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	345172	A. BUILDING _____ B. WING _____	C 09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN CENTER	**707 NORTH ELM STREET HIGH POINT, NC 27262**

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F 000	INITIAL COMMENTS An onsite complaint investigation survey was conducted from 09/03/24 through 09/04/24. Intakes NC00220059, NC00220600, NC00220930, NC00220930, NC00221181, NC00221259, and NC00221300 were investigated. Intake NC00221259 resulted in immediate jeopardy. 1 of the 13 complaint allegations resulted in a deficiency. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity J. The tag F689 constituted Substandard Quality of Care. Immediate jeopardy began on 6/12/24 and the facility came back into compliance effective on 6/14/24. A partial extended survey was conducted.	F 000		
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 observations, record review, and staff,	F 689	Past noncompliance: no plan of	

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

Electronically Signed | 09/18/2024

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resident, and Nurse Practitioner (NP) interviews the facility failed to transfer a resident safely from a shower to the resident's room. On 06/12/24 Resident #1 was being pushed in a shower chair down the hall by Nursing Assistant (NA) #1 and the resident fell forward out of the chair hitting the floor. The fall resulted in the resident being sent out to the hospital for complaints of severe pain. Resident #1 indicated from a 1-10 (10 being the most pain) her pain level was an 11 in her lower extremities and wanted to be sent out to the hospital immediately. Resident #1 was admitted to the hospital on 6/12/24 and was diagnosed with a left tibial plateau fracture (top part of the shin bone), right foot great toe fracture, and an acute displaced (bones are out of alignment) spiral (broken by twisting force) fracture of the right femur (thigh bone) requiring surgical repair. This was for 1 of 3 residents reviewed for providing supervision to prevent accidents (Resident #1).

Findings included:

Resident #1 was admitted to the facility on 07/20/22 with diagnoses which included pain, debility, and abnormalities of gait and motion.

Review of Resident #1's quarterly Minimum Data Set (MDS) dated 03/24/24 revealed Resident #1 was moderately cognitively impaired and was totally dependent with bathing and transfers. The MDS further revealed Resident #1 was coded for frequent pain and no impairment to range of motion. It was also indicated Resident #1 was coded for anticoagulants daily. Resident #1's MDS revealed the resident weighed 274 pounds (lb.) and was 62 inches in height.

correction required.

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Review of Resident #1's care plan revised 06/05/24 revealed Resident #1 was at risk for falls related to impaired mobility, impaired balance, weakness, pain, oxygen tubing (trip hazard), anxiety and use of psychotropics drugs and pain medication.

Review of progress note completed by Nurse #1 on 06/12/24 revealed Resident #1 was alert and oriented and was able to make needs known by staff. The note further revealed Resident #1 was being transported back to her room from a shower and the shower chair tilted over and the resident fell to the floor. The note indicated Resident #1 was assessed and Resident #1 appeared to be sluggish and the right hip was malformed. Nurse #1 and other staff attempted to assist Resident #1 off the floor using a mechanical life and Resident #1 screamed and cried of severe pain. The note revealed the Nurse Practitioner (NP), and Responsible Party (RP) were notified, and Resident #1 was sent to the hospital for evaluation and treatment.

Review of incident report dated 06/12/24 revealed Resident #1 had fallen with severe pain to the bi-lower extremities. NA #1 reported that as she returned from the shower Resident #1 started to slide from the shower chair and NA #1 immediately reported she stopped to attempt to assist however the resident fell from chair. The incident report further revealed the location of the fall was the hall and predisposing factors were the rugs/carpeting and equipment.

Review of Emergency Department note dated 06/12/24 revealed Resident #1 revealed she was in a shower chair that was being rolled across the floor when the wheels got stuck causing her to fall

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out of the chair. The note further revealed Resident #1 complained of severe right hip pain and bi-lateral knee pain. It was noted Resident #1's right leg was shortened and externally rotated. Resident #1 was given intravenous Fentanyl (narcotic analgesic) and Zofran (antiemetic). X-rays completed on 6/12/24 revealed Resident #1 sustained a left tibial plateau fracture, right foot great toe fracture, and an acute displaced spiral fracture of the right femur. An orthopedic surgeon was consulted and it was determined the femur fracture required surgical repair which would be completed the next day. Resident #1 returned to the facility on 06/25/24.

Interview conducted with Resident #1 on 09/03/24 at 12:10 PM revealed she had often showered in a shower chair and not had any issues before. Resident #1 further revealed she was only 5'2" and her feet were unable to touch the ground when she was sitting in the shower chair. Resident #1 stated on 06/12/24 she was leaving the shower room and, on the way back to her room NA #1 was pushing her fast pass the nurses' station. She felt the shower chair jerk when shower chair crossed over the threshold onto the carpeted hallway from the wood plank floor. Resident #1 indicated she felt like she went flying and hit her knees first and then went to her back. Resident #1 indicated from a 1-10 (10 being the most pain) her pain level was an 11 in her lower extremities and wanted to be sent out to the hospital immediately. Resident #1 stated she felt like the incident on 06/12/24 was a setback in being able to return home because of her physical mobility due to the injuries received. Resident #1 revealed she had a history of drug and alcohol abuse and was upset that she had to

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be on more pain medicine and was in more pain than before.

A phone interview conducted with NA #1 on 09/04/24 at 3:15 PM revealed on 06/12/24 she was transferring Resident #1 back to her room in a shower chair and the shower chair felt like it got caught and jerked when she passed the threshold onto the carpet past the nurses station. NA #1 further revealed the shower chair tilted forward, and Resident #1 went to her knees and then onto her back. NA #1 indicated Resident #1 immediately started to yell in pain and Nurse #1 had the resident sent out to the hospital. NA #1 indicated she often showered Resident #1, and the resident had always been able to balance and had no issues in the shower chair during transfers. NA #1 indicated the shower chairs were often hard to push on the carpet and the wheels would sometimes get stuck.

Interview conducted with Nurse #1 on 09/03/24 at 10:45 AM revealed on 06/12/24 she heard Resident #1 yelling "ouch, ouch, it hurts", and observed Resident #1 laying on the hallway floor on her back past the nurse's station in front of the shower chair. Nurse #1 further revealed NA #1 reported she was pushing Resident #1 back to her room in the shower chair and the wheelchair tugged like the resident's leg got caught and caused the wheelchair to tip forward. Nurse #1 stated she assessed Resident #1 and decided to have the resident sent out to the hospital due to the resident being in severe pain. Nurse #1 revealed Resident #1 was alert and oriented and was able to voice her own needs and concerns. Nurse #1 also revealed Resident #1 was able to sit up without assistance and her feet did not touch the floor in the shower chair due to the

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resident's height.

Interview conducted with the Director of Nursing (DON) on 09/03/24 at 11:10 AM revealed on 06/12/24 she was notified by a staff member that Resident #1 had fallen and found Resident #1 on the floor on her back with Nurse #1 and NA #1. The DON further revealed Nurse #1 had already assessed her and it was determined to send the resident out to the hospital due to the resident having pain in her legs. The DON further revealed NA #1 had reported to her that she had transferred the resident back to her room from the shower room and Resident #1 started to slide down in the chair onto the floor. The DON revealed she did not believe any fault in the incident but completed in-service training regarding transfers with staff and interventions included Resident #1 was changed to a shower bed for showers and footrests and safety belts added to shower chairs.

A phone interview conducted with the prior Nurse Practitioner (NP) on 09/03/24 at 11:55 AM revealed she was not present in the facility on 06/12/24 but was notified Resident #1 had a fall. The NP further revealed Resident #1 had history of osteopenia and comorbidities but was able to sit up without assistance that she could recall. The NP further revealed she did not recall details of the incident that occurred on 06/12/24.

An interview conducted with the Director of Rehab on 09/03/24 at 1:30 PM revealed Resident #1 was last seen for physical therapy in March 2024. It was further revealed Resident #1 was able to sit on the side of her bed with limited to no assistance with sitting up. The Director Rehab indicated the shower chair was appropriate for

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Resident #1.

The Administrator was notified of immediate jeopardy on 09/04/24 at 6:00 PM. The facility provided the following credible allegation of immediate jeopardy removal.

The corrective action plan was as followed:

Date of Immediate Jeopardy Removal: 06/14/24

How will corrective action be accomplished for those residents found to have been affected by the deficient practice?

On June 12, 2024 at 12:21pm, Nursing Assistant (NA) #1 was assisting resident #1 from the shower room back to her room as the resident was seated in the shower chair. Resident #1 fell out of the shower chair as she was being transported from the shower room to her room at an area on the carpeted hallway between the nurses' station and the resident's room.

Nurse #1 immediately assessed resident #1 to include vital signs, neuro checks, and pain assessment.

Nurse #1 noted Resident #1 to have increased pain to her lower extremities during assessment. Resident #1 was yelling and stating she was in pain. Resident #1 was unable to state specifically where her pain was located. The pain assessment conducted by Nurse #1 noted increased pain with movement to bilateral lower extremities by resident #1. A progress note dated June 12, 2024 at 12:21pm identified resident #1 right hip was malformed.

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Nurse #1 notified Nurse Practitioner (NP) and obtained an order to send resident #1 to the local hospital for further evaluation. Resident #1 was sent to the local hospital due to severe pain in bilateral lower extremities and her right hip being malformed.
The center recognizes that all residents that utilize shower chairs, shower stretchers and wheelchairs have the potential to be affected from the noncompliance with shower chairs, shower stretchers and wheelchairs. A review of resident#1 hospital admission records dated June 12, 2024 at 2:26pm releveled resident #1 had a left tibial plateau fracture, right foot great toe fracture, tibia/fibula fracture of the right leg, and an acute displaced spiral fracture of the right femur. Resident #1 was admitted to the local hospital on June 12, 2024. Resident #1 underwent an open reduction internal fixation of the right distal femur intramedullary (IM) nail retrograde on June 13, 2024.

How will the facility identify other residents having the potential to be affected by the same deficient practice?

On 6/12/24, the Director of Nursing audited incidents that occurred between 5/12/24 and 6/12/24 to ensure no significant events with any other residents were identified. No additional residents were identified to have significant injuries. The audit revealed no similar events, no injuries to any other residents.

On 6/12/24, the Director of Nursing and Unit Manager conducted a quality review to identify residents' mobility status as it relates to requiring the use of wheelchairs, shower stretchers and shower chairs. Identified residents' charts were

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reviewed to ensure no other significant events occurred during the transport by staff.

What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur?

The Maintenance Director completed a quality review on 6/12/24 on shower chairs and shower stretchers to ensure safety mechanisms were properly installed to ensure resident safety while being transported to and from the shower rooms. The safety mechanism is a safety belt designed for PVC shower chairs equipped with a quick release buckle. The safety belts were installed on all shower chairs.

On June 12, 2024, the Director of Nursing and/or Nursing Supervisor provided education to Licensed Nurses and Certified Nursing Assistants to include Agency Licensed Nurses and Agency Certified Nursing Assistants on Guidelines for Safe Bathing with the use of Shower Chair to prevent incidents and accidents as it relates to properly and safely transporting residents in shower chairs. The education provided to nursing staff includes shower chair use and description, safety instructions, guidelines for safe bathing with the use of a shower chair, stop and watch tool, and safety mechanism intended use. All newly hired Licensed Nurses and Certified Nursing Assistants to include newly hired Agency Licensed Nurses and Agency Certified Nursing Assistants will be educated during new hire orientation on Guidelines for Safe Bathing with the use of Shower Chair to prevent incidents and accidents as it relates to properly and safely transporting residents in shower chairs. The education provided to nursing staff includes

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shower chair use and description, safety instructions, guidelines for safe bathing with the use of a shower chair, stop and watch tool, and safety mechanism intended use.

How will the facility monitor its corrective actions to ensure the deficient practice will not recur?

Effective June 13, 2024, The Unit Manager and/or Director of Nursing will begin to observe a random sample of 8 residents per week for 4 weeks, then 5 residents per week for 4 weeks, then 3 residents per week for 4 weeks to ensure resident safety is maintained during transport in shower chairs by properly securing safety mechanisms on shower chairs.

On June 12, 2024, when the deficient practice was identified, The Nursing Home Administrator arranged an ADHOC Quality Assurance Performance Improvement meeting to be conducted on June 13, 2024, in collaboration with the Medical Director to discuss the root cause analysis of the deficient practice, implement a plan of correction to include monitoring beginning on June 13, 2024, to ensure resident safety during transportation in shower chairs.

The results of the quality monitoring will be brought to the monthly Quality Assurance meeting to ensure compliance of resident safety x 3 months. The improvement-monitoring schedule will be modified based on the findings of monitoring.

On 09/04/24, the facility's corrective action plan for immediate jeopardy removal effective 06/14/24 was validated by the following: Staff interviews revealed they had received education

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F 689	Continued From page 10 provided to nursing staff includes shower chair use and description, safety instructions, guidelines for safe bathing with the use of a shower chair, stop and watch tool, and safety mechanism intended use. A quality review was conducted to identify residents' mobility status. The Maintenance Director completed a quality review on all shower chairs and shower stretchers to ensure safety mechanisms were properly installed to ensure resident safety while being transported to and from the shower rooms and safety belt were installed on all shower chairs. Audits of transfers had been conducted and will continue to be conducted to be reviewed that residents had been transferred safely in shower chairs and beds. The immediate jeopardy removal plan was verified as corrected by 6/14/24.	F 689		