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	495330	A. BUILDING ______ B. WING ______	C 11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENBRIER REGIONAL MEDICAL CENTER	1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted from 11/13/23 through 11/16/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One (1) complaint was investigated during the survey: VA00059906 -Substantiated with deficiency. The census in this 120 certified-bed facility was 90 at the time of the survey. The survey sample consisted of 7 Resident reviews (Residents #1, through #7).	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 a family interview, staff interviews, clinical record review, and review of documents, the facility's staff failed to adequately position Resident #1 on an unfamiliar piece of equipment, an egg crate mattress used as a transfer/slide device for obese residents. The facility staff also failed to provide supervision by leaving the resident's room and not leaving the bed in the lowest position. Resident #1, one (1) of Seven (7) residents in the survey sample, fell from the bed and sustained injuries.	F 689	This plan of correction constitutes a written allegation of substantial compliance with the Federal Medicare and Medicaid requirements. The submission of this plan of correction does not constitute an agreement that the deficiencies exist, nor is it an admission that they existed. It is an expression of the Facilities desire to fully comply with the Medicare and Medicaid requirements. F689	12/8/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 12/07/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 689	Continued From page 1 The findings included: Resident #1 was no longer a resident of the facility; therefore, a closed record review was conducted. Resident #1 was originally admitted to the facility on 2/16/23 and readmitted on 7/31/23 after an acute care hospital stay. She was discharged from the facility on the same day back to an acute care hospital. The current diagnoses included end-stage renal disease with dependence on hemodialysis and morbid obesity. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 02/16/23 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring an 8. This indicated Resident #1 cognitive abilities for daily decision-making were moderately impaired. In section "G"(Physical functioning) the resident was coded as requiring total care of one person with bed mobility, transfers, locomotion, dressing, eating, toileting, personal hygiene and bathing, and supervision after set-up. Resident #1's person-centered care plan revised on 2/16/2023 identified the resident as having end stage renal disease. The goal for the resident was that she would have no complications related to hemodialysis (resident received Dialysis on Tuesdays, Thursdays, and Saturdays from 9:45 a.m. to 1:30 p.m.). An intervention was that the staff monitor vital signs as ordered and notify the physician of abnormal findings. A review of the incident report dated 7/31/23 at 4:35 p.m., read that Resident #1 had a fall from the bed, was observed lying face down on the floor, sustained a deep laceration to her left lower	F 689	1. Resident #1 is no longer in facility. 2. Review of residents that have had falls with major injuries from 11/27/23 and back 30 days. Care plans will be updated for resident's who want bed in higher position. 3. In-service all licensed nurses and aides on transferring protocol and not leaving unnecessary items under the resident when facility receives resident was done between July 31, 2023, and August 14, 2023. In-service all licensed nurses, aides, housekeepers, therapy, department heads that when out on floor to make sure if see a bed in high position they either put bed n proper height for resident or stay with resident until able to place bed at proper height was done between November 17, 2023, and December 1, 2023. Residents who request the bed in a higher or lower position will be care planned for this request. 4. Falls will be reviewed in clinical stand up, update care plan as needed. Director of nursing and/or designee will report falls monthly in QA for 3 months then quarterly until in substantial compliance. 5. Date of Compliance: December 8, 2023	

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extremity, a knot with bleeding on her face above her right eye. The staff applied dressing to open areas and the resident was sent to the Emergency Room at 4:50 p.m. The family member was notified at 5:15 p.m.

A late entry nurse's note dated 8/02/23 at 6:05 p.m., read on 7/31/23 around 4:30 p.m., Resident #1 was transferred on an air crate mattress left under her from the hospital. The resident was alert and verbal. Certified Nursing Assistants (CNAs) went into the resident's room to get her situated, but one of the CNAs noticed the resident wasn't wearing a brief, so the staff went to find briefs, and moments later a CNA yelled down the hall for help.

An interview was conducted on 11/14/23 at approximately 12:30 p.m., with Certified Nursing Assistant (CNA) #2. CNA #2 said that Resident #1 was brought into her room by transport via stretcher, laying on a blow-up mattress that the hospital used, once they got her on the bed, transport left the room. CNA #2 also said that she came out of the door of the resident's room and stood in the hallway, calling down the hall for another CNA to come help her with Resident #1. CNA #2 said that she noticed as she turned around the resident had her foot hanging off the blow-up mattress and hit the floor face-first. She said the incident happened so quickly. CNA #2 said that the bed was in an up position, and the top side rails were down. CNA #2 also said that transportation usually wouldn't have that type of mattress when transferring a resident and used a flat pad for transferring which is left under a resident. CNA #2 said that she told the other CNA to get everybody and bring the crash cart after the resident fell. She stated after the nurses arrived,

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she left the room.

An interview was conducted on 11/14/23 at approximately 12:50 p.m., with CNA #1. CNA #1 said that she noticed transport in the hallway heading to the resident's room. They had dropped the resident off and didn't let anyone know they were leaving her; normally they would have waited for a CNA to check the residents in a room. CNA #1 also said that she heard a loud sound, entered the resident's room noticed the resident was on the floor face down, and yelled for help. CNA #1 said that she was the first one on the scene and noticed that the skin on the resident's leg was split open, she had a knot on her head and noticed that she had been left on a plastic egg crate. CNA #1 said that Resident #2 responded when she asked her if she could hear her and said that her leg was hurting.

On 11/14/23 at approximately 1:00 p.m., an interview was conducted with the Assistant Director of Nursing (ADON). The ADON said transport was observed wheeling the resident towards her room, and then shortly afterward he heard someone (Licensed Practical Nurse (LPN) #1) yelling for help. The ADON said that upon entering the room, Resident #1 was observed lying face down on the floor with an open area on the skin on one of her legs with the resident saying "Ouch, ooh." The ADON said the bed appeared to be extremely high and he noticed a pink, foam, plastic device used as a slide transfer for the resident.

On 11/14/23 at approximately 1:15 p.m., a telephone call was made to Licensed Practical Nurse (LPN) #1 concerning the incident. LPN #1 said when Resident #1 arrived from the hospital

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medical transport transferred Resident #1 from their stretcher to the resident's bed with a bubble mattress left under her. The CNA was in the room at the time but went to get briefs to perform Activities of Daily Living (ADL) care. LPN #1 said that the resident shouldn't have been left alone with the bed left up. LPN #1 said that the resident was lying face down beside the bed with visible blood on the floor. She stated she observed a skin tear on her leg and a gash on her forehead. She said that Gauze was applied to the open areas until Emergency Medical Services (EMS) came. LPN #1 was asked if she was aware that Resident #1 was admitted back to the facility. She stated, "Yes, but I didn't anticipate her coming back to the facility because we hadn't received a call from the hospital admissions concerning the resident's discharge."

On 11/14/23 an interview was conducted with the Director of Nursing (DON), the Administrator and the Corporate Consultant Nurse (CCN) at 3:18 p.m. The DON said that if they needed to leave the room to get supplies, the bed should have been left in low position, and one staff should have stayed with the resident. The DON also said, "The egg-crate device caused the fall, the hospital said they didn't send it and the transport company said they didn't have it. It wasn't documented. Normally a transport sheet from the stretcher to the bed is under the resident." The Corporate Nurse Consultant (CCN) said, "They should have removed the thing (plastic egg-crate device) from under the resident. She slid on the floor because of that piece of equipment."

On 11/14/23 at approximately 3:50 p.m. an interview was conducted with the transportation dispatcher, Other Staff Member (OSM) #2. OSM

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F 689	Continued From page 5 #2 said that when they transport residents to the facility they stop at the front desk or the nurses' station to find out which room the resident is going in. OSM #2 also said that they transfer residents to their beds and never leave the room without staff being present. A telephone interview was conducted with the Responsible Party (RP) of Resident #1 on 11/16/23 at 11:05 a.m. The RP said that Resident #1 fell out of her bed onto the floor sustaining a fracture of her left leg, left ankle, a goose egg on her forehead, and a bruise to her brain. The RP said the fall incident occurred after two CNAs came to her room to change her bed linen and briefs leaving her alone on a transfer device. The RP also said that they operated on the resident's leg but because she had weak, brittle bones from diabetes the procedure didn't go well. The RP said that the doctors wanted to amputate the resident's leg due to an infection and her hardware not "working well." A telephone interview was conducted on 11/16/23 at approximately 12:10 p.m., with RN #2, a local dialysis center employee. RN #2 said that Resident #1 would come to the center with a lot of blankets, but he never saw anything underneath the resident during her transport to the center. He also said on the day she was receiving services she pulled out her needles and had to be transported to the hospital due to excessive bleeding. An interview was conducted with the non-medical transport owner, OSM #4 on 11/16/23 at approximately 1:50 p.m. OSM #4 said that they used a stretcher with a pad and hospital sheets on top to transfer residents. OSM #4 also said	F 689		

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that they will usually see one or two vinyl egg crate devices in a month. If a patient is heavy, they transport with four people called a Lyft assist. The transport devices and sheets are left with the resident at the facility. Everything stays at the facility with the resident. OSM #4 also said that they were not the company that transported the resident on 7/31/23 because the run was canceled.

An interview was conducted on 11/16/23 at approximately 2:00 p.m., concerning the plastic egg crate device left under Resident #1, with the inpatient case manager. The case manager said that the egg-crate device was a sliding mechanism used for overweight residents when a strong bed sheet does not help with transfers.

In a synopsis of the event dated 7/31/23, the Director of Nursing (DON) detailed the events of Resident #1's fall that read, the resident was being transported to the facility from the hospital via transport around 4:30 p.m. and that the facility was not expecting the residents return to the facility because they hadn't received a report from the hospital. The resident was received on a plastic egg crate mattress, along with the hospital sheets under her. Once the resident was in bed, the staff stepped out of the room to get Activities of Daily Living (ADL) supplies and briefs, when they heard a loud crash and ran back into the room to find that Resident #1 had slid off the plastic egg crate and hit the floor face down, sustaining a large hematoma to the center of her forehead above the eyes and a large wound on her left leg. The Certified Nursing Assistant (CNA) immediately called for assistance and the nursing team with the DON arrived to provide first aid to the resident while waiting for 911.

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The X-ray report dated 7/31/23 of the resident's left knee revealed that Resident #1 X-ray results revealed a comminuted and displaced distal femur fracture of the left knee. Compression fracture in the lateral tibial plateau and proximal tibia suspected. Fibular neck fracture of indeterminate age and left chronic appearing distal tibial shaft fracture, distal fibular fracture.

Distal Femur (Thighbone) Fractures of the Knee. A fracture is a broken bone. Fractures of the thighbone that occur just above the knee joint are called distal femur fractures. The distal femur is where the thighbone flares out like an upside-down Funnel.
https://orthoinfo.aaos.org/en/diseases--conditions/distal-femur-thighbone-fractures-of-the-knee/

A review of hospital records read on 7/31/23 Resident #1 was transferred to the hospital at 5:14 p.m., According to the hospital records Resident #1 sustained a moderate right forehead hematoma, a mild superficial hemorrhagic contusion in the left frontal cortex, a femur fracture and Tibial Fibular fracture.

A review of a trauma surgery note dated 7/31/23 at 5:31 p.m., read that the resident fell from her bed and on arrival was confused, not communicating well, and had an obvious open wound to her left lateral knee, suspicious of a fracture.

A review of the hospital History and Physical (H&P) dated 7/31/23 revealed that Resident #1 was in mild distress and had a hematoma on the right forehead with an overlying bleeding abrasion. An obvious deformity of the left thigh

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F 689	Continued From page 8 with laceration, significant tenderness, and right elbow abrasion, able to move all extremities, eyes opened spontaneously and to command, followed some commands, and spoke incomprehensible words. The hospital admission report dated 7/31/23 read, "Presented to the Emergency Room (ER) on 7/31/23 as trauma after a fall from her bed at the nursing home. She was found to have an open distal left femur fracture. On 8/2/23 she was taken for an Open reduction and internal fixation (ORIF) of a distal femur fracture (fx). She was recovering well for several days post-surgery. On 8/13/23 an infected hematoma of the left leg incision site, started on antibiotics with the plan to return to the OR the next day but later that day she was transferred to the Intensive Care Unit (ICU). A repeat Left Lower Leg Extremity Cat Scan (CT) revealed failure of hardware construct with proximal displacement of medial femoral condyle no longer secured with distal locking screws and much varus alignment at the fracture. At this time Orthopedic Surgery was recommended above the knee amputation and the family opted to treat with non-operative management. On 8/18/23 the family decided to forego surgery. On 8/22/23 the family opted to transition to comfort care." An interview was conducted with the Director of Nursing (DON) on 11/13/23 at approximately 3:50 p.m. concerning falls with major injuries in the facility. She said that Resident #1 had sustained a major fall with injuries on 7/31/23 after being transported back to the facility from a brief hospital stay. The DON also said that the transport company transferred the resident to the bed with everything under her. The CNAs left to	F 689		

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F 689	Continued From page 9 get things the resident needed but left her bed high and she suffered a fall with injuries. On 11/16/23 at approximately 4:15 p.m., the above findings were shared with the Administrator, Director of Nursing, and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.	F 689		