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	345159	A. BUILDING _____ B. WING _____	C 05/01/2025

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted on 4/30/25. Additional information was obtained offsite on 5/01/25. Therefore, the exit date was changed to 5/01/25. Event ID# L6CC11. Intakes NC00229458, NC00229630, NC00218914, and NC00221068 were investigated. 1 of the 8 complaint allegations resulted in deficiency.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Nurse Practitioner interviews, the facility failed to provide resident care in a safe manner for 1 of 3 residents (Resident #1) reviewed for accidents. The findings included: Resident #1 was admitted to the facility on 4/24/2023 with diagnoses including hemiplegia to the left side and muscle weakness. The quarterly Minimum Data Set (MDS) assessment dated 3/28/2024 indicated Resident #1 was cognitively intact and required substantial to maximal assistance with toileting hygiene and bed mobility.	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 05/09/2025

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The care plan dated 3/28/2024 revealed Resident #1 required two-person assistance for incontinent care and bed mobility.

An incident report dated 6/17/2024 at 6:26 AM completed by Nurse #1 indicated Nurse Aide (NA) #1 was providing care to Resident #1 in bed. NA #1 rolled Resident #1 to her left side and Resident #1 slid off the side of the bed feet first and NA #1 lowered her to the floor. Resident #1 was assessed, had no complaints of pain and no injuries were noted. The Nurse Practitioner (NP) and Resident Representative (RR) were notified as was the on-coming nurse (Nurse #2).

A skin assessment completed by Nurse #2 on 6/17/2024 at 9:32 AM revealed Resident #1 was noted to have discoloration to the right lateral (outer) upper arm, right axillary arm (armpit), right and left middle abdomen, left outer thigh, right inner heel, and a red area to the left knee. Abrasions were noted to the right second, fourth and fifth toe, tip of right second great toe, and right distal (top) foot. Also noted was a reddened area with slight abrasion to the middle back.

A Nurse Practitioner (NP) note dated 6/17/2024 at 10:05 AM indicated NA #1 was providing care for Resident #1 and she slid off the side of the bed and was lowered to the floor. Resident #1 started complaining of lower extremity pain and was noted to have a bruise on her right heel. Resident #1, at baseline, had atrophy (muscle wasting) to her lower extremities which made assessing for injury difficult and due to her complaints of pain she was transferred to the Emergency Department (ED) for further evaluation.

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The ED records dated 6/17/2024 revealed Resident #1 reported she was receiving care when she started sliding off the bed with her feet hitting the floor and then was lowered down to the floor. Resident #1 had bruising to her right foot and was complaining of leg pain, but no head trauma or other injury was noted. Left and right leg x-rays were obtained and negative for fracture or acute injury. Resident #1's condition was stable, and she was discharged back to facility with no new orders.

An interview conducted with Resident #1 on 4/30/2025 at 2:00 PM revealed she did not recall the date or the NA's name, but a NA was assisting her with incontinent care in bed, and she was turning from one side to the other and rolled off the side of the bed to the floor. Resident #1 stated usually two NAs assisted her with care but when the incident occurred only one NA was present. Resident #1 stated after the incident she started having lower leg pain and was transferred to the ED for further evaluation. Resident #1 revealed x-rays obtained were negative for fracture or injury and she was discharged back to the facility. Resident #1 indicated she had no further pain or discomfort related to the fall.

Several attempts made to contact NA #1 were unsuccessful.

A phone interview with Nurse #1 on 4/30/2025 at 2:43 PM indicated on 6/16/2024 to 6/17/2024 he was the third shift (11pm-7am) nurse assigned to Resident #1. Nurse #1 stated on 6/17/2024 at the end of his shift he responded to Resident #1's room when NA #1 activated the call bell. Nurse #1 revealed he observed Resident #1 lying on the

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floor beside her bed. He indicated NA #1 reported that Resident #1 was rolling to her left side, slid off the side of the bed and was lowered down to the floor. Nurse #1 indicated Resident #1 was not complaining of any pain or discomfort and he completed an assessment with no injuries noted. He revealed he reported the incident to the oncoming nurse and notified the NP and RR. Nurse #1 stated Resident #1 required two-person assistance with bed mobility, but he did not recall if NA #1 had a second person assisting her when the incident occurred.

An interview was conducted with Nurse #2 on 4/30/2025 at 3:30 PM. Nurse #2 stated she was the first shift (7a-3p) nurse assigned to Resident #1 on 6/17/24. She stated Nurse #1 reported at shift change that NA #1 was turning Resident #1 during care and she slid off the side of the bed and was lowered to the floor. Nurse #2 indicated that Resident #1 required two-person assistance with incontinence care and bed mobility and NA #1 did not have a second person assisting her when the incident occurred. She revealed that Nurse #1 completed an assessment and Resident #1 had no visible injuries and no complaints of pain. Nurse #2 revealed she completed a skin assessment a few hours after the incident and Resident #1 had a bruise on her right heel. Nurse #2 indicated Resident #1 started complaining of increased pain to both legs and she notified the NP. She stated the NP gave an order to transfer Resident #1 to the ED for further evaluation. Nurse #2 stated that Resident #1 was transferred to the ED around 10:00 AM and returned to the facility around lunch time. She indicated the ED report noted x-rays obtained of Resident #1's right and left leg were negative for fractures or injury and there were no new orders.

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F 689	Continued From page 4 An interview was conducted with the NP on 4/30/2025 at 1:20 PM. She stated on 6/17/2024 she was notified that Resident #1 rolled out of bed to the floor during care. The NP revealed due to Resident #1 having atrophy to her lower extremities at baseline, it was difficult to assess her for injuries and combined with her complaints of increased pain she was transferred to the ED for further evaluation. She indicated x-rays obtained in the ED were negative for fractures and Resident #1 was discharged back to the facility with no new orders. The NP revealed that one person should not assist a resident with incontinent care and bed mobility when two-person assistance was required to ensure the resident's safety. During an interview with the Director of Nursing (DON) on 4/30/2025 at 5:45 PM she stated she was aware of the incident that occurred on 6/17/2024. The DON indicated Resident #1 required two-person assistance with incontinent care and bed mobility and NA #1 assisting her without a second person was unsafe. An interview conducted with the Administrator on 4/30/2025 at 6:00 PM revealed he was aware of the incident that occurred on 6/17/2024. He stated to ensure care was provided in a safe manner a resident requiring two-person assistance should not be assisted by one person. 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.	F 689		

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On 06/17/2024 at approximately 6:26 AM, Nursing Assistant #1 was providing ADL care to Resident #1. As Nursing Assistant #1 turned Resident #1 towards her (left) side, the resident's feet begin to slide off the bed with her heels landing on the floor. Nurse Assistant #1 held Resident #1 up and lowered her to the floor into a supine position.

Nursing Assistant #1 then went to Floor Nurse #1 to notify him that the resident had slid off the bed and was laying on the floor. Floor Nurse #1 stated that Resident #1 didn't have any visual injuries or complaints of pain. The resident was assisted back to bed by Floor Nurse #1 and Nursing Assistant #1 using a mechanical lift.

Approximately 7:00 AM, Floor Nurse #1 reported to the oncoming nurse that resident had slid out of bed and didn't have any change in range of motion or visual injuries. At 9:32 AM a skin evaluation was completed by the oncoming nurse with noted discoloration to the right lateral upper arm, right axillary arm, right and left mid abdomen, right inner heel and abrasions to the right second toe, tip of right second great toe, distal foot, toes 4 and 5, a red area to (left) knee and discoloration to the left lateral thigh. Also noted was a reddened area with slight abrasion to the middle of her back.

At approximately 10:05 AM, the provider gave an order to transfer Resident #1 to the hospital due to pain. The Responsible Party (RP) was notified of order to transfer to hospital at the same time.

At 1:25 PM, Resident #1 returned to the facility by stretcher via emergency medical services (EMS)

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with no further orders. The Medical Director and RP were notified of Resident #1's return.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

Nursing Assistant #1's education file was audited by the Director of Nursing on 6/21/2024 to ensure that the employee received training validation of Kardex prior to providing resident ADL care. Nursing Assistant #1 was noted to have received the necessary training during general orientation on 3/19/2024.

On 6/17/2024 at 3:14 PM, verbal education was provided over the phone by the Unit Manager and the Assistant Director of Nursing, to Nursing Assistant #1 regarding accessing the Kardex and reading it to know the care residents required for bed mobility. Education was also provided to Nursing Assistant #1 on ensuring a resident's correct body position in the bed before rolling or asking resident to roll to their side while in bed.

On 6/21/2024, the Director of Nursing completed an audit of current residents to ensure that no falls/incidents had occurred in the last 30 days related to not providing the appropriate assistance with bed mobility. No occurrences were noted.

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

On 6/17/2024, education was initiated by the Staff Development Coordinator (SDC) to the direct care staff regarding checking the Kardex located

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F 689	Continued From page 7 in the Point of Care to know what assistance was required when providing ADL care. Staff education was completed 6/21/2024. Staff that did not receive the education by 6/21/2024 will receive prior to working next shift. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Include dates when corrective action will be completed. An ADHOC quality assurance (QA) meeting was held on 6/17/2024 by the interdisciplinary team and it was determined that Nursing Assistant #1 failed to follow the resident's Kardex that 2-person assist was required for bed mobility which resulted in a fall. On 6/24/2024 audits were initiated to observe 2 staff members providing 2 sampled residents' ADL care to ensure care is being provided according to the Kardex, weekly for 8 weeks by the Director of Nursing and or Unit Managers. Effective 6/17/2024, the Administrator and the Director of Nursing are ultimately responsible for ensuring the plan is implemented and monitored for effectiveness. The Quality Assurance Improvement Committee will review the results of the weekly audits during the monthly meetings for 3 months. The committee will determine if further actions are needed. The facility's alleged date of compliance is 6/22/2024.	F 689		

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F 689	Continued From page 8 Validation of the facility's corrective action plan was conducted 4/30/2025 which included record review and staff interviews. A phone interview conducted with the former Staff Development Coordinator revealed on 6/17/2024 she initiated providing education to all nursing staff related to accessing the electronic medical record (EMR), reviewing resident care needs and ensuring care was provided according to the EMR. Interviews conducted with nursing staff revealed they received education on accessing and reviewing the EMR prior to providing resident care and ensuring care was provided according to the EMR. The nursing staff interviewed also confirmed the observations of resident care audits were completed. The facility's corrective action plan completion date of 6/22/2024 was validated.	F 689		