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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 06/24/25 through 06/25/25. Event ID# D2LP11. The following intakes were investigated: NC00230329, NC00230840, and NC00231453. 2 of the 6 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 observations, record review, and resident, staff, family, and physician (MD) interviews, the facility failed to provide care in a safe manner when Resident #3, who was positioned onto her right side at the edge of her bed and was left unattended by MD #1 during wound care. Resident #3 fell from her bed and required transfer to the hospital for medical evaluation. This was for 1 of 3 residents (Resident #3) reviewed for accidents. Findings included: Resident #3 was admitted to the facility on 3/9/21 with a diagnosis of cerebral infarction (disruption in blood supply to the brain which causes tissue damage).	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 06/27/2025

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A review of Resident #3's comprehensive care plan revealed a focus area dated as initiated on 3/18/21 of actual fall with risk for further falls related to poor balance and unsteady gait. An intervention was to anticipate Resident #3's needs as much as possible.

A review of Resident #3's quarterly Minimum Data Set (MDS) assessment dated 5/15/25 revealed she was severely cognitively impaired. She had no functional limitation in range of motion of her upper or lower extremities. She was dependent for rolling left to right in bed, going from lying to sitting on the edge of the bed, and for transfers. She had no falls since her prior MDS assessment. Bed rails were not used as a restraint.

A review of Resident #3's quarterly Interdisciplinary Team (IDT) risk assessment dated 5/15/25 revealed she was at low risk for falls.

A review of Resident #3's quarterly Device and Bed Rail review dated 5/15/25 revealed she did not use bed rails.

A review of a Fall report for Resident #3 dated 5/20/25 completed by Nurse #1 revealed on 5/20/25 at 11:51 AM Physician (MD) #1 was in Resident #3's room providing treatment to Resident #3. MD #1 stepped out of Resident #3's room to make Nurse #1 aware that Resident #3 was on the floor. Nurse #1 immediately entered Resident #3's room and observed Resident #3 lying on the floor on her right side in the fetal position. Resident #3 was assessed for injuries, no injuries were observed, and Resident #3 was

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sent to the emergency room for evaluation.

Multiple attempts at telephone interview with Nurse #1 were unsuccessful.

On 6/24/25 at 12:59 PM a telephone interview with MD #1 indicated she had been the facility's Wound Care physician for approximately 6 months at the time of Resident #3's fall on 5/20/25. She reported she could not recall if she had provided treatment to Resident #3 prior to 5/20/25 but it was normal for her and Nurse #2 to provide wound treatments together. She stated on 5/20/25, she had originally been there to assess an area on Resident #3's sacrum (base of spine) but observed an area on Resident #3's buttock that she felt needed an incision and drainage. MD #1 stated Resident #3 had been positioned on her right side closer to the edge of the bed than the middle of the bed facing Nurse #2. She reported she realized she needed additional supplies as the procedure had not been planned, asked Nurse #2 to go get them, and she stayed with Resident #3. MD #1 went on to say she herself had been positioned very closely physically to Resident #3 when Nurse #2 left the room and she felt that if Resident #3 had been unsteady or otherwise began to roll or fall she could have prevented this. MD #1 recalled she remembered a few other supplies she needed, and without assisting Resident #3 back onto her back she left Resident #3 unattended as she was and exited the room. She reported she was out of Resident #3's room for a few minutes, and when she went back into the room she saw Resident #3 was on the floor beside her bed. She stated she had not thought of the safety implications of leaving Resident #3 unattended positioned on her side at the edge of her bed

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before Resident #3's fall on 5/20/25, but she did now. MD #1 reported she no longer provided wound care at the facility.

On 6/25/25 at 9:28 AM an interview with Nurse #2 indicated he was the facility's treatment nurse. He reported he was familiar with Resident #3 and had been involved in her fall incident on 5/20/25. He stated that morning, he accompanied MD #1 into Resident #3's room to assess Resident #3's sacral area. He went on to say he did not recall which side of the bed he had been on, and which side of the bed MD #1 had been on, but Resident #3 had been turned onto her right side positioned closer to the edge of the bed than in the middle, with the bed elevated approximately 18 inches from the floor during her treatment. Nurse #2 stated Resident #3 did not have bed rails. He reported MD #1 observed an area on Resident #3's buttock that she wanted to do a treatment on that was new, and he had not had the supplies at the bedside that MD #1 needed. Nurse #2 went on to say MD #1 did not have access to his treatment cart, which was located outside the room and locked, so MD #1 asked him to go obtain the supplies needed. Nurse #2 stated MD #1 had remained with Resident #3 when he left the room to obtain the supplies. He reported a few seconds later, MD #1 also came out of the room into the hallway. He stated he had not thought anything of it at the time, as he felt confident that MD #1 would have ensured Resident #3 was in a safe position before she left her unattended. Nurse #2 reported it was standard practice not to leave a resident you were working with in a vulnerable position, and if you needed to leave the room, to ensure that the resident was positioned safely in the middle of the bed with the bed in the lowest position. He stated

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he saw MD #1 go back into Resident #3's room, and as MD #1 got past the privacy curtain she called out that Resident #3 was on the floor. Nurse #2 reported he had not heard Resident #3 make any sound and had not heard her fall. He stated when he rushed back into Resident #3's room, she was lying on the floor on right side of her bed and positioned on her left shoulder facing her bed. He stated he assessed her for any injuries, didn't find any, placed a pillow under her head and covered her with a blanket. Nurse #2 reported by that point Resident #3's Nurse #1 and Nurse Aide (NA) #1 were there and stayed with Resident #3 until the Emergency Medical Services (EMS) arrived. Nurse #2 stated he provided his statement to the Administrator, and everyone received education after the incident regarding ensuring you collected all supplies before entering a residents room, safe positioning of residents, and ensuring residents were in a safe position in the middle of the bed with the bed lowered before you left the room.

On 6/24/25 at 2:41 PM an interview with Nurse Aide (NA) #1 indicated she was familiar with Resident #3 and cared for her regularly. She reported she had been caring for Resident #3 on 5/20/25 on the 7:00 AM to 3:00 PM shift. She indicated Resident #3 could use her upper body to help with turning herself in the bed, but she was not able to use her lower body at all to assist. She reported Resident #3 was not able to balance to sit by herself on the side of her bed and was dependent for all care and transfers. NA #1 stated she had just been coming back from her lunch break on 5/20/25 when she heard the overhead page for the fall and she immediately went to Resident #3's room. She reported she saw Resident #3 on the floor on the right side of

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her bed. She stated she had not seen any injuries, Resident #3 had not been complaining of anything, and had not said anything to her. She went on to say she had stayed with Resident #3 until the ambulance arrived to take her to the hospital.

A review of Resident #3's hospital discharge summary dated 5/21/25 revealed in part she presented to the hospital Emergency Room (ER) on 5/20/25 after an unwitnessed fall at the facility. Resident #3 was not on any anticoagulant (blood thinning) medication. Extensive imaging studies were performed to evaluate Resident #3 for any fractures and subdural hematoma (bleeding in the brain). All these imaging studies were negative. Resident #3 returned to the facility on 5/21/25.

A review of the untimed post-fall investigation report for Resident #3 dated 5/23/25 completed by the facility's Director of Nursing (DON) revealed after Resident #3's fall on 5/20/25 statements were obtained from the staff involved, camera footage of the incident was reviewed, immediate in-service education was provided to MD #1 regarding not leaving a resident unattended when they were being prepared for wound care, Resident #3's room environment was assessed for any factors that may have contributed to the fall, the fall was reviewed by the Interdisciplinary Team (IDT) and Resident #3's care plan was updated to reflect immediate interventions with the participation of Resident #3's family member.

On 6/25/25 at 8:58 AM an interview with the Director of Nursing (DON) indicated she participated in the investigation of Resident #3's

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fall on 5/20/25. She stated Physician (MD) #1 and Nurse #2 were in the room, Nurse #2 needed to leave the room to get additional supplies and left the Resident #3 under the supervision of MD #1. She reported MD #1 then left Resident #3 unattended positioned on her side at the edge of the bed, and when MD #1 went back into the room Resident #3 was on the floor. The DON stated statements were obtained, camera footage was reviewed, she provide immediate education regarding proper positioning and not leaving the resident unattended during care to MD #1. She reported she had been doing follow-up audits to ensure the corrective action the facility put into place after the incident remained effective.

On 6/24/25 at 10:23 AM Resident #3 was observed in a recliner chair in the facility's dining room. An interview with Resident #3 at that time indicated she did recall falling once out of bed at the facility. She stated she was asleep, and next thing she knew she woke up on the floor. She reported she had not been injured and felt safe when care was being provided to her.

On 6/24/25 at 1:14 PM a telephone interview with Resident #3's family member indicated she visited Resident #3 in the facility at least twice weekly. She reported on 5/20/25 in the morning a doctor had called her to get permission to lance (cut open) a boil (a painful pus filled lump) on Resident #3's bottom. She stated a little while later, the facility called to notify her Resident #3 had fallen out of her bed during wound care and was being taken to the hospital. Resident #3's family member stated when she got to the hospital, Resident #3 was shaking a little, but was not in any pain and she did not see any injuries. She reported the hospital had done a lot of tests

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and had not found any broken bones or other injuries.

On 6/24/25 at 2:49 PM an interview with Physical Therapist (PT) #1 indicated she was familiar with Resident #3 and had provided therapy to her multiple times during Resident #3's stay in the facility. She reported prior to 5/20/25, Resident #3's most recent therapy course had been from 5/14/25 through 5/19/25. She stated Resident #3 had cognitive impairment, and poor balance and upper body strength. PT #1 indicated Resident #3 would not have had the cognition, balance or strength to keep herself from falling from the bed if she had been left unattended positioned onto her right side at the edge of the bed and had begun to roll for any reason.

On 6/25/25 at 8:23 AM an interview with the Administrator indicated he participated in the investigation of Resident #3's fall from her bed on 5/20/25. He stated the investigation consisted of a review of video camera footage of the hall outside Resident #3's room at the time of the incident, obtaining statements from staff involved, root cause analysis of the incident, and corrective action which included immediate education of MD #1, and education all staff who provided care to residents including therapy staff, nurses, nurse aides, and all the facility's medical providers. The Administrator stated the conclusion of the investigation was that MD #1 and Nurse #2 were in Resident #3's room providing care, Nurse #2 exited the room to gather supplies leaving Resident #3 with MD #1, and then MD #1 left Resident #3 unattended in an unsafe position while she exited Resident #3's room. He reported that follow up audits were done to monitor the corrective action plan, and the

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incident was taken through the facility's Quality Assurance and Performance Improvement (QAPI) process to ensure continued effectiveness of the corrective action. He stated that regardless of a physician's background or experience a resident's safety was everyone's responsibility. The Administrator indicated MD #1 should have positioned Resident #3 back onto her back and ensured she was in a safe position before leaving the room or stayed with Resident #3 until Nurse #2 returned and then went to get any additional supplies.

The facility provided the following corrective action plan with a completion date of 5/26/25.

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

On 5/20/2025 resident #3 was assessed post incident by the assigned nurse for any potential injuries or alteration in skin integrity. The results included: no noted injuries or new skin integrity concerns.

On 5/20/2025 the physician and responsible party were notified, and the resident was transferred via EMS to ER for further evaluation.

2. Address how the facility will identify other residents having the potential to be affected.

On 5/21/2025 the Director of Nurses audited all falls for the last 14 days to assure that no fall from bed had occurred related to positioning of the resident during care. The results included: No concerns were identified.

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On 5/21/2025 the Director of Nurses audited all falls for the past 14 days to assure the post fall process was in compliance. The results included: No concerns identified with the post fall process to include: completion of nursing fall assessments, notification of the MD or responsible party, development of an incident report of the event and review of resident care plans and interventions.

On 5/21/2025 the MDS coordinator audited falls for the last 14 days to assure that care plans were current for falls with fall interventions in place. The results included: No concerns identified.

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

On 5/20/2025 the Director of Nurses educated the wound care provider post incident on: prevention of falls from a bed.

On 5/20/2025 the Staff Development Coordinator began education of all licensed nurses and certified nursing assistants and facility providers - Full time, Part time and PRN on fall prevention and the post fall process.

The education included:

- What are the common causes of falls.

- What is a fall.

- Fall prevention strategies: to include:

o It is important that in the event that you have to

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move away from resident you must reposition the resident back in a safe position and bed in lowest position prior to stepping away.

- Identifying fall risk and potential negative effects to include pain post fall

- General Fall Prevention Strategies.

- What should I do if I see a resident fall or see a resident on the floor?

- Nursing immediate actions: to include nurse assessment prior to moving a resident and if c/o pain or the potential for an injury- do not move the resident. Contact MD and send resident to ER for further evaluation.

- Post fall and method for assisting a resident from the floor.

- Post Fall Documentation and Ongoing Assessment

- Completing the incident report and the fall assessment UDA's.

- Fall investigation and development of Root Cause.

The Director of Nursing will ensure that any of the above identified staff who does not complete the in-service training by 5/25/2025 will not be allowed to work until the training is completed.

This training was incorporated into the general orientation program and will be discussed during all general orientation programs that are completed for identified staff.

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4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

The Director of Nurses/Staff Development Coordinator will monitor bed positioning safety weekly for 2 weeks and monthly for 3 months for compliance with the safe provision of care. Monitoring started on 5/20/2025. The monitoring will include direct observation of 4 staff (including providers) on various shifts, to include weekends, for appropriate resident bed positioning, resident bed mobility safety/provision of safe care by staff. Reports will be presented to the monthly Quality Assurance Committee by the Administrator or Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The Quality Assurance Meeting is attended by the Administrator, Director of Nurses, Minimum Data Set Coordinator, Therapy, Health Information Manager, and the Dietary Manager.

On 6/25/25 at 11:10 AM the facility's corrective action was verified via a review of observations of staff repositioning residents including Resident #3 back into a safe position and returning the bed to lowest position prior to stepping away from the resident, the facility's initial audits and follow-up weekly audits, the in-service education records, staff, Physician and Nurse Practitioner interviews, and a review of the facility's audit tools and QAPI minutes.

The facility's date of completion of 5/26/25 was verified.