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	345182	A. BUILDING _____ B. WING _____	C 11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CRYSTAL COAST	2416 US HIGHWAY 70 EAST BEAUFORT, NC 28516

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted onsite from 11/12/24 through 11/14/24. Additional information was obtained remotely on 11/15/24. Therefore, the exit date was 11/15/24. Event ID# 0X7W11. The following intakes were investigated: NC00223876, NC00223091, and NC00223893. 1 of the 8 complaint allegations resulted in deficiency.	F 000		
F 689 SS=D	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 record review, staff and physician interviews, the facility failed to provide close supervision to a severely cognitively impaired resident and to implement effective interventions to prevent further falls when a resident was readmitted from the hospital after a fall. Resident #3 was at high risk for falls due to generalized weakness, lack of coordination, and impaired judgment. This deficient practice affected 1 of 3 residents reviewed for accidents. The findings included: Resident #3 was initially admitted to the facility on	F 689	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #3 was discharged on 10/05/24 and did not return. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 11/14/2024, a 30 day look back of all falls was reviewed. The audit	11/18/24

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

Electronically Signed | 12/12/2024

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F 689	Continued From page 1 09/11/24 with diagnoses which included orthopedic aftercare for fracture of left hip joint, presence of an artificial hip joint, Alzheimer's disease, vascular dementia severe with mood disturbance, peripheral vascular disease, osteoarthritis, chronic kidney disease stage 4, and long-term use of aspirin. A review of Resident #3's admission Minimum Data Set (MDS), dated 09/24/24, revealed the resident was severely cognitively impaired and had behavioral symptoms not directed towards others 1 to 3 days which put her at significant risk for physical illness or injury. The MDS indicated the resident had impairment on one side of her lower extremities and used a wheelchair as a mobility device. The MDS assessment indicated Resident #3's functional abilities as follows: 1) totally dependent on staff for sit to stand, chair/bed-to-chair transfer, and toilet transfers; 2) required the substantial/maximal assistance of staff for sit to lying and lying to sitting on side of bed; 3) walking 10 feet or her ability to bed/stoop from a standing position to pick up a small object was not assessed due to medical conditions or safety concerns. The MDS indicated Resident #3 had a fall in the last month prior to admission and had a fracture related to a fall in the 6 months prior to admission and had two or more falls since admission and had an injury (not major) on one fall. Resident #1's hospital discharge summary dated 10/4/24 indicated she was admitted on 10/02/24 following a fall and was found to have areas of small volume subarachnoid hemorrhage (occurs when a blood vessel bursts and bleeds into the space between the brain and the membrane that covers it) at her right cerebral (brain) hemisphere.	F 689	encompassed reviewing for fall occurrence process per facility policy. As of 11/15/2024, the facility has implemented the falls reduction program per facility policy for all affected residents that have the potential to be affected. 100% of staff were educated on the falls process was completed on 11-18-24. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: A falls monitoring form has been created to be able to quickly review each fall for compliance to ensure we are following our fall occurrence process per facility policy. The DHS will complete the audit during clinical meetings and the information will be presented to the administrator for review as a double check. This data is to be reviewed, completed and finalized by the Director of Health Services and then will be re-checked by the administrator. If any discrepancies are found the Director of Health Services will counsel the attending nurse who completed the data and reinforce education on the importance of each task. Indicate how the facility plans to monitor its performance to make sure solutions are sustained: 100% of Pruitt Health Crystal Coast staff were in-serviced on the need to follow the facility fall occurrence reduction policy to ensure we are following our fall	

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F 689	Continued From page 2 Neurosurgery recommended nonoperative management. She was noted to reply to questions, did not open her eyes, and was not oriented. Her discharge condition was listed as fair. The resident was discharged back to the facility on 10/4/24. A review of Resident #3's Care Plan, active as of 10/04/24, included a problem/focus area for being at risk for falls and fall-related injury due to generalized weakness, lack of coordination, psychotropic drug use, personal history of falls and impaired judgement secondary to dementia (initiated 9/18/24). The goal of this problem was that the resident would have a reduced risk for falls and fall-related injury. Approaches to this problem included assisting for toileting and transfers as needed; cueing for safety awareness as often as necessary; frequent rounds to monitor for attempts to ambulate without assistance; if head injury is suspected, nursing to initiate neurological checks per facility protocol; and keep environment safe; and place call light within reach; fall from bed times two without injury on 09/23/24; moved closer to a nurses' station to facilitate more frequent observation; and fall mats to bedside to reduce risk for injury related to falls were discussed during morning meeting and declined at this time due to increased risk for falls due to weakness, lack of coordination, and impaired cognition limiting ability to navigate mats. A review of Resident #3's 10/05/24 fall incident report, completed by Nurse #1 on 10/05/24, indicated the resident had an unwitnessed fall and had been found lying on the floor of her room, with her face up, at 6:45 A.M. Nurse #1 indicated Resident #3 had an injury to her left	F 689	occurrence process per facility policy for each fall. Fall audits will be performed 5x weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months until a pattern of compliance is achieved. An AD HOC QAPI meeting was completed on 11-14-24 which included facility Medical Director. This data will be presented during our QAPI Meetings monthly. Compliance Date: 11-18-24	

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lower extremity and that the resident complained of pain, rating it 6 out of 10 (10 being excruciating pain). The nurse noted the resident told her she had hit her head but had no obvious injuries. Nurse #1 indicated Resident #3's speech was clear, she responded to her name, she was agitated and complained of a headache. The nurse documented the resident's neurological exam as being normal, and documented first aid was rendered to the left lower extremity "skin tear versus laceration" by applying a dressing. The report indicated Resident #3 was not moved from the floor and a nursing assistant (NA) stayed with her until an Emergency Medical Technician (EMT) arrived.

A review of the Facility Event Investigation form, dated 10/05/24, revealed Resident #3 had been found on the floor, face up, next to her bed. Prior to the fall, the author of the form indicated the resident had been in her bed, which had been in a low position, and that her call bell was "in place." The author indicated that Resident #3 was very confused and unaware of her limitations and noted that dementia and prior falls had been contributing factors.

A review of Resident #3's change in condition communication form, completed by Nurse #1 on 10/05/24, revealed that Resident #3 was sent to the Emergency Room (ER). It indicated "history of falls and dementia" as other relevant information. Vital signs were documented as within normal limits and the nurse documented that Resident #3 "has been more agitated and vocal tonight" and that she had been "yelling a lot this shift" and had a 4 inch "laceration versus skin tear" to her left lower extremity. Nurse #1 documented the resident was having pain and

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wrote that it was "hard to tell if pain is new, has been yelling all night." The nurse documented notifications were made to the facility's medical director and the resident's Responsible Party and 911 had been called.

A telephone interview was conducted with Nurse #1 on 11/14/24 at 9:24 A.M. Nurse #1 confirmed she worked on 10/04/24 from 7PM until 7AM on 10/05/24 and had been assigned to care for Resident #3. Nurse #1 explained that she rounded on all of her residents after getting report from the off-going nurse. Nurse #1 stated that Resident #3 was always extremely confused and frequently tried to climb out of her bed. She stated that she was not sure of the falls prevention interventions that may have been in place for Resident #3, but she always made sure that all of her residents' beds were in the low position, that they had non-skid socks on, placed their call bells within their reach, and educated the residents to call for assistance when needed. Nurse #1 stated Resident #3's cognition was poor and stated she tried to educate her on calling for assistance but before she would walk away, the resident had already forgotten what she told her. When asked about Resident #3's 10/05/24 fall, Nurse #1 stated she did not recall that fall.

A telephone interview was conducted with Nurse #2 on 11/14/24 at 4:49 P.M. Nurse #2 confirmed she had been the one who found Resident #3 on the floor in her room on 10/05/24; she could not recall the time she found the resident, only that it was around the time of her medication pass. She explained she had been walking down the 600 hall and when she passed by Resident #3's room, she noticed her lying on the floor. She stated she went into the resident's room, quickly assessed

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her, and then called out for help. Nurse #2 stated there was a lot of blood and determined it had come from an injury one of her lower legs but was unable to recall which leg. She was able to recall that Resident #3 did not have socks on, her bed had been in the lowest position, and confirmed there were no fall mats beside the bed. Nurse #2 further explained that once Nurse #1 arrived at the resident's room, she stayed and dressed the resident's leg wound and then left the room. Nurse #2 stated she had been unaware that Resident #3 was considered a high fall risk and was unsure as to what fall prevention interventions had been in place for the resident. Nurse #2 stated she had been informed by Nurse #1 that the resident had other falls recently and that one of them had resulted in a brain bleed, and because of that, Nurse #1 told her that she was sending the resident out the ER for evaluation.

A telephone interview was conducted with Nursing Assistant (NA) #2 on 11/14/24 at 10:53 A.M. NA #2 confirmed she had worked 10/04/24 from 7PM until 7AM on 10/05/24 and had been assigned to care for Resident #3. NA #2 stated she had never been assigned to care for the resident before that shift but had been aware the resident had a lot of falls and had been considered a high fall risk. NA #2 explained that Resident #3 had been very confused throughout the night and had been yelling out almost all night. NA #2 stated that another NA (who she had been unable to recall), informed her the resident was always trying to get out of her bed. She indicated because of this, she made sure to keep the resident's bed in a low position and used pillows around her body and under her legs to help keep her positioned in the center of the bed.

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NA #2 stated that because another resident (who resided in a room near Resident #3's room) was actively dying and had family present through the night, she had tried to check on Resident #3 frequently because she wanted to keep her clean and dry and attempt to calm and quiet her. NA #2 stated that despite using the pillows, Resident #3 would push them away or kick away the one under her legs. She said that one time during the night, she found the resident with her legs hanging off one side of the bed and she had to pick them up and position her body in the center of the bed. NA #2 stated she recalled that Resident #3 "settled down" and slept for approximately one hour that night but that the rest of the night had been a challenge.

A telephone interview was conducted with NA #3 on 11/14/24 at 11:16 A.M. NA #3 confirmed she worked 10/04/24 from 7PM until 7AM on 10/05/24 and had not been assigned to care for Resident #3. NA #3 was unsure who found the resident on the floor the morning of 10/05/24 and thought it might have been a nurse. NA #3 stated she might have been assigned to care for the resident once or twice in the past but could not recall any specific fall prevention interventions that had been put into place for the resident. NA #3 stated she had been in the resident's room several times throughout the night because the resident had been hollering all night. After it was made known to her that the resident had fallen, she went to the room to assist. She stated she recalled noticing Resident #3's bed had been in the low position. NA #3 stated she thought the resident had gotten a cut on one of her legs but was unsure which leg and where the cut was. She remembered the resident did not complain about having any pain but said the resident kept telling the staff to get

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her up off the floor. NA #3 explained that she sat with the resident on the floor until EMS arrived.

A telephone interview was conducted with Nurse #3 on 11/14/24 at 11:49 P.M. Nurse #3 confirmed he worked 10/05/24 from 7AM until 7PM on 10/05/24 and had been assigned to care for Resident #3. Nurse #3 stated he vaguely remembered caring for the resident that morning. He stated he knew that she had a fall that morning which required him to check her vital signs and do neurological checks and thought he may have had time to do one set of the neurological checks prior to the resident leaving with EMS. Nurse #3 stated he had been aware that Resident #3 was considered a high fall risk and that she had dementia and had been very confused. He was unsure of any injuries the resident may have sustained from the fall on 10/05/24 and stated the resident did not return to the facility that day.

A review of the Emergency Medical Services (EMS) 10/05/24 transport record for Resident #3 revealed they had been called by the facility to transport Resident #3, who had fallen, to the local hospital. EMS assessments were documented and included normal vital signs and normal Glasgow Coma Scale (a clinical scale used to measure a person's level of consciousness after a brain injury) scores. Their documentation indicated Resident #3 had fallen 2 feet from her bed to the floor on 10/05/24 at 6:25 A.M. which resulted in a 1.5-inch abrasion to her inner right ankle.

Computed Tomography (CT) scan of the head completed on 10/5/24 with a comparison to a previous CT scan from 10/02/24 indicated

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evolving right greater than left predominantly frontal convexity (surface of the brain) subarachnoid hemorrhages.

An interview was conducted with the facility's Medical Director (MD) on 11/14/24 at 3:13 p.m. The MD stated that Resident #3 was very confused and also very fragile and weak. He stated that she was strong enough to stand up but not strong enough to stay up, so when she would stand up, she would go right down. The MD recalled she fell on the day of her admission to the facility (09/11/24) and had several more falls throughout the course of her stay. The MD thought that he remembered reading in her hospital records after the fall on 09/11/24 and that she might have had a mild heart attack which could have contributed to that fall. He explained she had been placed on Plavix (blood thinner) and aspirin for its anticoagulant properties as Resident #3 was not a candidate for a heart catheterization secondary to her multiple medical comorbidities including kidney disease. (Plavix and aspirin were held on readmission 10/04/24.) The MD stated he had been made aware of Resident #3's fall at the facility on 10/05/24 and could not recall the exact reason he sent her to the hospital but that he relied on the nurse's assessment and request to send her out for evaluation and treatment at the hospital as he had not been in the facility at the time of that fall. He also recalled her fall on 10/02/24 where her fall had caused a subarachnoid hemorrhage and stated the CT scan taken on 10/05/24 resulted in evolving right greater than left subarachnoid hemorrhages which he explained as the hemorrhages were worsening. In other words, he said the hemorrhages she had suffered from the 10/02/24 fall were not resolving. He further

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explained that Resident #3 was a very sick individual, and she had been sent back to the facility after the 10/02/24 fall because nothing could be done medically for her. The MD said he would expect the facility to have the same "generic fall prevention interventions" with all their residents who were considered a high fall risk. He did not elaborate on what these generic fall prevention interventions were. He also stated that the facility could not provide one on one supervision to residents who were considered a high fall risk. When asked, the MD stated that he would expect the facility to provide the same generic fall prevention interventions to a resident with a subarachnoid hemorrhage as they would to any resident that was deemed a high fall risk. The MD indicated Resident #3's prognosis was very grim as any resident's mortality rate increased after a fractured hip. He concluded and said that Resident #3 had significant mental status changes after the fall that resulted in her broken hip prior to admission to the facility.

A telephone interview was conducted with the Director of Nursing (DON) on 11/15/24 at 2:53 P.M. The DON confirmed that he was responsible for reviewing residents' falls in the facility as he was the Falls Coordinator. He stated that he was not fully aware of the facility's policy related to falls and putting fall prevention interventions in place after a resident's fall. He explained that he had yet to be trained by anyone regarding this. The DON further explained that he had wanted to discuss the falls policy with a corporate consultant and had been told they would come to the facility for this, however, they never came. He stated that he did have conversations with Resident #3's family regarding them hiring someone to sit with her for a

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F 689	Continued From page 10 one-to-one supervision to help prevent falls but stated he was not sure of the facility's policy for allowing this. The Administrator provided a statement via email on 11/15/24 at 3:55 P.M. A root-cause-analysis of Resident #3's falls and/or corrective action plan was not completed before this date. The Administrator wrote, "It is the expectation of our facility that all nursing staff follow our policies regarding falls."	F 689		