a Nurse to assess Resident #1 because NA #1 stated Resident #1 had not fallen. NA #1 got another mechanical lift pad, placed it around Resident #1, transferred Resident #1 with the sit to stand mechanical lift to the shower chair and gave her a shower without further incident.

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She stated that she transferred Resident #1 back to her wheelchair with the sit to stand mechanical lift and transported her to the dayroom. She stated after Resident #1 was transported to the dayroom, she told Nurse #1 about Resident #1 yelling but did not tell her about Resident #1's foot slipping from the mechanical lift and being lowered to the ground. NA #1 stated that she had not received orientation or education on resident transfers or lift equipment from the facility but had completed a checkoff list with her agency. NA #1 also stated that she was not educated on how to access resident care plans and she followed staff directions for resident care.

Record review of the shower sheet dated 4/24/24 revealed that Resident #1 was given a shower with no identified concerns and no skin issues noted and was signed by NA #1.

A phone interview on 5/7/24 at 12:22 PM with NA #2 revealed that on 4/24/24 she was in another resident's room when NA #1 came out into the hall and asked her to come into the shower room. When she entered the shower room, she saw Resident #1 sitting on her bottom on the floor. She asked NA #1 what happened, and NA #1 stated that Resident #1 slid out of the sit to stand mechanical lift. She asked NA #1 if Resident #1 was alright, and NA #1 stated that Resident #1 was okay. She stated she and NA #1 got on each side of Resident #1, grabbed her by the pants, placed their arms under Resident #1's arms, lifted her into a wheelchair and then NA #2 left the shower room. She further revealed that Resident #1 was supposed to use a total mechanical lift but that Resident #1 "can stand well" which was why she chose to use the sit to stand mechanical lift and had used the sit to stand mechanical lift to

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transfer Resident #1 prior to the incident. She stated that the Kardex is located at the nurse's station with all resident's lift requirements as well as it being on the resident's closet doors. She stated that she was Resident #1's assigned NA on 04/24/24 and she had not instructed NA #1 on how to transfer Resident #1. She stated that she worked from 7:00 AM to 3:00. She stated that Resident #1 had not displayed any signs or symptoms of pain or discomfort during her afternoon observations of her on 4/24/24. NA #2 stated that she had not thought to use the mechanical lift to get Resident #1 off the floor. She stated that she provided incontinence care to Resident #1 on 4/25/24, transferred her with the sit to stand lift to her wheelchair with no signs or symptom of pain or discomfort and Resident #1 was not yelling, moaning, screaming, or guarding her leg. She stated that when she went to take Resident #1 to the day room on 04/25/24, she noticed her foot dragging and went and told the NP. She stated that she did not tell the NP about the incident in the shower the previous day because she had not associated the foot drag with the shower room incident.

A phone interview on 5/8/24 at 10:32 AM with Nurse #2 revealed he was Resident #1's assigned nurse on 4/24/24 and neither NA #1 nor NA #2 had mentioned anything to him about Resident #1's fall. He stated that during his interactions with Resident #1 on 4/24/24 she displayed no signs or symptoms of pain. He stated that his next shift was on 4/26/24 and he got report from the off going nurse that they were waiting for a hip x-ray to be completed for Resident#1. When the x-ray results were received on 04/26/24 and revealed that Resident #1 had a hip fracture, she was sent out to the

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emergency room (ER).

An interview on 5/7/23 at 12:06 PM with Nurse #1 revealed that residents had a care guide posted on the door or in the resident's closet regarding how to transfer the residents and the information was also posted in the Kardex (NA guide that contains individualized care information) that was in a book at the nursing station desk.

An observation of the Kardex and resident care guides revealed they contained information on what type of lift and how many people to utilize with each specific type of lift were posted in the resident's rooms and at the nurses station.

Record review of the Change in Condition document by Nurse #3 and dated 04/25/24 revealed in part: Resident #1 was assessed due to a change in condition. Her vital signs were obtained and within normal limits. Resident #1 received anticoagulant medication and had no changes in mental or functional status. Resident #1 displayed signs/symptoms of pain and an order was received for a STAT (immediate) x-ray of the left hip for decrease range of motion and pain.

An interview on 5/7/24 at 10:27 AM with the NP revealed on 4/25/24 when she was coming down the hallway, NA #2 stopped her and told her something was wrong with Resident #1's leg. She stated that NA #2 told her when she (NA #2) had provided care to Resident #1 she yelled, and her leg dragged when (NA #2) attempted to push her in the wheelchair. When she assessed Resident #1, she yelled and guarded her left leg upon examination. She stated that Resident #1 was normally up in her wheelchair with a very

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AUTUMN CARE OF SALUDA	501 ESSEOLA CIRCLE SALUDA, NC 28773

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calm personality, and she was not herself that day. The DON notified her on 4/26/24 of the x-ray results showing a fracture to the left hip and then she had the facility to send Resident #1 to the ER. She stated that NA #2 helped NA #1 on 4/24/24 when Resident #1 had the fall in the shower. The NP stated that NA #2 had not told her about the fall when she was alerted to Resident #1's pain on 4/25/24. She further revealed that had she known about Resident #1's fall she would have sent Resident #1 directly to the ER.

Record review of the physician's orders for Resident #1 revealed in part:
- Tylenol Oral Tablet 325 milligrams (MG) (Acetaminophen), give 650 mg by mouth three times a day for pain started on 4/25/2024.
- STAT X-ray for left hip for decreased range of motion and pain dated 4/25/24 at 12:48 PM.

Record review of the radiology report dated 4/26/24 at 11:28 AM revealed there was an acute fracture of the left hip.

An interview on 5/7/24 at 4:07 PM with the DON revealed that on 4/24/24 NA #1 that had taken Resident #1 into the shower. She stated agency staff were given a "rundown" (information that was necessary for care delivery) from all nursing staff about the residents they would be caring for and told any nursing staff was a resource for questions they may have about giving care to the residents. She stated all total mechanical lifts required 2-person assistance. She stated that Resident #1 was a total lift for transfers and staff should have used the correct mechanical lift with 2-persons during the transfer.

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An interview on 5/8/24 at 10:00 AM with the Medical Director revealed the staff should have used the correct mechanical lift for Resident #1. He stated that those interventions were in place for the safety of the residents and the staff. He stated that if NA #1 and NA #2 had not used the incorrect mechanical lifts Resident #1 would not have fallen and acquired a fracture. He stated that NA #1 and NA #2 should have informed the facility about the fall, and he would have wanted Resident #1 assessed before being moved. He stated that the fall was directly related to Resident #1's death. He stated that if Resident #1 had not fallen, she would not have fractured her hip, and therefore would not have needed surgery which she did not recover from.

An interview on 5/8/24 at 1:49 PM with the Administrator revealed going forward he and the DON will be reviewing skills for all agency staff to ensure they have the required skills to provide safe patient care. His expectation was that nursing staff use the correct mechanical lifts that were care planned. He stated that Resident #1's fall with major injury was avoidable if staff had followed the care plan. He stated that any change of plane (an unintentional change in position that results in coming to rest on the ground or floor) that happens to a resident was considered a fall.

On 5/8/24 at 2:24 PM an observation of NA #3 and the Unit Manager revealed a total lift used with a 2-person assist during transfer of Resident #2. A green sling was secured to the lift and the brakes locked, the resident was lifted out of wheelchair; the lift brakes were unlocked, and Resident #2 was moved slowly over bed and lowered without difficulty. NA #3 stated she had

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training upon hire and recently related to the proper use of a total mechanical, sit-to-stand lift, and use of gait belt when transferring a resident. She explained a total lift transfer was used for Resident #2 because he cannot bear weight and always to used 2-person assistance; sit-to-stand was used when for resident that can bear weight and use a 1-person assist. She further stated the nurses helped with 2-person assist total lift transfers if the NAs were busy.

The Administrator was notified of Immediate Jeopardy on 5/8/24 at 4:41 PM. The facility provided the following corrective action plan with a completion date of 5/4/24.

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

The facility failed to transfer resident #1 in a safe manner which resulted in a left hip fracture. Resident #1 was supposed to be transferred using a total lift and was transferred by C.N.A #1 with a sit to stand when the fall occurred. C.N.A. # 1 requested help from C.N.A. # 2. Both C.N.A.'s transferred the resident from the floor to her chair without the use of the proper lift. X-ray was obtained on 4/26/24 which revealed fracture of left hip, facility notified Nurse Practitioner and orders were obtained to transfer resident to the hospital for further evaluation and treatment. Immediate investigation for Injury of Unknown Origin was initiated on 4/26/24. Director of Nursing conducted an interview with C.N.A. #2 which confirmed that resident was on the floor in the shower room and she assisted C.N.A #1 in returning resident to chair. CNA #1 is no longer permitted to work at facility, CNA #2

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has been terminated.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.
Director of Nursing and/or designee completed interviews with communicative residents on 4/26/24, 5/2/24 and 5/3/24 regarding care and services provided to identify any other injury of unknown origin. No other issues were identified. Unit managers completed skin check on all residents on 4/26/24 to ensure there were no signs or symptoms of injury noted, no negative findings were noted. Current lift status was obtained from therapy department. Unit managers cross referenced the lift status to the Kardex and Care Plans on 4/26/24.

3. Address what measure will be put into place or systemic changes made to ensure that the deficient practice will not recur.

The Director of Nursing and/or their designee on 4/29/24 educated 100% C.N.A.'s and licensed nurses on safe transfers, reporting of incidents and accidents, reporting protocols, and what constitutes a fall, which is a change of plane. Director of Nursing and/or their designee educated agency staff on 5/3/24 on proper lifts, facility policies, reporting all incidents and accidents, change in condition and what constitutes a fall, which is a change of plane. New hires to the facility are educated with the onboarding procedures by the Director of Nursing and/or their designee. On 5/2/24 through 5/3/24 Director of Nursing and/or their designee educated all C.N.A.s and licensed staff on lift competencies and transfers. Education also included proper use of the lift, with return

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demonstration by the licensed staff and C.N.A.'s. Staff were educated on how to report accidents and incidents, how to understand the Kardex for proper transfers, and how to report change of condition with residents. Director of Nursing and/or designee educated Agency staff on 5/3/24 prior to taking an assignment on the units and completed return demonstration to ensure understanding and compliance with education.

4. Indicate how the facility plans to monitor it performance to make sure that solutions are sustained.

The facility made the decision to have an ad hoc QAPI committee meeting on 5/3/24 as a result of our investigation into the incident. It was the decision of the QAPI committee to begin monitoring of this deficient practice beginning on 5/6/24 for a period of 12 weeks.

To monitor ongoing compliance the Director of Nursing and/or their designee will complete observations of five (5) residents per week for 12 weeks to ensure residents utilizing a lift are receiving the proper transfer.

Unit Mangers will select 5 residents weekly over the next 12 weeks that currently use a lift and compare therapy lift status to the current care plan and Kardex to ensure accuracy.

Results of the audits will be presented monthly to the QAPI committee meeting by the Director of Nursing and/or their designee for review/revision as needed for three months.

Corrective action will be completed: May 4, 2024

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F 689	Continued From page 42 The facility alleged a IJ removal date of 5/4/24. The Corrective Action plan was validated on 5/16/24 and concluded the facility had implemented an acceptable corrective action plan on 5/4/24. Interviews with nursing staff, including agency staff, revealed the facility had provided education and training on use of mechanical lift transfers that included requiring two-person assistance for all transfers, using the proper lift, identifying a resident's lift status on the Kardex, and lift identifying tag on the door, and gait belt training. Staff interviewed all verbalized they were observed performing a mechanical lift transfer after receiving reeducation. Review of the monitoring tools of mechanical lift transfers that began on 4/26/24 and continued weekly for the next 12 weeks were completed as outlined in the corrective action plan with no concerns identified.	F 689		
F 726 SS=J	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents'	F 726		

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F 726	Continued From page 43 needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure all nursing staff, including agency staff, received orientation to include the location of resident care guides or the Kardex (nurse aide guide that contains individualized care information) and verify competencies including resident transfers and total and sit to stand lifts prior to providing care for the residents in the facility. On 4/24/24 Nurse Aide (NA) #1 transferred Resident #1 independently using a sit to stand mechanical lift. Resident #1's care plan indicated the resident required use of a total mechanical lift with 2-person assistance. During the transfer from the toilet to the sit to stand mechanical lift, Resident #1's foot slipped, and NA #1 had to lower Resident #1 to the floor. NA #1 requested help from NA #2 and they both assisted Resident #1 off the floor without using a mechanical lift. Transfers continued without using the total mechanical lift and assistance from two people. On 4/26/24 x-ray results for Resident #1 revealed an acute fracture of the left hip. The Director of Nursing (DON) notified the	F 726	Past noncompliance: no plan of correction required.	

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NP who ordered Resident #1 to be sent out to the hospital for further evaluation and treatment. On 4/28/24 Resident #1 underwent surgery to repair the left hip fracture. On 5/1/24 Resident #1 was discharged from the hospital to hospice care and Resident #1 expired on 5/2/2024. This was for 1 of 5 staff members reviewed for competency.

Findings included:

Record review of the competency checklist dated 2/28/24 from the agency for NA #1 revealed for transfers it stated the skill as "transfer patient" and it was marked as previous training and experience. There was no additional information to indicate knowledge of using mechanical lifts.

Resident #1 was admitted to the facility on 12/11/22 with diagnoses that included Alzheimer's disease, mild protein-calorie malnutrition, cerebral infarction (a disruption of blood flow to the brain), severe vascular dementia severe, history of falling, unsteadiness on feet, abnormalities of gait and mobility, other reduced mobility, and lack of coordination.

An Activity of Daily Living (ADL) care plan, last revised 03/08/24, revealed Resident #1 had an ADL self-care performance deficit related to mobility, weakness, pain, temporal sclerosis (scarring of the temporal lobe of the brain), polyphagia rheumatic (an inflammatory disorder that causes muscle pain and stiffness). The care plan included was an intervention that noted Resident #1 required a total mechanical lift with a sling and two-person assistance for all transfers.

A phone interview on 5/7/24 at 10:52 AM with NA #1 (agency) revealed that she was assigned to

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Resident #1 for a shower only on 4/24/24 and had worked at the facility for approximately one month. She stated she gathered her items and the sit to stand mechanical lift and went to Resident #1's room. NA #1 stated she transferred Resident #1 from her bed with the sit to stand lift, proceeded to the shower room where she placed Resident #1 on the toilet. She then transferred Resident #1 off the toilet with the sit to stand mechanical lift, Resident #1's foot slipped, and she lowered Resident #1 to the floor using the sling from the sit to stand mechanical lift. Once Resident #1 was lowered to the floor, NA #1 stated she stepped out into the hallway and called for help from NA #2. NA #2 came to help NA #1. NA # 1 explained what happened to NA #2 and NA #2 replied Resident #1 yelled like that sometimes. NA #1 and NA #2 then performed a two-person manual lift to get Resident #1 up off the floor to her wheelchair. NA #1 got another mechanical lift pad, placed it around Resident #1, transferred Resident #1 with the sit to stand mechanical lift to the shower chair and gave her a shower without further incident. She stated she transferred Resident #1 back to her wheelchair with the sit to stand mechanical lift and transported her to the dayroom. NA #1 stated she had not received orientation or education on resident transfers or lift equipment from the facility but had completed a check list with her agency. NA #1 also stated that she was not educated on how to access resident care plans in the electronic health record nor that they were located at the nursing station, she was also unaware of the Kardex information, the care guide, and she followed nursing staff directions for resident care.

A phone interview on 5/7/24 at 12:22 PM with NA

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#2 revealed that on 4/24/24 she was Resident #1's assigned NA on 4/24/24 and she had not instructed NA #1 on how to transfer Resident #1 because NA #1 never asked her. She explained she was familiar with the Kardex system, how to use the care guides, and where each of those were located.

A phone interview on 5/8/24 at 10:32 AM with Nurse #2 revealed he was Resident #1's assigned nurse on 4/24/24 and NA #1 had not mentioned anything to him about Resident #1 or asked about a care guide.

An interview on 5/7/23 12:06 PM with Nurse #1 revealed residents had a care guide posted on the door or in the resident's closet regarding how to transfer the residents and the information was also posted in the Kardex that was in a book at the nursing station desk.

An interview was conducted on 5/8/24 at 12:12 PM with the Director of Nursing (DON) and the Scheduler. The Scheduler revealed she received a packet from the staffing agency with a skills competency check off sheet for NA #1. The Scheduler further revealed she had no clinical background and when she received packets from the staffing agency, she reviewed the skills competency check off sheet and "just asked questions about skill checkoff received from agencies," to the DON or Unit Manager if she had any questions about the skills of agency staff. When the DON and Scheduler were shown NA #1's skills competency check off sheet and asked to describe what "patient transfers" meant the DON responded the Scheduler did what not know what that meant and the Scheduler nodded her head in agreement.

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An interview on 5/7/24 at 4:07 PM with the DON revealed that NA #1 (agency) had not received orientation. She stated agency staff were given a "rundown" (basic resident care information not including Kardex or care guide locations) from facility staff about the residents they would be caring for and told any nursing staff was a resource for questions they may have about giving care to the residents. She further revealed she had the Scheduler review NA #1's competency skills paperwork that was sent over from the staffing agency, but she (DON) had had not done a skills competency check off with NA #1 prior to her providing resident care.

An interview on 5/8/24 at 1:49 PM with the Administrator revealed he and the DON would be reviewing skills for all agency staff to ensure they have the required skills to provide safe patient care. His expectation was that nursing staff use the correct mechanical lifts that were care planned. He stated Resident #1's fall with major injury was avoidable if staff had followed the care plan.

The Administrator was notified of Immediate Jeopardy on 5/8/24 at 4:41 PM. The facility provided the following corrective action plan with a completion date of 5/4/24.

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

The facility failed to ensure that the competency skills of C.N.A. #1 were verified prior to providing care to Resident #1 and failed to ensure that C.N.A #1 knew the location of the care guide

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information for the care of Resident #1 prior to the transfer of Resident #1 that resulted in a fall with major injury. C.N.A. #2 asked C.N.A. #1 about what type of transfer Resident #1 needed and was guided to use the sit to stand lift for Resident #1's transfer. Resident #1 was care planned to be transferred using a total lift, C.N.A. #2 advised C.N.A. #1 to utilize a sit to stand which resulted in a left hip fracture.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.
Director of Nursing and/or their designee on 5/2/24 and 5/3/24 completed education with facility licensed nurses and C.N.A.'s on lift competency with return demonstration. Licensed agency nurses and C.N.A.'s were educated on proper lift competency with return demonstration on 5/3/24. Education was also provided on where licensed nurses and C.N.A.'s can locate current lift status on 5/3/24.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

Director of Nursing and/or their designee educated all licensed nurses and C.N.A.'s, including agency staff on location of resident care guides.

All new facility licensed nurses and C.N.A.'s will receive education from the unit managers on the location of the resident care guides during their orientation. Unit Managers were notified of this responsibility on 5/3/24.

All licensed nurses and C.N.A.'s from an agency

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are required to come in prior to their first shift to receive lift training and review facility policies. This training is completed by the Director of Nursing and/or their designee. The nursing scheduler is responsible for scheduling agency staff for this orientation. The nursing scheduler notified the agencies on 5/3/24 of this requirement. Each agency staff is now required to read through facility policies and procedures related to resident care which are located at each nurse's station in the Agency Orientation book. They are to acknowledge understanding of these policies by signing the Policy Acknowledgement Sheet. Agency staff are required to complete lift competency prior to working, this is completed by the Director of Nursing and/or their designee. The facility is requiring the agency to provide the skills checklist of each agency staff member for review prior to working. The Director of Nursing and/or their designee will review the skills check list to ensure that they have the skills to meet the needs of our residents.

The Director of Nursing and/or their designee completed lift competencies with return demonstration for all licensed nurses and C.N.A.'s and agency staff on 5/3/24.

New hires will be educated Director of Nursing and/or designee on facility policies and lift competencies upon hire.

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

The facility made the decision to have an ad hoc QAPI (Quality Assurance and Process Improvement) committee meeting on 5/3/24 as a

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AUTUMN CARE OF SALUDA	501 ESSEOLA CIRCLE SALUDA, NC 28773

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F 726	Continued From page 50	F 726		

result of our investigation into the incident. It was the decision of the QAPI committee to begin monitoring of this deficient practice beginning on 5/6/24 for a period of 12 weeks.

The Director of Nursing and/or their designee will audit five (5) agency staff, licensed staff and C.N.A.'s, to the location of the care guides for the residents.

The Director of Nursing and/or their designee will audit five (5) facility and agency C.N.A.'s weekly for 12 weeks observing lift transfers. Any negative observations will be corrected immediately.

Results of the audits will be presented monthly to the QAPI committee meeting by the Director of Nursing and or their designee for review and/or revision as needed for three (3) months.

Corrective action will be completed: May 4, 2024

The facility alleged a IJ removal date of 5/4/24.

The Corrective Action plan was validated on 5/16/24 and concluded the facility had implemented an acceptable corrective action plan on 5/4/24. Interviews with nursing staff, including agency staff, revealed the facility had provided education and training on use of mechanical lift transfers that included requiring two-person assistance for all transfers, using the proper lift, identifying a resident's lift status on the Kardex, and lift identifying tag on the door, and gait belt training. Staff interviewed all verbalized they were observed performing a mechanical lift transfer after receiving re-education. Review of the monitoring tools of mechanical lift transfers that

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F 726	Continued From page 51 began on 4/26/24 and continued weekly for the next 12 weeks were completed as outlined in the corrective action plan with no concerns identified.	F 726		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will	F 867		5/31/24

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F 867	Continued From page 52	F 867		

systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

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F 867	Continued From page 53 §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by:	F 867		

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F 867	Continued From page 54 Based on record reviews and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the complaint investigation survey conducted on 12/12/23. This failure was for one deficiency originally cited in the area Free from Abuse and Neglect (F600) that was subsequently recited on the current complaint investigation survey conducted on 05/16/24. The repeat deficiencies during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The findings included: This tag is cross referred to: F600: Based on observation, record review, and staff, Nurse Practitioner, and Medical Doctor interviews, the facility failed to protect a resident's right to be free from neglect when staff disregarded Resident #1's plan of care and transferred the resident without the use of a total mechanical lift and two-person assistance. During the first transfer Resident #1 was assisted to the floor. The following day (4/25/24) the Nurse Practitioner was asked to assess Resident #1 due to her left foot dragging on the floor and x-ray results revealed an acute fracture of the left hip. On 4/28/24 Resident #1 underwent surgery to repair the left hip fracture. On 5/1/24 Resident #1 was discharged from the hospital to hospice care and Resident #1 expired on 5/2/2024. During a complaint investigation survey conducted on 12/12/23, the facility failed to	F 867	The Quality Assurance process was re-evaluated by the Administrator and the Director of Nursing on 5/31/2024 regarding Abuse/Neglect. The Administrator and the Director of Nursing reviewed the Federal Regulation F-867 Quality Assurance and Performance Improvement/Quality Assessment and Assurance (QAPI/QAA) Improvement Activities and policy and procedure for QAPI on 5/31/2024. On 5/17/2024 the Administrator and the Director of Nursing reviewed QAPI Committee meeting minutes from December 2023 to present, to identify any additional monitoring that needed to occur regarding F-600. It was determined that monitoring from the 12/12/2023 complaint was continuing through March 2024 with no additional recommendations from the committee. As a result of the incident on 4/24/2024, the QAPI Committee implemented additional monitoring. This monitoring was put into place on 5/3/2024 and will continue for 12 weeks. The Director of Nursing and/or their designee educated all facility and agency staff on reporting of abuse/neglect on 5/2/2024 and 5/3/2024. On 5/31/2024 the Administrator and the Director of Nursing were re-educated by the Regional Vice President of Operations (RVPO)related to the requirements of F-867 QAPI/QAA Improvement Activities and policy and procedures for QAPI. The RVPO and/or their designee will	

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F 867	Continued From page 55 protect the resident's right to be free of abuse when a family member pulled the TV remote from the resident's hands resulting in a fracture of the left index finger. An interview on 05/16/24 at 3:30 PM with the Administrator and Director of Nursing (DON) revealed the Quality Assurance and Process Improvement (QAPI) committee met monthly. The attendees included Department Heads, the Medical Director, and Pharmacist. The Administrator stated the deficiency from the previous survey involved a family member who was also a facility employee that was terminated and the survey of 05/16/24 was related to neglect when two Nurse Aides (NA) chose to use the incorrect mechanical lift to transfer the resident, and both were terminated. He stated the employees were terminated based on his zero tolerance for abuse and neglect and all staff were made aware of this and received abuse education. The DON stated education, monitoring, and audits continued of all staff including agency and they have been spoken to with stern emphasis on the concerns identified during the surveys. The Administrator stated the two abuse incidents were not related and he attributed the deficiency of the 05/16/24 survey related to neglect as poor and/or lack of judgement by the two NA staff.	F 867	complete a QAPI Audit Tool monthly for a minimum of three months beginning in June 2024 to ensure systems and processes continue to be monitored and follow-up is completed as required. Results of the audits will be presented monthly to the QAPI committee by the Administrator and/or their designee for review/revision as needed for three months. Completion Date: June 10, 2024	