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PIEDMONT HILLS CENTER FOR NURSING AND REHAB	109 S HOLDEN RD GREENSBORO, NC 27407

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F 000	INITIAL COMMENTS An onsite complaint investigation was conducted from 1/29/25 through 1/31/25. The survey team returned to the facility from 2/3/25 to 2/4/25 to investigate new allegations and to validate the credible allegation of immediate jeopardy removal and exited on 2/4/25. Additional information was obtained on 2/10/25, therefore the exit date changed to 2/10/25. The following intakes were investigated. NC00225016, NC00225611, NC00225615, NC00226191, NC00226562, NC00226772, NC00227091, and NC00227101. 10 of the 10 complaint allegations did not result in deficiency. Immediate jeopardy was identified at: CFR 483.25 at tag F689 as a scope and severity J. The tag F689 constituted Substandard Quality of Care. Immediate jeopardy began on 1/26/25 and was removed on 1/31/25. A partial extended survey was conducted.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 657		2/21/25

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

Electronically Signed | 02/21/2025

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F 657	Continued From page 1 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a comprehensive care plan for a newly admitted resident that required assistance with bed mobility for 1 of 3 residents reviewed for supervision to prevent accidents. (Resident #1) Findings included: Resident #1 was admitted to the facility on 12/18/24, with a diagnosis that included dialysis dependent end stage renal disease (ESRD), metabolic encephalopathy, hypertension, congestive heart failure, diabetes, history of seizures, venous sinus thrombosis 12/2024 (rare form of a stroke), and history of pulmonary	F 657	Resident #1 no longer resides in the facility. Residents currently residing in the facility have the potential to be affected by the deficient practice. On 1/28/2025 the Director of Nursing (DON), Unit Managers (UM), and Minimum Data Set (MDS) nurse initiated an audit of resident care plans to ensure Activities of Daily Living (ADL) care plans include a level of assistance of minimum, moderate, or maximum assistance with bed mobility and assistive devices in use to are care planned and Kardex is updated. Audit was completed on 2/3/2025. Any ADL	

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F 657	Continued From page 2 embolism. Resident #1's admission Minimum Data Set (MDS) assessment dated 1/6/25 revealed she was cognitively intact. The assessment also indicated Resident #1 required partial/moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with roll left and right (the ability to roll from lying back to left and right side, and return to lying on back on the bed.) Care Area Assessment (CAA) worksheet for functional abilities (Self-Care and Mobility was triggered for admission MDS assessment dated 1/6/25 and completed on 1/11/25). Review of the worksheet revealed that the triggering conditions included but were not limited to, brief interview for mental status (BIMS) summary was 14 (intact cognition), while activities of daily living (ADL) was required at partial/moderate assistance for toileting hygiene, upper body dressing, roll left and right, sit to lying, lying to sitting on side of bed and toilet transfer. Analysis of findings indicated that Resident #1 needed assistance with self-care and mobility items due to physical limitation, weakness, limited range of motion, poor coordination, poor balance, visual impairment, pain etc. CAA worksheet indicated that functional abilities (self-care and mobility) functional status would be addressed in the care plan. The facility did not provide a care plan that focused on Resident #1's functional abilities (self-care and mobility) functional status care plan. Interview with the MDS Nurse was conducted on 1/30/25 at 10:57 am. The MDS nurse confirmed	F 657	care plans that did not include the level of assistance and/or assistive devices the resident required and Kardex updated were corrected by the UMs, SDC, and/or DON. On 2/3/2025 the Regional Nurse Consultant completed education with the MDS nurse, UM, Staff Development Coordinator (SDC), and DON regarding ADL care planning to ensure the level of assistance the resident requires during care is care planned and the Kardex updated. The SDC initiated education with the nurses and nurse aides to ensure they understand where and how to access the resident's care plan and/or Kardex in order to identify the resident's level of assistance. The nurse and nurse aid education was completed on 2/21/2025. Any newly hired MDS nurses, UMs, SDC, and/or DON will be educated during orientation on ensuring level of care is care planned and Kardex updated by the Nursing Home Administrator. Any newly hired nurses and nurse aides will be educated during orientation by the SDC or DON. A review of five resident care plans will be completed by the Interdisciplinary Team (IDT) five times a week for four weeks then five residents care plans two times a week for eight weeks to ensure ADL care plans are completed following admission and the level of assistance/assistive device required during care is care planned and the Kardex is updated. The UMs, SDC, or DON will inform	

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F 657	Continued From page 3 that Resident #1 required assistance with self-care and mobility and did not have a functional abilities (self-care and mobility) functional status care plan. The MDS Nurse further stated that Resident #1 should have a care plan that addressed self-care and mobility. An interview was conducted with the facility Administrator on 1/30/25 at 3:35 pm. The Administrator indicated that care was to be provided according to the plan of care.	F 657	nurses/nurse aides of level of care and/or assistive device changes made to resident care plans. The Nursing Home Administrator (NHA) will review audits weekly to ensure ADL care plans are completed accurately. The NHA will present the findings of the audits to the Quality Assurance Performance Improvement (QAPI) committee monthly for three (3) months. The QAPI Committee will review the audits to determine trends and/or issues that may need further interventions and/or the need for additional monitoring. Completion Date: 02/21/2025	
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 record review, observation and interviews with staff and the Medical Director, the facility failed to provide care in a safe manner for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #1). On 1/26/25 Resident #1 requested incontinence care and Nurse Aide (NA) #1 gathered supplies and raised the level of the bed to provide care. NA #1 asked	F 689	Resident #1 no longer resides in the facility. Residents currently residing in the facility have the potential to be affected by the deficient practice. On 1/28/2025 an audit was conducted by the Director of Nursing, Regional Nurse Consultant, and the	2/21/25

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F 689	Continued From page 4 Resident #1 to turn on her side away from NA #1. NA #1 stated she had her right-hand touching Resident #1 and while the resident was turning the brief fell on the floor. NA #1 took her hand off Resident #1 when she bent down to pick up the brief and Resident #1 rolled off the bed onto floor hitting her head. Nurse #1 was called to the room and assessed Resident #1 and noted she was incoherent and unable to answer questions. When Nurse #1 palpated Resident #1's head she yelled out in pain her head and neck hurt. Resident #1 yelled out in pain when Nurse #1 assessed her upper extremities. Resident #1 was sent to the Emergency Room (ED) on 1/26/25 and results of x-rays completed on 1/26/25 revealed fractured left 6th and 7th ribs and the CT scan (computed tomography scan is a medical imaging procedure that uses x-rays to create detailed images) of the head noted an acute on chronic bilateral subdural hematomas (collection of blood on the surface of the brain) that had increased in size from compared with prior imaging on 1/20/25 and a possible trace acute subarachnoid hemorrhage (bleeding in the space below one of the thin layers that cover and protect the brain). On 1/27/25 Resident #1 had a neurological change (a change in the function of the brain, spinal cord, or nerves) to include expressive aphasia (condition that makes it difficult to speak or write) with right-sided weakness, seizure activity, and admission to Intensive Care Unit (ICU). On 1/28/25 Resident #1's neurological status worsened due to an increase in subdural hematoma. On 1/29/25 Resident #1 was made comfort care and died on 1/30/25 at 5:00 pm. The Death Certificate indicated the immediate cause of death for Resident #1 was complications of blunt force injury to the head.	F 689	Minimum Data Set nurse, to identify any residents at risk during care utilizing the fall risk analysis report and Morse Scale report. The Activities of Daily Living care plans of the residents who are at risk for falls and/or have had falls in the past 30 days were reviewed to ensure they included if the resident required a level of assistance of minimum, moderate, or maximum assistance with bed mobility. This audit included residents who currently have devices care planned to ensure the device is in place. This audit was completed on 1/30/2025. On 1/28/2025 the Activities Director conducted interviews with residents that had a Brief Interview for Mental Status (BIMS) > 12, to identify any resident concerns related to turning and repositioning during care. Interviews were completed by 1/29/2025. The wound nurse and unit manager completed skin assessments on residents with a BIMS of 11 or less. No concerns were identified. On 1/30/2025 the Staff Development Coordinator began education on turning and repositioning during care, utilizing the appropriate level of care required, maintaining resident safety during care by maintaining physical contact, and utilizing any assistive devices are according to resident□s care plan/Kardex with the certified nurse assistants and nurses. Education was completed on 1/30/2025. Nurses and certified nurse assistants who were not educated will be educated prior to starting their next shift. Newly hired nurses and certified nurse assistants will	

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F 689	Continued From page 5 Immediate jeopardy began on 01/26/25 when Resident #1 rolled out of bed to the floor while incontinence care was provided. The immediate jeopardy was removed on 1/31/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (No actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective. Findings included: Resident #1 was admitted to the facility on 12/18/24, with a diagnosis that included dialysis dependent end stage renal disease (ESRD), metabolic encephalopathy, hypertension, congestive heart failure, diabetes, history of seizures, venous sinus thrombosis 12/2024 (rare form of a stroke), and history of pulmonary embolism. Physician orders dated 12/18/24 included Eliquis (blood thinner used to prevent blood clots and stroke) 5 mg (milligrams) one tablet by mouth two times a day related to thrombosis and remained current until the resident was discharged to hospital on 1/26/25. Resident #1's admission Minimum Data Set (MDS) assessment dated 1/6/25 revealed she was cognitively intact, with no behaviors, with a height of 65 inches and weighed 213 pounds Resident #1 required partial/moderate assistance (helper does less than half the effort, Helper lifts, holds, or supports trunk or limbs, but provides	F 689	receive the education during orientation, and this will be conducted by the Staff Development Coordinator or Director of Nursing. On 1/30/2025 the Unit Managers initiated resident care observations for 10 resident encounters a week for twelve weeks to ensure care is performed according to the residents care plan/Kardex and utilizing the appropriate level of care and using needed assistive devices. The Director of Nursing is responsible for forwarding the results of the audits to the Quality Assurance Performance Improvement Committee monthly for three months. The Quality Assurance Performance Improvement Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. Completion Date: 02/21/2025	

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F 689	Continued From page 6	F 689		

less than half the effort) with roll left and right (the ability to roll from lying back to left and right side, and return to lying on back on the bed.)

The facility did not provide a care plan that focused on Resident #1's functional abilities (self-care and mobility).

Review of ED provider notes dated 1/20/25 revealed Resident #1 was transferred to the hospital for evaluation due to an episode of hypotension (abnormally low blood pressure) and altered mental status after being found unresponsive at the facility. The resident was awake and at her baseline and had normal blood pressure by the time she got to the ED. She did not remember passing out. The initial CT scan completed on 1/20/25 showed bilateral subdural calvarial convexities (subdural hematomas) which were likely subacute to chronic with some acute component not excluded. Laboratory tests were unremarkable. It was noted she had not had any falls and had no subdural hematomas on her scans last month. Neurosurgery recommended a repeat CT scan in 8 hours. The resident was admitted given her episode of syncope, hypotension and new onset subdural hematomas. The hospital discharge summary note dated 1/21/25 indicated that resident was discharged in stable condition with active problems, end stage renal disease on hemodialysis, hypotension and subdural hematoma. It was noted the follow up CT head scan was done with no acute changes and per neurology department and Resident #1 should have a neurological outpatient follow up to determine duration of anticoagulation and follow-up CT scan. Eliquis 5 mg twice daily was listed as a medication to be continued.

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Physical Therapy (PT) evaluation for start of care dated 1/22/25, indicated that Resident #1 was worried about falling. The functional mobility assessment on the PT evaluation report revealed that Resident #1 required partial/moderate assistance to roll left and right during bed mobility. It also showed that the mobility function score (ranges from 0-12; 12 being the highest function) was a 3. The self-care performance assessment indicated on the PT evaluation revealed that Resident #1's self-care function score (score 0-12; 12 being the highest function) was a 0. The musculoskeletal system assessment on the PT evaluation indicated that Resident #1 had impaired right and left lower extremity strength.

Occupational Therapy (OT) evaluation for start of care 1/22/25, indicated that Resident #1 required substantial/maximal assistance with toileting hygiene, and bed mobility. The mobility function score (ranges form 0-12;12 being the highest function) was a 1. The musculoskeletal system assessment on the OT evaluation revealed that Resident #1 had impaired right and left upper extremity strength, and impaired right upper extremity shoulder, elbow, forearm and wrist.

An interview with the Rehabilitation Director was conducted on 1/30/25 at 11:58 am. The Rehabilitation Director confirmed that Resident #1 required minimum to moderate staff assistance with bed mobility to include rolling left and right. Rehab Director indicated that Resident #1 was never independent with bed mobility but required assistance with bed mobility to include rolling left and right while in bed.

The facility Transfer/Mobility Evaluation

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Assessment completed by Unit Manager #1, on 1/23/25 was reviewed. The resident evaluation/functional ability section indicated that Resident #1 was non-ambulatory, had unsteady gait, with difficulty standing and required partial support to sit on bedside. The assessment further indicated that resident was able to sit on bedside with partial support (rail or person).

Interview was conducted with Unit Manager #1 on 1/30/25 at 2:54 pm. Unit Manager #1 confirmed that she completed the transfer/mobility evaluation assessment. Unit Manager #1 indicated that Resident #1 required assistance with bed mobility and could not turn side to side in bed without assistance.

Daily skill assessment completed on 1/23/25 by Nurse #3 was reviewed. Assessment indicated that Resident #1 required total assistance of one person with bed mobility.

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

Facility Incident report dated 1/27/25 completed by Nurse #1 at 1:28 am indicated under the nursing description; nurse aide [NA #1] states the resident [Resident #1] fell from bed when she rolled resident over to clean her bottom. The report revealed that Resident #1 had an injury to the back of head, left shoulder and top of scalp with occasional moaning or groaning, low level of speech with a negative quality and facial grimacing. The report also mentioned that upon the initial assessment immediately after the fall, Resident #1 could not answer questions and staff had to say Resident #1's name and physically stimulate Resident #1 to get a response. As time

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passed while waiting for emergency medical services (EMS), Resident #1 became more coherent but seemed to become more lethargic. The level of consciousness reflected on the incident report indicated Resident #1 was responsive only to vigorous stimulation after fall.

NA #1's signed statement dated 1/27/25 indicated the incident occurred on Sunday 1/26/25 and NA #1 had seen Resident #1 about 6:00 pm when picking up the dinner tray from and Resident #1 was watching TV (television). NA #1 was doing rounds between 7:30 pm and 7:45 pm and Resident #1 requested to be changed. NA #1 gathered her supplies, raised the bed up and the brief fell on the floor. NA #1 she bent down to pick up the brief, and [Resident #1] "rolled over to the window and rolled off the bed." A chair was by the air conditioner and NA #1 was unsure whether Resident #1 hit the chair. NA #1 indicated "was screaming" and she called for a nurse and called NA #2 on her cell phone. NA #1 requested NA #2 to send a nurse to Resident #1's room. Nurse #2 entered the room and immediately asked about how high the bed was but did not evaluate Resident #1. Nurse #1 came in and helped and assessed Resident #1. NA #1 Nurse #1 and NA #2 remained with Resident #1 and did not move the resident until EMS arrived. Resident #1 was talking and knew the day and time. Initially Resident #1 refused to go to the hospital, and her family was called and helped convince her to go. EMS transferred Resident #1 to the hospital.

An interview with NA #1 was conducted on 1/29/25 at 4:06 pm. NA #1 revealed that Resident #1 was under her care from 7:00am, until she finished her shift at about 8:56 pm, on 1/26/2025. NA #1 confirmed that Resident #1 was able to

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make her needs known. NA #1 indicated that at around 7:15 pm, she went to check on Resident #1 and Resident #1 requested assistance with incontinence care. NA #1 indicated that she gathered her supplies which included a brief, wash clothes and towels to assist Resident #1 with incontinence care. NA #1 explained that once she entered the room, she got a basin of water, washcloths, brief and soap to provide care. NA #1 then confirmed that she raised the height of the bed to where she did not have to bend at all. NA #1 indicated that the height of bed was approximately at her chest level. NA #1 emphasized that she did not think the bed was too high, because she always brought it up that high. NA #1 revealed that after she completed washing Resident #1's perineal area, she told Resident #1 "could you turn over there." NA #1 stated she was pointing Resident #1 towards the window, which was away from NA #1. NA #1 confirmed that she was standing to the left of Resident #1, facing the window. NA #1 further explained that prior to asking Resident #1 to turn from her back towards her right side, NA #1 did not move Resident #1 towards Resident #1 left side first, to ensure that Resident #1 was not close to the to the edge of the bed when she turned. NA #1 stated she did not recall how Resident #1 was positioned on the bed prior to requesting her to turn. NA #1 indicated the brief fell just when she had completed telling Resident #1 to turn towards the window, away from NA #1. NA #1 indicated that Resident #1 turned over, and then NA #1 turned from Resident #1 to bend down and pick up the fallen brief off the floor. NA #1 stated that Resident #1 fell off the bed onto the floor. NA #1 stated that she thought Resident #1 fell because, when the brief fell to the floor next to the bed, and she (NA #1) went to get it,

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she (NA #1) let go of Resident #1 and Resident #1 fell. NA #1 indicated that she did not touch Resident #1 while she turned /rolled over and Resident #1 turned herself to the side. NA #1 explained that she had her right-hand touching Resident #1 after Resident #1 was on her side. NA #1 continued to explain that when she went bent down to get the brief from the floor, she took her right hand off the resident. NA #1 stated when she picked up the brief off the floor, and stood up, it was too late for her to stop Resident #1 from falling because she was already falling off the bed, and she (NA #1) could not reach her at that point. NA #1 stated that Resident #1 fell, hit her head on the floor with a loud thud. NA #1 stated that she (NA #1) started screaming asking for assistance. NA #1 repeatedly stated that Resident #1 rolled too far and fell. NA #1 further stated that she did not leave Resident #1 alone, but sat with her on the floor, while screaming for help. NA #1 continued to state that NA #2 was at the nursing station and notified Nurse #1 and Nurse #2 about the incident. NA #1 indicated that both Nurse #1 and Nurse #2 came into Resident #1's room. NA #1 revealed that Nurse #1 asked her what happened. NA #1 explained to Nurse #1 that she was changing Resident #1 and Resident #1 fell. NA #1 revealed that while Resident #1 was on the floor, she was trying to talk to Nurse #1. NA #1 explained that when EMS arrived at the facility, Resident #1 has initially refused to go to the hospital, because she did not want anyone to take her television. NA #1 indicated that EMS convinced Resident #1 to go to the hospital. Nurse #1 contacted Resident #1's family member, who stated that Resident #1 was not in her right mind at the moment due to the fall. NA #1 indicated that Resident #1 was then lifted off the floor, onto the stretcher by EMS, Nurse #1

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and NA #1. NA #1 indicated that the facility Administrator typed out a statement about the incident and told her to sign. NA #1 explained she was trying to write a statement on the day of the incident, but was told that the facility did not have any paper for her to use. NA #1 indicated that she never wrote a statement.

Progress note written by Nurse #1 on 1/27/25 at 12:48 am which referenced Resident #1 stated at approximately 7:35 pm, while receiving shift report from off-going nurse, writer responded to nursing assistant [NA#1] calling out for help in Resident #1's room. Upon entering the room, the resident observed lying on the floor on her left side with the back of her head on the ac/heating unit. The NA stated the resident fell off bed when being rolled over to have her bottom cleaned. Nurse #1 noted the bed was significantly elevated. Upon assessment, resident was somewhat incoherent and unable to answer questions appropriately. Resident noted to have dazed look in her eyes and tremoring of lips. While palpating the resident's head and attempting to move head off ac/heating unit, the resident yelled out in pain stating her head and neck hurt. No further attempts were made to move neck or head but placed pillow for comfort. While assessing upper extremities, resident also yelled out in pain, especially during manipulation of left extremity. Neurological checks (assessment to check change in the function of the brain, spinal cord, or nerves) revealed change of LOC (level of consciousness), "movement of upper extremities." Lower extremities were not assessed due to the resident's increasing pain. While writer was assessing resident, off-going nurse notified the on-call provider of fall and resident's use of Eliquis. An order given to send

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resident to ER. EMS was called and family was notified of events. When EMS arrived, resident initially refused to be transported to hospital. EMS called the resident's family and explained that they could not take resident if she did not want to be transported. Eventually, EMS and staff were able to encourage resident to go to hospital to be evaluated. At 8:15 pm, EMS left the facility and transported the resident to the ED. Family was notified of transport to the ED. The Director of Nursing was notified of fall and transport to hospital.

A phone interview with Nurse #1 was conducted on 1/29/25 at 4:40pm. Nurse #1 indicated that she worked from 7:00 pm on 1/26/25 to 7:00 am on 1/27/25. Nurse #1 stated that she was at the nursing station, having completed taking report from the outgoing Nurse #2 when NA #1 called out for help. Nurse #1 indicated that NA #1 came out to the hallway outside Resident #1's room and shouted, "[Resident #1] is not responding." Nurse #1 indicated she immediately ran to Resident #1's room and upon entering Resident #1's room, Nurse #1 observed the bed was raised to the highest level. Nurse #1 further stated NA #1 explained to her that she raised the bed up to give Resident #1 care and when she rolled Resident #1 over to wipe her back side, she realized she did not have the diaper and wipes. NA #1 indicated she turned around to get the supplies and when she let go of Resident #1, she fell over. Nurse #1 added that NA #1 also stated that "she rolled over Resident #1 too far." Nurse #1 indicated she observed Resident #1 on the floor with the back of her head against the air conditioning unit. Nurse #1 further revealed that Resident #1 was lying on the floor on her left side and her left arm was over her head. Nurse #1

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indicated she rubbed Resident #1's head and Resident #1 made a groaning noise like it hurt. Nurse #1 informed NA #1 and Nurse #2 that they could not move Resident #1, but they had to notify provider and EMS as Resident #1 required immediate medical attention. Nurse #1 revealed that when she attempted to talk to Resident #1, resident was super dazed as if she was "knocked out" and not focused. Nurse #1 emphasized that if NA #1 did not let go of Resident #1, Resident #1 would not have fallen out of the bed. Nurse #1 stated Resident #1 could make her needs known but could not turn to her side without assistance. Nurse #1 repeated this statement "NA #1 did it. She let her go. She did not hold onto to her, and she did not have the stuff next to the bed." Nurse #1 indicated that the bed was high to its maximum height, a height that she had never seen before. Nurse #1 further stated that NA #1 kept saying "I had to raise the bed high." Nurse #1 indicated that she notified Resident #1's family member of the incident and also stayed with Resident #1 until EMS arrived.

Statement provided by facility with no date or signature was reviewed. The Administrator indicated in the document that she typed out, that she (Administrator) told Nurse #2 to sign it, and Nurse #2 refused. The statement documented indicated "Fell [Resident #1] about 7:30pm. Aide yelled down hall for the nurse. 'She's not responding.' Me [Nurse #2] and Nurse #1 were sitting at the nurses' station getting report. [NA #1] ran screaming '[Resident #1] is not responding.' We got to the room. [NA #1] said she was changing her, turned back to get something off the nightstand. Grabbed brief or wipe or 'something.' Resident #1 was between heater and bed on her left side. I left the room and printed

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the paperwork to go to ED for Nurse #1. She was responsive. She was not talking. I did not assess Resident #1. The other nurse was in the room. 'Resident #1 eyes were fixed. Looked like she was having a seizure. 'I told aide 'why is the bed so high?' The aide explained she was giving patient care and turned around to get something. I left the room about 7:32 pm."

A phone interview was conducted with Nurse #2 on 1/31/25 at 10:00am. Nurse #2 indicated that she worked from 7:00 am to 7:00 pm on 1/26/25. Nurse #2 explained that after she had completed giving report to oncoming Nurse #1, NA #1 came out of a room into the hallway and said "[Resident #1] was not responding." Nurse #2 indicated that she thought Resident #1 had become unresponsive and required cardiopulmonary resuscitation (CPR). Nurse #2 stated she ran into Resident #1's room and the first thing she noted was the bed was at its highest level. Nurse #2 indicated that she was 5 feet 3 inches tall, and the bed was all the way up to her chest. Nurse #2 indicated that the bed was raised to its highest position. Nurse #2 indicated that she asked NA #1 what happened, and NA #1 stated she was changing Resident #1, turned around to grab something off the dresser, and Resident #1 fell on the floor. Nurse #2 indicated that Nurse #1 was in the room as well. Nurse #2 stated that Nurse #1 requested that EMS and the provider be notified. Nurse #2 then left the room, notified the provider, called EMS and prepared the discharge paperwork. Nurse #2 revealed that she had cared for Resident #1 multiple times and indicated that Resident #1 was able to make her needs known and required extensive assistance from staff with turning in bed. Nurse #2 indicated she explained the incident to the Administrator but was not

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allowed to write a statement. Nurse #2 indicated the Administrator typed a statement and asked Nurse #2 to sign it. Nurse #2 confirmed that she refused to sign the statement the Administrator typed because she did not agree with what was written on the form about the incident. Nurse #2 indicated the Administrator had changed her words to imply something else had happened and that is why she refused to sign it.

Resident #1's emergency department (ED) provider note dated 1/26/25 indicated she had a history of ESRD with hemodialysis, recent venous sinus thrombosis on Eliquis, recent seizures on Keppra, and diabetes mellitus. Resident #1 reported she was being changed when she rolled about 3 feet off the bed, landing on the floor on her right side. She was not sure if she lost consciousness. The ED physician noted per chart review Resident #1 was admitted 1/20/25 through 1/21/25 following a syncopal episode and was found to have a new subdural hematoma and was restarted in Eliquis prior to discharge. Results of x-rays completed on 1/26/25 revealed fractured left 6th and 7th ribs and the CT scan of the head noted an acute on chronic bilateral subdural hematomas that had increased in size from compared with prior imaging and a possible trace acute subarachnoid hemorrhage. Neurosurgery was consulted due to worsening of the prior subdural hematomas and possible new acute subarachnoid hemorrhage. The Neurosurgeon recommended a follow-up CT scan in 6 hours and to hold Eliquis.

Hospital progress notes dated 1/27/25 through 1/30/25 revealed on 1/27/25 while boarding in the ED neurological changes were noted including expressive aphasia with right-sided weakness.

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The repeat head CT scan revealed an increase in the left subdural hematoma without a midline shift (shift of the brain past its center line due to bleeding or swelling). Neurology was consulted and recommended admission to the intensive care unit for frequent neurological checks and Eliquis reversal. An Internal Medicine consultation note dated 1/27/25 indicated serial CT scans were now showing increase in the size of the subdural hematomas with a new midline shift measuring 3 mm (milliliters). The consulting Physician also noted that during the exam that morning Resident #1 appeared to be actively seizing. Neurology was paged urgently and intravenous Keppra (antiepileptic drug) was given. On 1/28/25 hospital progress notes indicated that Resident #1 had a worsened neurological status due to increase in subdural hematoma. On 1/29/25 Resident #1 was made comfort care and died on 1/30/25 at 5:00 pm.

Certificate of Death, dated 2/6/25, from North Carolina vital records, indicated that the immediate cause of death for Resident #1 as "complications of blunt force injury to the head."

An interview with the Director of Nursing (DON) was conducted on 1/30/25 at 3:35 pm. DON indicated that she was notified by Unit Manager #1 on 1/26/2025 at 7:45 pm that Resident #1 fell out of the bed while receiving care from NA #1. DON indicated that she then contacted the Administrator about the incident. DON indicated that Resident #1 was receiving care from NA #1, who did not use the proper positioning technique to assist the resident onto her side, and thus Resident #1 fell out of the bed. DON indicated that Resident #1 needed assistance to be turned to her side.

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An interview was conducted with the facility Administrator on 1/30/25 at 3:35 pm. The Administrator indicated she interviewed NA #1 on 1/27/2025. The Administrator explained that NA #1 was able to show a return demonstration of what happened during care with Resident #1, while in the Administrator's office. The Administrator stated that NA #1 demonstrated that she (NA #1) had her right hand on Resident #1 and her left hand was not touching Resident #1. The Administrator continued to state that NA #1 indicated that the brief fell to the floor, and NA #1 demonstrated that she turned to pick up the brief from the floor and her right hand moved away from Resident #1. The Administrator added that NA #1 confirmed that once she moved her right hand away from Resident #1 and went to pick up the brief form the floor, Resident #1 fell out of the bed onto the floor. The Administrator stated that NA #1 was not able to indicated how high the bed was raised.

A phone interview with the Medical Director was conducted on 2/10/25 at 4:39pm. The Medical Director confirmed that he did not examine or see Resident #1 upon readmission on 1/21/2025. The Medical Director indicated that he was scheduled to assess Resident #1 on 1/23/2025, but the resident was out of facility. The Medical Director stated that he had reviewed the discharge summary from the acute care hospital dated 1/21/2025. The Medical Director stated that with the combination of the fact that Resident #1 was on Eliquis the fall did contribute to the increase in the subdural hematoma. The Medical Director revealed the head injury sustained from the fall off the bed, contributed to increased hemorrhage in combination with the use of Eliquis.

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The Administrator was notified of immediate jeopardy on 1/30/25 at 4:30 pm.

The facility provided the following plan for IJ removal.

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

Resident #1 was admitted to the facility on 12/18/24 with diagnoses that included a recent venous sinus thrombosis, and a chronic bilateral hematoma. She was ordered anticoagulation prior to admission to the facility for the venous sinus thrombosis. The Resident was discharged to the hospital on 1/20/25. She was readmitted on 1/21/25. On 1/26/25 at 7:20 p.m. Resident #1 requested incontinent care. Nursing Assistant (NA) #1 prepared supplies, that included a brief, and began by raising the bed to hip height, per recommended care safety guidelines for staff. The brief fell to the floor and NA #1 bent over to pick up the brief. NA #1 did not have her hands on Resident #1 when she picked up the brief and Resident #1 rolled over to face the window, on the right side of the bed, and rolled off the bed. NA #1 immediately responded to the Resident by walking to that side of the bed and called for assistance from NA #2. NA #2 notified Nurse #1 that there was a fall. Nurse #1 responded to the fall immediately, observed Resident #1 on the floor on the right side of the bed. Nurse #1 called for assistance from Nurse #2. Nurse #2 finished the assessment while Nurse #1 contacted Emergency Medical Services (EMS) to transport Resident #1 to an acute care hospital. While EMS was in route to the facility, Nurse #2 continued to

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conduct assessments that included neurological examinations, vital signs, and a skin assessment. Nurse #2 reported there were no visible signs of broken skin. Resident #1 was admitted to the hospital on 1/26/25.

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

On 1/26/25 Nurse #2 notified the unit manager that Resident #1 had a fall from the bed during care. The Unit Manager (UM) notified the Director of Nursing (DON) and the Administrator. The intervention included Resident was to be seen at the acute care hospital and for the fall to be discussed in the morning clinical risk meeting on 1/27/25.

On 1/27/25 Resident #1's care plan was updated to indicate she would require two staff assistance during care related to most recent fall. Following interview with CNA #1, it was determined that CNA #1 removed her hand from Resident #1 in order to pick up the brief from the floor and resident rolled away from CNA #1.

On 1/28/25 an audit was conducted by the DON, Regional Nurse Consultant (RNC), and the Minimum Data Set (MDS) nurse, to identify any residents at risk for falls utilizing fall risk analysis report and Morse Scale report. The Activities of Daily Living (ADL) care plans of the residents who are at risk for falls and/or have had falls in the past 30 days were reviewed to ensure they included if the resident required a level of assistance of minimum, moderate, or maximum assistance with bed mobility. This audit included

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residents who currently have devices care planned to ensure the device is in place. Kardex updates automatically in Point Click Care (PCC) when the intervention is updated in the care plan, which CNAs can review under their documentation system of Point of Care (POC). The DON identified 2 items related to Dycem and a weighted blanket. These two items were corrected immediately by DON and/or SDC. This audit was completed on 1/30/25.

On 1/28/25 the Staff Development Coordinator (SDC) began education on turning and repositioning during care, utilizing the appropriate level of care required, maintaining resident safety during care by maintaining physical contact, and utilizing any assistive devices are according to resident's care plan/Kardex. Education was conducted in person with staff with an observed return demonstration completed to SDC. The education included an emphasis on the procedure for turning and repositioning resident when providing care, obtaining assistance when needed, maintaining resident's safety during care by maintaining physical contact, and repositioning a resident to the center of the bed when care is completed. SDC observed return demonstration included answering any questions, and/or re-educating 1:1. The education will be completed by 1/30/25 for clinical staff currently working and will continue with staff who provide care to residents including nurses, nurse aides, therapy. Those who were not educated by 1/30/25 will be educated and provide return demonstration prior to beginning their next scheduled shift. Newly hired staff including nurses, nurse aides, and therapy will receive the education from the SDC or designee and provide return demonstration to SDC, DON, or UMs during orientation and this will

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be conducted by the SDC or DON.

On 1/28/25 the Activities Director conducted interviews with residents that had a Brief Interview for Mental Status (BIMS) > 12, to identify any resident concerns related to turning and repositioning during care. Interviews were completed by 1/29/25. No concerns were identified.

On 1/30/25 the DON conducted observations of residents and resident rooms identified to be at risk for falls to ensure the fall interventions placed on the plan of care were in place.

Effective 1/30/25 the Administrator will be responsible for ensuring implementation of this immediate jeopardy removal for this alleged non-compliance.

Date of immediate jeopardy removal: 1/31/25

Validation of the immediate jeopardy removal plan was conducted in the facility on 02/03/25. The facility's initial plan audit was verified and signature sheet for education reviewed with no concerns. Facility nurses and nursing assistants were interviewed and were aware of turning and repositioning during care, utilizing the appropriate level of care required, maintaining resident safety during care by maintaining physical contact, obtaining assistance when needed, repositioning a resident to the center of the bed when care is completed and utilizing any assistive devices are according to resident's care plan/Kardex. The facility's immediate jeopardy removal date of 01/31/25 was validated.