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	345381	A. BUILDING _____ B. WING _____	C 01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

(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 An unannounced onsite complaint investigation survey was conducted from 01/08/25 through 01/10/25. Additional information was obtained offsite on 01/17/25. Therefore, the exit date was changed to 01/17/25. Event ID #KGG611. The following intakes were investigated:NC00225476, NC00225205, NC00225160, and NC00223623. 3 of the 4 complaint allegations resulted in a deficiency.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that	F 580		

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

Electronically Signed | 02/04/2025

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F 580	Continued From page 1 all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, and resident, staff, and Medical Director interviews, the facility failed to notify the physician of a change in condition for 1 of 3 residents (Resident #1) reviewed for notification of changes. On 10/22/24 Resident #1 was lifted manually by Nursing Assistant (NA) #1 from the shower chair to the bed, causing Resident #1's right leg to hit the shower chair, get caught in between the shower chair and the bed, causing severe pain and swelling. On 10/22/24 Nurse #1, was notified by NA #1 that Resident #1 complained of pain. Nurse #1 did not notify the	F 580	Past noncompliance: no plan of correction required.	

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physician. On 10/22/24, Nurse #2, was informed by Resident #1 of her right leg hurting, and did not notify the physician. On 10/23/24, Nurse #3, who worked from 11:00 pm (10/22/24) to 7:00 am (10/23/24), was notified by NA (Unknown) that resident complained of pain, and did not notify the physician. On 10/23/24, Nurse #4, who worked from 7:00 am to 11:00 pm, was notified by NA (Unknown) that resident complained of pain. Nurse #4 did not notify the physician.

Findings included:

Resident #1 was admitted to the facility on 05/22/23 with diagnosis that included right hand contracture, spondylolisthesis (a condition where a vertebra in the spine slips out of place and onto the bone below it), spinal stenosis (narrowing of the spinal canal that occurs over time), and hypertension (HTN).

Resident #1's quarterly Minimum Data Set (MDS) dated 08/30/24 revealed she was cognitively intact.

An interview was conducted with Resident #1 on 01/08/25 at 1:15 pm. Resident #1 indicated that she recalled when her right leg got hurt. Resident #1 indicated that NA #1 had just finished giving her a shower and had returned Resident #1 to the room. Resident #1 indicated that she was on the shower chair, when NA #1 lifted her manually to transfer her back to bed. Resident #1 indicated that NA #1 transferred her by using NA #1's two arms underneath Resident #1's underarms and lifting her off the shower chair onto the bed. Resident #1 indicated that she could not stand or walk. Resident #1 indicated that when NA #1 lifted her manually from the shower chair to the

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bed, Resident #1's right leg hit the chair and got stuck between the shower chair and bed. Resident #1 indicated that she informed NA #1 that she was hurting. Resident #1 indicated that NA #1 proceeded with lifting her manually during the transfer, even after informing her that her leg was in severe pain of a 10/10 (with 0 being the least pain and 10 being the worst pain imaginable). Resident #1 indicated NA #1 completed the transfer and placed her in bed and she did not fall during the transfer. Resident #1 indicated that no nurse came in to assess her after she had reported to NA #1 that her leg was in severe pain. Resident #1 indicated that 2 days later, the pain got worse, and she could not bear it. Resident #1 indicated that she informed another NA (Resident could not recall name) about her pain getting worse. Resident #1 indicated at that time, Nurse #5 came in to assess her and that Nurse #5 was the only nurse who assessed her right leg. Resident #1 indicated that her pain was 10/10. Resident #1 indicated that Nurse #5 notified the provider, who ordered an x-ray that revealed she had fracture. Resident #1 indicated that she refused to go to the hospital and opted to be seen by an orthopedic doctor. Resident #1 indicated that she received new orders for additional pain medication for the severe pain in her right leg.

A telephone interview was conducted with NA #1 on 01/10/25 at 9:08 am. NA #1 indicated that she worked from 7:00 am to 3:00 pm on 10/22/24 and provided care to Resident #1. NA #1 stated on 10/22/24, Resident #1 had a shower scheduled. NA #1 indicated, after she completed the shower, she took Resident #1 back to her room, to transfer her back to bed at around 11am. NA #1 indicated that she transferred Resident #1 from

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the shower chair to the bed, by lifting her manually, with Resident #1's feet not touching the floor. NA #1 indicated that she placed Resident #1 on the bed. NA #1 indicated that after completion of the transfer and Resident #1 was in bed, Resident #1 verbalized that her leg was hurting but she was fine. NA #1 indicated that she reported to Nurse #1 that Resident #1 complained that her leg was hurting. NA #1 indicated that Nurse #1 did not go to assess Resident #1 or ask Resident #1 about the pain.

An interview was conducted with Nurse #1 on 01/09/25 at 12:11 am. Nurse #1 indicated that on 10/22/24 NA #1 reported that while giving Resident #1 a shower, Resident #1 stated her leg was hurting. Nurse #1 further stated that he went to Resident #1's room and asked if she was in pain, for which Resident #1 stated "no". Nurse #1 indicated he did not assess Resident #1 because he "did not see any reason to do anything further", when Resident #1 had stated she was not in pain. Nurse #1 indicated that he did not notify the physician because he did not assess Resident #1.

A telephone interview with Nurse #2 was conducted on 01/09/25 at 2:44 pm. Nurse #2 confirmed she worked on 10/22/24 between 3:00 pm to 11:00 pm and was assigned to Resident #1. Nurse #2 indicated Resident #1 reported to her that when the NA that gave her a shower was putting her to bed Resident #1's right leg got caught in the wheelchair and the bed and her right leg was hurting. Nurse #2 did not report the incident to the administration because she did not have a way of notifying them. Nurse #2 stated she put Resident #1's name on the medical director's book for "them to follow up" the next

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day (10/23/24). Nurse #2 indicated that she did assess Resident #1 and that she did not see any bruising or swelling. Nurse #2 could not recall which leg she assessed for Resident #1 or what she had written in the medical director's book.

Progress note dated written by Nurse #3 on 10/23/24 at 3:04 am indicated that "NA called this nurse to the room, resident complained of pain to right leg. Resident #1 had taken Tramadol 30 minutes prior. Applied ice and elevated. Call light in reach. Bed in lowest position. Will continue to monitor."

Multiple attempts made to reach Nurse #3 for an interview were unsuccessful.

Review of progress note dated 10/23/24 at 4:04 pm, written by Nurse #4, indicated that "Resident #1 has no complaints of pain at this time, will continue to monitor."

A telephone interview with Nurse #4 was conducted on 01/09/25 at 12:29 pm. Nurse #4 indicated that she recalled an NA notified her on 10/23/23, that Resident #1's ankle was hurting. Nurse #4 stated that she went in to ask Resident #1 if she was having pain, and Resident #1 stated she felt pretty good. Nurse #4 indicated that she did not assess the leg and did not notify the physician because she did not have anything to report or notify about Resident #1.

A progress note dated 10/24/24 at 10:41 am written by Nurse #5 revealed that "during morning medication pass author noted new medication for lidocaine patch to right leg. Author asked Resident #1 what happened to her leg that she is now needing that. Resident #1 stated on Tuesday

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(10/22/24) her leg got caught when being transferred and her leg has been hurting on/off since. Author asked Resident #1 how her pain has been, and Resident stated it hurt last night but once she got her pain medication she felt better and was able to rest and this morning she is having trouble flexing her toes to right leg. Author removed cover, right ankle noted, swollen, discolored. Author asked resident to wiggle toes and is able to do so slightly. Pedal pulses present. Nurse Practitioner (NP) made aware, ok for x-ray to site. Power of Attorney (POA) made aware. Resident #1 made aware of order. Foot elevated as tolerated and cold compress applied. Resident #1 stated that felt good. Call bell within reach."

On 10/24/24 at 10:41 am, order for "right ankle x-ray 2 view" was obtained by Nurse #5. X-ray results received on 10/24/24 at 3:46 pm that revealed "acute appearing distal tibia/fibula fracture."

A progress note dated 10/25/24 written by the NP indicated "86-year-old female patient is being seen today for right tibia/fib fracture. Contacted yesterday (10/24/24) about increased swelling and pain to right ankle and x-ray was ordered demonstrating fracture. Patient is refusing the hospital however she is okay with a stat orthopedic referral. Asked physical therapy for boot to be placed and it is present. Patient is thankful for pain medications. Resident stated on Tuesday (10/22/24) her leg got caught when being transferred and her leg has been hurting on/off since but that it was an accident."

Multiple attempts were made to reach NP for an interview were unsuccessful.

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On 1/9/25 at 11:00 am the Medical Director was interviewed about Resident #1. The Medical Director indicated that he did not assess Resident #1 at the time of the fracture but had reviewed the NP's assessment that was done on 10/25/24. The Medical Director stated he was not notified about the Resident #1 complaints of right leg pain on 10/22/24 but was aware that notification was made on 10/24/24. The Medical Director indicated that he would have expected staff to notify the physician with a change of condition.

An interview with Regional Nurse Consultant was conducted on 01/09/25 at 2:18 pm. The Regional Nurse Consultant indicated that Nurse #5 was the first nurse to notify the previous Director of Nursing (DON) and herself on 10/24/24 that Resident #1 had x-ray results indicating she had a right tibia fracture. The Regional Nurse Consultant stated Nurse #1, Nurse #2, Nurse #3 and Nurse #4 did not notify the physician. The Regional Nurse Consultant further stated they did not have any record of Nurse #2 or any other nurse notifying the physician or documenting in the medical director's book about Resident #1's complaints of pain. The Regional Nurse Consultant indicated that notification to the physician in reference to Resident #1's change of condition was initially made by Nurse #5 on 10/24/24.

An interview was conducted with the Administrator on 01/10/25 at 11:30 am. The Administrator indicated that all residents should have their needs met and that she required for the physician to be notified with resident change of condition.

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F 580	Continued From page 8 The facility provided the following corrective action plan. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 10/22/24 the nurse aide transferred Resident #1 using stand and pivot of one assist, the resident's leg got caught in shower chair, and the resident reported pain to the nurse aide. The nurse aide did not notify the nurse that the resident was transferred stand and pivot and did not notify the nurse that the resident's leg was caught in the shower chair and the resident reported pain. The licensed nurse on the following shift noted the new pain and treated the resident's pain with ice but did not notify the provider since the event did not happen on their shift. On 10/23/24 the licensed nurse noted that the resident reported pain to their leg and was treated with a prior existing as needed Tramadol order, but did not notify the provider of any change in condition. There was no documentation in the chart that the provider was notified until 10/24/24. On 10/24/24 the medical provider was notified of the change in condition with the transfer resulting in leg pain. New orders were obtained for an x-ray of the right leg. On 10/24/24 the provider was notified of the results of the x-ray which revealed a right distal tibia/fibula fracture. The resident declined to go to the hospital and a follow-up orthopedic appointment was made for 10/29/24. Address how the facility will identify other	F 580		

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residents having the potential to be affected by the same deficient practice:

On 10/24/24 the Administrator or designee interviewed all alert and oriented residents if they have been transferred appropriately by staff and if they have any unreported injuries or changes in condition. On 10/24/24 the Director of Nursing or designee assessed all non-alert residents for new unreported injuries or changes in condition. No other issues were identified.

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

On 10/24/24 the Director of Nursing or Designee educated all facility licensed nurses and certified nurse aides and all agency licensed nurses and certified nurse aides on change of condition notification to the nurse and timely change of condition notification to the provider. Education was provided verbally and in writing. Nurses were educated to check the resident record for documentation of notification to the provider and if there is no documentation to notify the provider and document the notification. Nurse aides were educated to notify the nurse as soon as a new change of condition was identified. For example as soon as new pain is identified the aide should immediately inform the nurse and inform the nurse if there was a situation to cause the new pain, like an issue with a transfer. Staff will not be able to work until they receive this education. All new and agency licensed nurses and certified nurse aides will receive this same education during orientation. The Scheduler will track that newly hired staff and agency staff have been educated.

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F 580	Continued From page 10 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: A Quality Assurance and Performance Improvement (QAPI) meeting was held with the Administrator, Minimum Data Set Coordinator, Therapy Director, Business Office Director, Medical Records, Director of Nursing, Housekeeping, Maintenance, Admissions, and Payroll on 10/28/24 to review the plan of correction and the decision was made to continue audits for 8 weeks. Beginning 10/28/24 the Director of Nursing or designee will complete a head-to-toe assessment on 3 residents per week for unreported injuries or changes in condition. Audits will continue for 8 weeks. Results of the audits will be reviewed by the QAPI committee and the plan of correction will be edited as needed. Alleged Compliance date: 10/29/24 The facility's corrective action plan was validated by the following: On 01/10/25 the facility's plan of correction was validated upon review of the sign-in sheets for in-service education provided to all licensed nurses and certified nurse aides on change of condition notification to the nurse and timely change of condition notification to the provider. Review of the monitoring audits revealed no concerns identified. Interviews conducted with licensed nurses and	F 580		

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F 580	Continued From page 11 certified nurse aides revealed they had received education on the change of condition notification to the nurse and timely change of condition notification to the provider. In addition, the plan of correction was validated upon review of the sign-in sheets for in-service education provided to all licensed nurses and certified nurse aides on notification of change in condition policy. Record review of sampled residents who recently had changes in condition revealed no concerns. The compliance date of 10/29/24 for the corrective action plan was validated.	F 580		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 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 resident, staff and Medical Director interviews, the facility failed to complete and document ongoing comprehensive assessments after Resident #1 reported leg pain which delayed medical treatment and interventions for 1 of 3 residents (Resident #1) reviewed for assessments. On 10/22/24 Resident #1 was lifted manually by Nursing Assistant (NA) #1 from the shower chair to the bed, causing Resident #1 right leg to hit the shower chair, get caught in between the shower chair and the bed, causing pain and swelling. On 10/22/24, between	F 684	Step 1 Resident remains in the facility. She transfers with the mechanical lift and is no longer having pain related to the fracture. Step 2 On 1/30/25 the Director of Nursing or designee reviewed the last two weeks of progress notes, and events for changes in condition to ensure the nurse completed a comprehensive assessment. Any changes of condition that were identified without a comprehensive nurse assessment was	2/7/25

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F 684	Continued From page 12 11:00 am and 11:30 am, Nurse #1 was notified by NA #1 that Resident #1 complained of pain and Nurse #1 did not complete an assessment. Nurse #2 was assigned to Resident #1 on 10/22/24 from 3:00 pm to 11:00 pm and did not complete a comprehensive assessment and only documented she did not observe any bruising or open area. Nurse #3 (assigned to Resident #1 on 10/22/24 at 11:00 pm to 7:00 am on 10/23/24) and Nurse #4 (assigned to Resident #1 10/24/24 from 7:00 am to 11:00 pm) were notified by an NA that Resident #1 was in pain and did not document assessments of Resident #1's right leg. On 10/24/24, Resident #1 reported right leg pain to Nurse #5 who assessed the resident and noted Resident #1's leg was swollen and discolored and notified the physician. Findings included: Resident #1 was admitted to the facility on 05/22/23 with diagnosis that included right hand contracture, spondylolisthesis (a condition where a vertebra in the spine slips out of place and onto the bone below it), spinal stenosis (narrowing of the spinal canal that occurs over time), and hypertension (HTN). Review of physician orders revealed on 4/01/24 Resident #1was prescribed Tramadol 50mg (milligrams) three times a day for pain. Resident #1's quarterly Minimum Data Set (MDS) dated 08/30/24 revealed she was cognitively intact. An interview was conducted with Resident #1 on 01/08/25 at 1:15 pm. Resident #1 indicated that she recalled when her right leg got hurt. Resident	F 684	discussed with the provider. On 2/4/25 all alert and oriented residents were interviewed if they have had any changes of condition, staff who have worked in the last 24 hours were interviewed if they are aware of any changes in condition and the medical record was reviewed for a comprehensive nurse assessment. Any issues identified a comprehensive assessment was completed and the provider was notified. Step 3 On 1/30/25 the Director of Nursing or designee educated all licensed nurses that a comprehensive nurse assessment must be completed and documented in the electronic medical record and the provider must be notified with each change in condition. Any licensed nurse who did not receive this education on 1/30/25 will receive this education prior to their next shift. All new hired licensed nurses will receive this education during orientation. All agency licensed nurses will receive this education prior to taking an assignment. The IDT staff will interview and observe residents during concierge rounds for changes in condition and review for a comprehensive nurse assessment during clinical meeting. Step 4 Beginning the week of 2/3/25 the Director of Nursing or designee will review five resident records per week for a change in condition and to ensure the nurse completed a comprehensive assessment and notified the provider. Director of Nursing or designee will interview five residents' records per week for a change	

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F 684	Continued From page 13 #1 indicated that NA #1 had just finished giving her a shower and had returned Resident #1 to the room. Resident #1 indicated that she was on the shower chair, when NA #1 lifted her manually to transfer her back to bed. Resident #1 indicated that NA #1 transferred her by using NA #1's two arms underneath Resident #1's underarms and lifting her off the shower chair onto the bed. Resident #1 indicated that she could not stand or walk. Resident #1 indicated that when NA #1 lifted her manually from the shower chair to the bed, Resident #1's right leg hit the chair and got stuck between the shower chair and bed. Resident #1 indicated that she informed NA #1 that she was hurting. Resident #1 indicated that NA #1 proceeded with lifting her manually during the transfer, even after informing her that her leg was in severe pain of a 10/10 (with 0 being the least pain and 10 being the worst pain imaginable). Resident #1 indicated NA #1 completed the transfer and placed her in bed and she did not fall during the transfer. Resident #1 indicated that no nurse came in to assess her after she had reported to NA #1 that her leg was in severe pain. Resident #1 indicated that days later, the pain got worse, and she could not bear it. Resident #1 indicated that she informed another NA (Resident could not recall name) about her pain getting worse. Resident #1 indicated at that time, Nurse #5 came in to assess her and that Nurse #5 was the only nurse who assessed her right leg. Resident #1 indicated that her pain was 10/10. Resident #1 indicated that Nurse #5 notified the provider, who ordered an x-ray that revealed she had fracture. Resident #1 indicated that she refused to go to the hospital and opted to be seen by an orthopedic doctor. Resident #1 indicated that she received new orders for additional pain medication for the	F 684	of condition and audit that there was a comprehensive assessment completed. The Director of Nursing or designee will interview five staff and five residents per week for changes in conditions and audit that a comprehensive assessment has been completed. Audits will continue for 12 weeks. Results of these audits will be brought before the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for three months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. The Director of Nursing will be responsible for implementation of the plan. Date of Compliance: 2/7/2025	

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severe pain in her right leg.

Written statement from NA #1, with no date indicated, was reviewed. The statement stated, "I NA #1 gave Resident #1 a shower and transferred her to bed with another NA in the room. At this time and Resident #1 said she hurt but proceeded to tell NA#1 that she (Resident#1) was ok and not to worry. Resident #1 was fine, and NA#1 did report it to the nurse."

A telephone interview was conducted with NA #1 on 01/10/25 at 9:08 am. NA #1 indicated that she worked from 7:00 am to 3:00 pm on 10/22/24 and provided care to Resident #1. NA #1 stated on 10/22/24, Resident #1 had a shower scheduled. NA #1 indicated, after she completed the shower, she took Resident #1 back to her room, to transfer her back to bed at around 11:00 am. NA #1 indicated that she transferred Resident #1 from the shower chair to the bed, by lifting her manually, with Resident #1's feet not touching the floor. NA #1 indicated that she placed Resident #1 on the bed. NA #1 indicated that after completion of the transfer and Resident #1 was in bed, Resident #1 verbalized that her leg was hurting but she was fine. NA #1 indicated that she reported to Nurse #1 that Resident #1 complained that her leg was hurting. NA #1 indicated that Nurse #1 did not go to assess Resident #1 or ask Resident #1 about the pain. NA #1 indicated that she could not recall if she had informed Nurse #1 she transferred Resident #1 from shower chair to bed, by lifting Resident #1 manually. NA #1 stated that Resident #1 did not fall during transfer. NA #1 further stated, she could not recall if Resident #1 hit her leg or foot on anything during transfer. NA #1 revealed she did not recall if Resident #1's foot got stuck

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between the shower chair and the bed during transfer.

Written statement from Nurse #1, dated 10/25/24, was reviewed. Nurse #1 stated "On 10/22/24 NA reported to me that Resident #1 moaned while receiving care but was now okay. Upon administering medication to Resident #1, I asked Resident #1 if she was in pain/discomfort as I had heard that Resident #1 expressed a groan upon being repositioned. Resident #1 stated she was fine. I asked Resident #1 for a number on 1-10 pain scale, and she reported none. I was not aware that Resident #1 had been transferred and more importantly transferred inappropriately at that time, as that was not reported to me by the aide."

An interview was conducted with Nurse #1 on 01/09/25 at 12:11 am. Nurse #1 indicated that on 10/22/24 NA #1 reported that while giving Resident #1 a shower, Resident #1 stated her leg was hurting. Nurse #1 further stated that he went to Resident #1's room and asked if she was in pain, for which Resident #1 stated "no". Nurse #1 indicated he did not assess Resident #1 because he "did not see any reason to do anything further", when Resident #1 had stated she was not in pain. Nurse #1 also revealed that he did not ask Resident #1 what happened. Nurse #1 could not recall if he reported to the oncoming nurse about Resident #1's complaint of pain.

Review of progress note dated 10/22/24 at 11:31 pm, written by Nurse #2, indicated that "patient stated to nurse that the NA that gave her a shower, while putting her to bed, patients right leg got caught in the wheelchair and the bed. She stated that her right leg was hurting and wanted

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to put some ice on it, which nurse did. No bruising or open area on leg. Will have medical doctor follow up."

A telephone interview with Nurse #2 was conducted on 01/09/25 at 2:44 pm. Nurse #2 confirmed she worked on 10/22/24 between 3:00 pm to 11:00 pm and was assigned to Resident #1. Nurse #2 indicated Resident #1 reported to her that when the NA that gave her a shower was putting her to bed Resident #1's right leg got caught in the wheelchair and the bed and her right leg was hurting. Nurse #2 did not report the incident to the administration because she did not have a way of notifying them. Nurse #2 stated she put Resident #1's name on the medical director's book for "them to follow up" the next day (10/23/24). Nurse #2 indicated that she did assess Resident #1 and that she did not see any bruising or swelling. Nurse #2 could not recall which leg she assessed for Resident #1 or what she had written in the medical director's book.

Review of the medical record revealed Nurse #2 did not document an assessment of Resident #1's leg on 10/22/24.

Progress note dated written by Nurse #3 on 10/23/24 at 3:04 am indicated that "NA called this nurse to the room, resident complained of pain to right leg. Resident #1 had taken Tramadol 30 minutes prior. Applied ice and elevated. Call light in reach. Bed in lowest position. Will continue to monitor."

Multiple attempts made to reach Nurse #3 for an interview were unsuccessful.

Review of progress note dated 10/23/24 at 4:04

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pm, written by Nurse #4, indicated that "Resident #1 has no complaints of pain at this time, will continue to monitor." The progress noted did not include an assessment of Resident #1's right leg.

A telephone interview with Nurse #4 was conducted on 01/09/25 at 12:29 pm. Nurse #4 indicated that she worked 10/23/24 from 7:00 am to 11:00 pm and recalled that an NA notified her on 10/23/24, that Resident #1's ankle was hurting. Nurse #4 stated that she went in to ask Resident #1 if she was having pain, and Resident #1 stated she felt pretty good. Nurse #4 indicated that she did not assess the leg and did not notify the provider. Nurse #4 indicated that she did not assess Resident #1 leg because, Resident #1 had reported that she felt good. Nurse #4 indicated that she did not recall reporting to the oncoming nurse about Resident #1's ankle hurting.

Physician order initiated 10/23/24 for Lidocaine adhesive 5% patch, applied once a day to right leg for pain with first dose administered on 10/24/24.

A progress note dated 10/24/24 at 10:41 am written by Nurse #5 revealed that "during morning med (medication) pass author noted new medication for lidocaine patch to right leg. Author asked Resident #1 what happened to her leg that she is now needing that. Resident #1 stated on Tuesday (10/22/24) her leg got caught when being transferred and her leg has been hurting on/off since. Author asked Resident #1 how her pain has been, and Resident stated it hurt last night but once she got her pain medication she felt better and was able to rest and this morning she is having trouble flexing her toes to right leg.

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Author removed cover, right ankle noted, swollen, discolored. Author asked resident to wiggle toes and is able to do so slightly. Pedal pulses present. Nurse Practitioner (NP) made aware, ok for x-ray to site. Power of Attorney (POA) made aware. Resident #1 made aware of order. Foot elevated as tolerated and cold compress applied. Resident #1 stated that felt good. Call bell within reach."

A phone interview with Nurse #5 was conducted on 1/9/25 at 1:45 pm. Nurse #5 indicated that on 10/24/24 she worked from 7:00 am to 3:00 pm. Nurse #5 indicated that on 10/24/24, Resident #1 informed her she was in pain. Nurse #5 revealed that it was not normal for Resident #1 to complain of pain especially because she was already on scheduled pain medication. Nurse #5 further stated that she asked Resident #1 what was hurting her, even with her having received scheduled pain medication. Nurse #5 indicated that Resident #1 stated that her right leg was hurting. Nurse #5 indicated that she then assessed Resident #1's leg and noted that it was swollen and discolored. Nurse #5 indicated that she then notified the physician, who ordered x-ray's to be done.

On 10/24/24 at 10:41 am, order for "right ankle x-ray 2 view" was obtained by Nurse #5. X-ray results received on 10/24/24 at 3:46 pm that revealed "acute appearing distal tibia/fibula fracture."

A progress note dated 10/25/24 written by the NP indicated "86-year-old female patient is being seen today for right tibia/fib (fibula) fracture. Contacted yesterday about increased swelling and pain to right ankle and x-ray was ordered

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demonstrating fracture. Patient is refusing the hospital however she is okay with a stat orthopedic referral. Asked physical therapy for boot to be placed and it is present. Patient is thankful for pain medications. Resident stated on Tuesday (10/22/24) her leg got caught when being transferred and her leg has been hurting on/off since but that it was an accident. Oriented X 3. Boot applied to right leg. Assessment and Plan for fracture of tibia and fibula: Norco (hydrocodone-acetaminophen) 5/325 milligrams (mg) give 1 tablet by mouth every 6 hours as needed. Continue scheduled tramadol, start ortho referral and continue wearing boot to right leg until further recommendations from ortho."

Multiple attempts made to reach NP for an interview were unsuccessful.

A physician order dated 10/24/24 prescribed hydrocodone-acetaminophen (Norco) 5/325mg, give 1 tablet by mouth every six hours for Resident #1.

Review of Resident #1's orthopedic consultation dated 10/29/24 revealed "tender to palpitation distal tibia over fracture site on right. Mildly tender to palpation distal fibula, mild swelling. Gentle ankle range of motion. Pain with inversion and eversion" Diagnosis: nondisplaced right distal tibia fracture. Recommendations to include non-weight bearing to right lower extremity, continue fracture boot. Avoid non-steroidal anti-inflammatory drugs (NSAIDs) as they delay bone healing."

An interview with Regional Nurse Consultant was conducted on 01/09/25 at 2:18 pm. The Regional Nurse Consultant indicated that Nurse #5 was the

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first nurse to notify the previous Director of Nursing (DON) and herself on 10/24/24 that Resident #1 had x-ray results indicating she had a right tibia fracture. The Regional Nurse Consultant stated at that point in time staff were questioned and it was revealed that Resident #1 had an incident during a transfer with NA #1 on 10/22/24. Regional Nurse Consultant further stated per Resident #1's interview, that during transfer, Resident #1's leg got caught in wheelchair and resident verbalized pain. The Regional Nurse Consultant also indicated that during facility investigation it was discovered Nurse #5 was the only nurse who assessed Resident #1, and this did not occur until 10/24/24. The Regional Nurse Consultant indicated that Resident #1 was not assessed on 10/22/24 or 10/23/24 by a nurse. The interview further revealed that the Regional Nurse Consultant expected that nurses would document resident assessment for each change of condition.

On 1/9/25 at 11:00 am the Medical Director was interviewed about Resident #1. The Medical Director indicated that he did not assess Resident #1 at the time of the fracture but had reviewed the NP's assessment that was done on 10/25/24. The Medical Director stated he was not notified about the Resident #1 complaints of right leg pain on 10/22/24 but was aware that notification was made on 10/24/24. The Medical Director indicated that he would have expected staff to assess any resident who had a change of condition.

An interview was conducted with the Administrator on 01/10/25 at 11:30 am. The Administrator indicated that all residents should have their needs met and she would require

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F 684	Continued From page 21 nursing staff to assess residents with a change of condition.	F 684		
F 689 SS=G	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, and resident and staff interviews, the facility failed to provide care in a safe manner for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #1). On 10/22/24 Resident #1 was lifted manually by Nursing Assistant (NA) #1 from the shower chair to the bed, causing Resident #1 right leg to hit the shower chair, get caught in between the shower chair and the bed, causing severe pain and swelling. An x-ray completed on 10/24/24 confirmed Resident #1 sustained an acute distal tibia/fibula (the two long bones in the lower leg) fracture. Findings included: Resident #1 was admitted to the facility on 05/22/23 with diagnosis that included right hand contracture, spondylolisthesis (a condition where a vertebra in the spine slips out of place and onto the bone below it), spinal stenosis (narrowing of the spinal canal that occurs over time), and hypertension.	F 689	F689 Step 1 Resident remains in the facility. She transfers with the mechanical lift and is no longer having pain related to the fracture. Step 2 On 1/30/25 Director of Rehabilitation or designee completed an audit of the transfer status of all residents that reside in the facility. Any changes in transfer status was reported to the interdisciplinary team, and care plans were updated. The Director of Nursing or designee reviewed all resident care plans to ensure the correct transfer status was recorded, any discrepancies identified were immediately corrected. An audit was completed on all residents with mechanical lift to review accurate documentation of their transfer status. Any discrepancy identified was clarified with the staff member to correct the inaccurate documentation or 1:1 education was provided on using the	2/7/25

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F 689	Continued From page 22 Resident #1's quarterly Minimum Data Set (MDS) dated 08/30/24 revealed she was cognitively intact, with no behaviors and weighed 104 pounds. The quarterly assessment further indicated Resident #1 had impaired functional limitation in range of motion to both sides of her upper extremity (shoulder, elbow, wrist, hand) and lower extremity (hip, knee, ankle, foot) and required a wheelchair for mobility. The quarterly assessment also indicated Resident #1 was dependent (Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with transferring from chair/bed-to-chair transfer (the ability to transfer to and from a bed to a chair [or wheelchair]) and was unable to walk. An interview with the Regional Nurse Consultant was conducted on 01/09/25 at 2:18 pm. The Regional Nurse Consultant indicated that she could not provide the printed and updated manual care plan for Resident #1, because the Care Plan books for all residents were missing. The Regional Nurse Consultant provided a care plan for Resident #1 which was revised after the incident on 10/22/24. Interview with the Rehabilitation Director was conducted on 01/10/25 at 10:29 am. The Rehabilitation Director stated Resident #1 could not walk or bear any weight to her extremities prior to the incident that occurred. The Rehabilitation Director further stated Resident #1's last transfer status, assessed by the therapy department, indicated Resident #1 transfer status as "maximum assistance (staff does more than half the effort) with 2 people with sliding board".	F 689	transfer method in the careplan. On 2/4/25 all alert and oriented residents were interviewed if they have been transferred correctly and if they have any concerns about their transfer status. No concerns were voiced. Step 3 On 1/30/25 the Director of Nursing or designee educated all certified nurse aides and licensed nurses that they are responsible for reviewing the resident profile and care plan in the electronic medical record prior to transferring a resident, and to notify a nurse supervisor if they have any questions or concerns about a resident transfer status. Licensed nurses and certified nurse aides were also educated on making sure their documentation of the transfer status is accurate. Any licensed nurse, certified nurse aides, and licensed therapist who did not receive this education on 1/30/25 will receive this education prior to their next shift. All new hired licensed nurses, certified nurse aides, and licensed therapist will receive this education during orientation. All agency staff will receive this education prior to taking an assignment. The resident profile / care plan will be updated with changes in transfer status by a member of the IDT team. Mechanical lift transfer documentation will be reviewed during clinical morning meeting. Step 4 Beginning the week of 2/3/25 the Director of Nursing or designee will audit 5 resident records to ensure the correct transfer status is noted on the care plan	

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F 689	Continued From page 23 The Rehabilitation Director indicated Resident #1 was non weight bearing and was supposed to be transferred using a sliding board due to the fact that her lower extremities were contracted, and she could not stand. The Rehabilitation Director noted that therapy does not instruct any staff to lift residents manually. The Rehabilitation Director added that if a resident is not able to bear weight, they recommend that staff use sliding board or mechanical lift. The Rehabilitation Director indicated that as far as she knew, Resident #1 was always maximum assistance of one to two persons using a sliding board for transfers, prior to 10/24/24. The Point of Care History report for "What appliances or assistive devices were used for transferring?" dated 10/01/24 -10/31/24 was reviewed. The report indicated that NA #3 documented on 10/02/24 at 4:40 pm "lifted manually." A telephone interview was conducted with NA #3 on 01/09/25 at 2:39 pm. NA #3 indicated that she had cared for Resident #1 and that Resident #1 needed extensive assistance with transfers and did not recall Resident #1 using mechanical lift for transfers prior to her incident on 10/22/24. The Point of Care History report for "Type of bath?" dated 10/01/24 -10/31/24 was reviewed. The report indicated that NA #2 documented on 10/22/24 at 11:57 am that Resident #1 had received a shower. The Point of Care History report for "How did resident transfer?" dated 10/01/24 -10/31/24 was reviewed. The report indicated that NA #2 documented on 10/22/24 at 11:57 am that	F 689	and that staff are documenting the correct transfer status in the electronic medical record. The Director of Nursing or Designee will observe 5 staff members per week to ensure they are transferring the resident correctly according to the care plan and that staff are using proper technique during the transfer. The Director of Nursing or designee will interview 5 residents per week to ensure they are being transferred appropriately and that they have no concerns about their transfer status. Audits will continue for 12 weeks. Results of these audits will be brought before the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. The Director of Nursing will be responsible for implementation of the plan. Date of Compliance: 2/7/2025	

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Resident #1 was "total dependence."

The Point of Care History report for "Staff support provided for transferring?" dated 10/01/24 -10/31/24 was reviewed. The report indicated that NA #2 documented on 10/22/24 at 11:57 am that Resident #1 required "1-person physical assist."

The Point of Care History report for "What appliances or assistive devices were used for transferring?" dated 10/01/24 -10/31/24 was reviewed. The report indicated that NA #2 documented on 10/22/24 at 11:57 am that "transfer aid."

An interview was conducted with Resident #1 on 01/08/25 at 1:15 pm. Resident #1 indicated that she recalled when her right leg got hurt. Resident #1 indicated that NA #1 had just finished giving her a shower and had returned Resident #1 to the room. Resident #1 indicated that she was on the shower chair, when NA #1 lifted her manually to transfer her back to bed. Resident #1 indicated that NA #1 transferred her by using NA #1's two arms underneath Resident #1's underarms and lifting her off the shower chair onto the bed. Resident #1 indicated that she could not stand or walk. Resident #1 indicated that NA #1 did not use a mechanical lift for the transfer, and no staff, Nurse or NA, ever used a mechanical lift to transfer her prior to that incident. Resident #1 indicated that majority of the time staff lifted her manually and a couple of times staff used a sliding board to transfer her. Resident #1 indicated that sometimes it would be one staff member lifting her manually during a transfer or two staff lifting her manually, but no one ever used a mechanical lift to transfer her. Resident #1 indicated that when NA #1 lifted her manually

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from the shower chair to the bed, Resident #1's right leg hit the chair and got stuck between the shower chair and bed. Resident #1 indicated that she informed NA #1 that she was hurting. Resident #1 indicated that NA #1 proceeded with lifting her manually during the transfer, even after informing her that her leg was in severe pain of a 10/10 (with 0 being the least pain and 10 being the worst pain imaginable). Resident #1 indicated NA #1 completed the transfer and placed her in bed and she did not fall during the transfer. Resident #1 indicated that NA #1 did not have another NA assist her during the transfer from the shower chair to the bed. Resident #1 indicated that no nurse came in to assess her after she had reported to NA #1 that her leg was in severe pain. Resident #1 indicated that days later, the pain got worse, and she could not bear it. Resident #1 indicated that she informed another NA (Resident could not recall name) about her pain getting worse. Resident #1 indicated at that time, Nurse #5 came in to assess her and that Nurse #5 was the only nurse who assessed her right leg. Resident #1 indicated that her pain was 10/10. Resident #1 indicated that Nurse #5 notified the provider, who ordered an x-ray that revealed she had fracture. Resident #1 indicated that she refused to go to the hospital and opted to be seen by an orthopedic doctor. Resident #1 indicated that she received new orders for additional pain medication for the severe pain in her right leg. Resident #1 indicated that facility staff initiated using a mechanical lift for transfer only after x-ray results showed she had a fracture to her right leg.

Written statement from NA #1, with no date indicated, was reviewed. The statement stated, "I NA #1 gave Resident #1 a shower and transferred her to bed with another NA in the

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room. At this time and Resident #1 said she hurt but proceeded to tell NA#1 that she (Resident#1) was ok and not to worry. Resident #1 was fine, and NA#1 did report it to the nurse."

A telephone interview was conducted with NA #1 on 01/10/25 at 9:08 am. NA #1 indicated that she worked from 7:00 am to 3:00 pm on 10/22/24 and provided care to Resident #1. NA #1 stated on 10/22/24, Resident #1 had a shower scheduled. NA #1 indicated that Resident #1 was in bed and needed to be transferred from the bed to the shower chair. NA #1 stated that she asked NA #2 to assist her during the transfer. NA #1 indicated that NA #2 held onto the shower chair so that Resident #1 could be transferred. NA #1 revealed that, while NA #2 was holding onto the shower chair, she lifted Resident #1 manually because Resident #1 was not able to put her feet on the floor because they (Resident #1's legs) were contracted. NA #1 confirmed that Resident #1's feet never touched the floor, while she lifted her manually from the bed onto the shower chair. NA #1 indicated Resident #1 was not able to bear her own weight on both lower extremities and Resident #1 was not able to walk. NA #1 stated that there was no "emergency" situation occurring that would have required for her to lift Resident #1 manually, and that she was just transferring Resident #1 per care plan. NA #1 indicated that Resident #1 did not have any concerns during the shower. NA #1 indicated, after she completed the shower, she took Resident #1 back to her room, to transfer her back to bed at around 11:00 am. NA #1 indicated that during this transfer (from shower chair to bed) she did not have any other staff to assist. NA #1 indicated that she transferred Resident #1 from the shower chair to the bed, by lifting her manually, with Resident #1

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feet not touching the floor. NA #1 indicated that she placed Resident #1 on the bed. NA #1 stated that Resident #1 did not fall during transfer. NA #1 further stated, she could not recall if Resident #1 hit her leg or foot on anything during transfer. NA #1 revealed she did not recall if Resident #1's foot got stuck between the shower chair and the bed during transfer. NA #1 indicated that after completion of the transfer and Resident #1 was in bed, Resident #1 verbalized that her leg was hurting but she was fine. NA #1 indicated that she reported to Nurse #1 that Resident #1 complained that her leg was hurting. NA #1 indicated that Nurse #1 did not go to assess Resident #1 or ask Resident #1 about the pain. NA #1 indicated that after this day (10/22/24), she worked again from 7:00 am to about 3:00 pm on 10/24/24 and provided care to Resident #1. NA #1 indicated that Regional Nurse Consultant informed her that she would be suspended for "breaking Resident #1's leg" due to not transferring her using a total mechanical lift. NA #1 indicated that Resident #1 did not have a care plan to transfer Resident #1 using a total mechanical lift. NA #1 indicated that the care plan indicated that Resident #1 required extensive assistance of one person to transfer. NA #1 indicated that on 10/24/24, she was informed by Nurse #5 that Resident #1 was supposed to be a mechanical lift. NA #1 indicated that when she looked for the care plan books with Nurse #5 at the nursing station, the care plan books were missing. NA #1 indicated that Resident #1 never had a care plan to use a mechanical lift and that all staff lifted Resident #1 manually during all transfers.

Written statement from NA#2, dated 10/24/24 was reviewed. NA #2 indicated, "On 10/24/24 I

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received a call from facility on behalf of Resident #1 and informed me that Resident #1 leg was broken. 10/22/24 Resident #1 shower day, I witnessed another transfer Resident #1 to shower chair. NA pick Resident #1 up and put Resident #1 in shower chair. Also, on 10/24/24 facility informed that Resident #1 is a mechanical lift. I only witness the transfer from bed to shower chair. I did not make any contact with Resident #1."

Multiple attempts made to reach NA #2 for an interview were unsuccessful.

A progress note dated 10/24/24 at 10:41 am written by Nurse #5 revealed that "during morning medication pass author noted new medication for lidocaine patch to right leg. Author asked Resident #1 what happened to her leg that she is now needing that. Resident #1 stated on Tuesday (10/22/24) her leg got caught when being transferred and her leg has been hurting on/off since. Author asked Resident #1 how her pain has been, and Resident stated it hurt last night but once she got her pain medication she felt better and was able to rest and this morning she is having trouble flexing her toes to right leg. Author removed cover, right ankle noted, swollen, discolored. Author asked resident to wiggle toes and is able to do so slightly. Pedal pulses present. Nurse Practitioner (NP) made aware, ok for x-ray to site. Power of Attorney (POA) made aware. Resident #1 made aware of order. Foot elevated as tolerated and cold compress applied. Resident #1 stated that felt good. Call bell within reach."

On 10/24/24 at 10:41 am, order for "right ankle x-ray 2 view" was obtained by Nurse #5. X-ray

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results received on 10/24/24 at 3:46 pm that revealed "acute appearing distal tibia/fibula fracture."

A progress note dated 10/25/24 written by the NP indicated "86-year-old female patient is being seen today for right tibia/fib fracture. Contacted yesterday about increased swelling and pain to right ankle and x-ray was ordered demonstrating fracture. Patient is refusing the hospital however she is okay with a stat orthopedic referral. Asked physical therapy for boot to be placed and it is present. Patient is thankful for pain medications. Resident stated on Tuesday (10/22/24) her leg got caught when being transferred and her leg has been hurting on/off since but that it was an accident. Oriented X 3. Boot applied to right leg. Assessment and Plan for fracture of tibia and fibula: Norco (hydrocodone-acetaminophen) 5/325 milligrams (mg) give 1 tablet by mouth every 6 hours as needed. Continue scheduled tramadol, start ortho referral and continue wearing boot to right leg until further recommendations from ortho."

Multiple attempts were made to reach NP for an interview were unsuccessful.

Review of Medication Administration Record (MAR) for 10/01/24 - 10/31/24 was reviewed. MAR indicated new order initiated on 10/24/24 of hydrocodone-acetaminophen (Norco) 5/325mg, give 1 table by mouth every six hours pain. New order initiated on 10/23/24 for Lidocaine adhesive 5% patch, applied once a day to right leg for pain, with first dose administered on 10/24/24.

Review of Resident #1's orthopedic consultation dated 10/29/24 revealed "tender to palpitation

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distal tibia over fracture site on right. Mildly tender to palpation distal fibula, mild swelling. Gentle ankle range of motion. Pain with inversion and eversion" Diagnosis: nondisplaced right distal tibia fracture. Recommendations to include non-weight bearing to right lower extremity, continue fracture boot. Avoid non-steroidal anti-inflammatory drugs (NSAIDs) as they delay bone healing."

Interview with MDS Nurse #1 was conducted on 01/09/25 at 12:35 pm. MDS Nurse #1 indicated that she did not recall anything about Resident #1's incident with transfers being discussed or reviewed by the interdisciplinary team. MDS Nurse #1 indicated that Resident #1 could not walk or bear her own weight.

An interview with Regional Nurse Consultant was conducted on 01/09/25 at 2:18 pm. The Regional Nurse Consultant indicated that Nurse #5 was the first nurse to notify the previous Director of Nursing (DON) and herself on 10/24/24 that Resident #1 had x-ray results indicating she had a right tibia fracture. The Regional Nurse Consultant stated at that point in time staff were questioned and it was revealed that Resident #1 had an incident during a transfer with NA #1 on 10/22/24. The Regional Nurse Consultant further indicated that NA #1 transferred Resident #1 from a shower chair to the bed with NA #2. The Regional Nurse Consultant further stated Resident #1 was supposed to be transferred using a mechanical lift because she could not stand. Regional Nurse Consultant indicated NA #1 stated that she transferred Resident #1 using "stand and pivot" technique. Regional Nurse Consultant revealed that NA #1 took Resident #1 back to her room after completing a shower, and

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F 689	Continued From page 31 while in room, transferred Resident #1 from shower chair to bed. The Regional Nurse Consultant stated during interview Resident #1 indicated that during the transfer her leg got caught in the wheelchair and Resident #1 verbalized pain. Regional Nurse Consultant indicated that NA #1 did not verbalize or report that there was an issue with the transfer when interviewed on 10/24/24. An interview was conducted with the Administrator on 01/10/25 at 11:30 am. The Administrator indicated that all residents should have their needs met per plan of care.	F 689		