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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 11/20/2023-11/21/2023. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey (VA00060037 substantiated w/deficiency at past non-compliance). The census in this 80 certified bed facility was 77 at the time of the survey. The survey sample consisted of 4 resident reviews.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		1/3/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/22/2023

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 656	Continued From page 1 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review, the facility staff failed to implement the person-centered care plan for one resident (Resident # 1) in a survey sample of 4 residents. Findings included: For Resident # 1, the facility staff failed to implement the care plan intervention of use of a gait belt during a transfer from the Geri-chair to bed on 10/28/2023. Resident # 1 was admitted to the facility on 10/6/2023 for skilled nursing care services with	F 656	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: LPN B was provided training on proper implementation of Resident #1's person-centered care plan, with a focus on using the care planned transfer method. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:	

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F 656	Continued From page 2 diagnoses that included but were not limited to: Chronic Obstructive Pulmonary Disease with Chronic Hypoxic Respiratory Failure, Chronic Heart Failure, Atrial Fibrillation on Eliquis, history of Stroke. Review of the clinical record was conducted on 11/20/2023 and 11/21/2023. Review of Nurses Notes revealed documentation of an incident on 10/28/2023 when Resident # 1 received a deep laceration on the right lower leg from a jagged edge on the bed frame. The Nurses note written on 10/28/2023 at 7:38 p.m. by LPN (Licensed Practical Nurse)-B stated "around 6:50 p.m., while pt was being transferred from geri chair to bed the residents right leg came into contact with the lower bed frame. writer then observed a deep laceration into the right lower anterior/lateral of leg shin area. site wrapped...." Review of the handwritten witness statement by LPN (Licensed Practical Nurse) -B revealed the following documentation: "On 3-11 around the 6:50 time, Resident was being transferred to room in geri chair with legs up. when go to room__ (room number redacted) rolled in resident feet first, past 1st (first) bed and partially past 2nd bed, then backed pt as closest to wall next to bed. 3-11 CNA stood to side behind geri chair when stopped and in position. lowered legs of chair. (geri chair was closest to bed as could get) and IV pole was moved to the right side of pt. had resident scoot forward in chair and with writers arm under pts armpit and right leg between pts R & L (right and Left) feet/legs lifted Pt to standing position and	F 656	All incident reports for the last 30 days were reviewed to determine if the incidents were caused by a failure of staff to implement the residents person-centered care plan. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: All RNs, LPNs, and CNAs will be provided training on proper implementation of person-centered care plans, with a focus on using the care-planned transfer method. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Director of Nursing/ Designee will review all incident reports weekly for 6 weeks to ensure direct care staff are implementing person-centered transfers per the resident's care plan. Any trends or variances will be reported to the Quality Assessment and Performance Improvement Committee. 5. Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)	

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F 656	Continued From page 3	F 656		

pivoted to bed. Writer noticed wound to the right leg/shin area of pt. Sat pt to bed, assessed deep laceration to R (right) leg/shin area."

The handwritten witness statement by the Certified Nursing Assistant (CNA)-C who assisted with the transfer stated ""While transferring patient to bed, patient received injury in the process. 3-11 nurse was made away [sic] of the incident." The note was signed and dated by CNA-C.

Review of Resident # 1's care plan revealed documentation on page 10 of 55 that stated:
"Goal: Maintain safety through appropriate assistance and safety measures."
"Interventions: Provide transfer assistance when transferring to and from different surfaces. Gait belt attended by at least 1 staff member." For transfers, a gait belt should be used.

Review of the Facility's Transfer Assistance Program Policy, reviewed and approved on 07/24/2023 revealed the following excerpts:

"Policy: All staff will be responsible for utilizing mechanical lifting devices, transferring devices, proper body mechanics to lift, transfer and/or pivot non-ambulatory residents as indicated. Employees should avoid manually lifting any resident, except in life threatening situations. Any employee in violation of this policy will be subject to disciplinary action, up to and including termination"
Under Procedure:
"All direct care staff members are responsible for knowing and following the transfer method determined by the residents' plan of care. Direct care staff should notify the nurse immediately if

Date of compliance will be January 3, 2024.

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there is a change in the residents' ability to transfer with the evaluated transfer method an/or if the resident requests to use an alternative transfer method."
Under Mechanical Lifting Device Selection:
3/ Gait Belt will be used when:
a. The resident can bear weight on at least one foot, AND
b. The resident is able to follow simple instructions, AND
c. The resident can maintain trunk control in the sitting position, and requires
minimal assistance with this task;"

On 11/21/2023 at 11:38 a.m., an interview was conducted with Licensed Practical Nurse-B who stated they transferred Resident # 1 from the Geri-chair to the bed on 10/28/2023. LPN-B stated CNA (Certified Nursing Assistant)-C was present during the transfer. LPN-B stated they did not use a gait belt. LPN-B stated Resident # 1 "could stand and had no resistance" during the transfer.

On 11/21/2023 at 1:20 p.m., an interview was conducted with the Director of Nursing who stated care plans should be tailored for each resident and staff should follow the plan of care. The Director of Nursing stated that for transfers, a gait belt should have been used for Resident #1. The Director of Nursing stated that she assessed Resident # 1 after he returned to the facility using the transfer assistance evaluation and determined that a total lift (Hoyer lift) would be utilized in all future transfers.

On 11/21/2023 at 2:15 p.m., the Corporate Consultant stated a gait belt was not used by the staff on the day a laceration on the right lower leg

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F 656	Continued From page 5 was sustained by Resident # 1 when he was transferred from the Geri-chair to the bed. The laceration was caused by a sharp edge on the bed frame when Resident # 1's leg came in contact with the jagged edge during the transfer technique to the bed. On 11/21/2023 during the end of day debriefing, the Administrator, Director of Nursing and Corporate Consultants were informed of the findings that the staff did not utilize the proper method of transfer utilizing the gait belt. They all agreed that a gait belt should have been used as written in the care plan. The nurse, LPN-B, was counseled and educated about ensuring limbs were protected during transfers. The nurse was also educated about following the plan of care. No further information was provided.	F 656		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review, the facility staff failed to ensure a safe environment resulting in harm for one resident (Resident # 1) in a survey sample of 4 residents. This was cited at past non-compliance.	F 689	Past noncompliance: no plan of correction required.	

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Findings included:

For Resident # 1, the facility staff failed to ensure the bed frame was free of jagged edges resulting in a large laceration on the right lower leg requiring stitches and hospitalization that was sustained during a transfer from Geri-chair to bed on 10/28/2023, resulting in harm for Resident #1. The facility staff failed to use a gait belt during transfer per the plan of care.

Resident # 1 was admitted to the facility on 10/6/2023 for skilled nursing care services with diagnoses that included but were not limited to: Chronic Obstructive Pulmonary Disease with Chronic Hypoxic Respiratory Failure, Atrial Fibrillation on Eliquis, and history of Stroke.

Review of the clinical record was conducted 11/20/2023-11/21/2023.

Review of Nurses Notes revealed documentation of an incident on 10/28/2023 when Resident # 1 received a deep laceration on the right lower leg contact with the lower bed frame. Resident # 1 was transferred to the hospital.

Further review revealed the laceration required stitches and Resident # 1 was admitted to the hospital for 4 days. (Resident # 1 returned to the facility on 11/1/2023) It was determined that the bed frame had a jagged edge that caused the injury.

The Nurses note written on 10/28/2023 at 7:38 p.m. by LPN (Licensed Practical Nurse)-B stated "around 6:50 p.m., while pt was being transferred from geri chair to bed the residents right leg

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came into contact with the lower bed frame. writer then observed a deep laceration into the right lower anterior/lateral of leg shin area. site wrapped...."

Review of the handwritten witness statement by LPN (Licensed Practical Nurse) -B revealed the following documentation:
"On 3-11 around the 6:50 time, Resident was being transferred to room in geri chair with legs up. when go to room__ (room number redacted) rolled in resident feet first, past 1st (first) bed and partially past 2nd bed, then backed pt as closest to wall next to bed. 3-11 CNA stood to side behind geri chair when stopped and in position. lowered legs of chair. (geri chair was closest to bed as could get) and IV pole was moved to the right side of pt. had resident scoot forward in chair and with writers arm under pts armpit and right leg between pts R & L (right and Left) feet/legs lifted Pt to standing position and pivoted to bed. Writer noticed wound to the right leg/shin area of pt. Sat pt to bed, assessed deep laceration to R (right) leg/shin area."

The handwritten witness statement by the Certified Nursing Assistant (CNA)-C who assisted with the transfer stated ""While transferring patient to bed, patient received injury in the process. 3-11 nurse was made away [sic] of the incident." The note was signed and dated by CNA-C.

Review of Resident # 1's care plan revealed documentation on page 10 of 55 that stated:
"Goal: Maintain safety through appropriate assistance and safety measures."
"Interventions: Provide transfer assistance when transferring to and from different surfaces. Gait

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belt attended by at least 1 staff member."

The Plan of Correction (POC) Required Elements document was reviewed and revealed:

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

Employee had received verbal education on 11/3/23, signed on 11/5/23 regarding monitoring resident arms and legs placement before transfers to ensure that limbs are not too close to hard surfaces that may cause injury.
Administrator met with direct care staff during huddles to discuss resident safe transfers and repositioning.
Once the bed frame was identified as the source of injury, the resident bed was immediately assessed and repaired 10/31/2022. Before the resident's return to the facility, a different bed was provided to the resident.

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

On 11/2/2023, all bed frames for resident use had been inspected to ensure there are no potential hazards to residents.
Any potential hazards identified were addressed with either a permanent or temporary solution.
Facility has purchased 15 new beds on 10/11/2023 with delivery expected on 11/30/2023.

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

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The Operations Assistant Administrator or designee will include bed frames, headboard and foot board inspection as part of quarterly bed management inspection.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained, and
Operations Assistant Administrator or designee will perform bedframe checks weekly for 8 weeks and per bed management inspection schedule thereafter to ensure there are no potential hazards to residents. Incident reports are being reviewed to ensure no additional resident injuries occurred from bed frames. Administrator designee will review the audit results for any patterns or trends and report any findings to our Quality Assurance Performance Improvement Committee.

5. Include dates when the corrective action will be completed. (The "outside " date by which all corrections must be made is the 45th calendar day after the survey ended.

Date of compliance will be November 5, 2023." The form was signed by the Administrator.

In addition, the Licensed Practical Nurse-B was counseled/educated on monitoring resident arms and legs placement before transfers to ensure that limbs are not too close to hard surfaces that may cause injury.

On 11/21/2023 at 11:38 a.m., an interview was conducted with Licensed Practical Nurse-B who stated they transferred Resident # 1 from the

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F 689	Continued From page 10 Geri-chair to the bed on 10/28/2023. LPN-B stated CNA (Certified Nursing Assistant)-C was present during the transfer. On 11/21/2023 at 1:20 p.m., an interview was conducted with the Director of Nursing who stated all of the beds were examined for any sharp edges. She stated the facility nursing staff have been educated to protect the limbs of the residents from contact with the bed frames. On 11/21/2023 at 2:15 p.m., the Corporate Consultant stated Resident # 1 sustained a laceration on the right lower leg when he was transferred from the Geri-chair to the bed. The laceration was caused by a sharp edge on the bed frame when Resident # 1's leg came in contact with the jagged edge during the transfer technique to the bed. The Corporate Consultant stated she participated (along with the administrative team) in reenactments to determine exactly how the injury could have happened, She stated she felt pressure on her own skin from the sharp edge that was consistent with where the injury was sustained by Resident #1. The Corporate Consultant stated the facility's administrative team immediately checked all of the beds in search of any other hazards. She stated 15 beds had already been ordered for the facility and were scheduled for delivery on 11/30/2023. On 11/21/2023 during the end of day debriefing, the Administrator, Director of Nursing and Corporate Consultants were informed of the findings. The jagged edge of the bed frame caused the injury. The plan of correction for past non-compliance was accepted after review of the facility's documentation and staff interviews were	F 689		

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conducted.

Protective Caps were placed on the edge of the bed frame and the bed was taken out of circulation. All beds were examined for any hazards or safety concerns. Audits of the beds were conducted weekly. The Administrator stated audits would continue. Interviews were conducted with staff members who all stated they had been educated on checking beds for safety hazards and protecting limbs from contact with bed frames. There was documentation of temporary and permanent fixes being applied to any beds that were found to have safety hazards.

Evidence showed that the nurse, LPN-B, was counseled and educated about ensuring limbs were protected during transfers.

During the 2 days of survey, residents were observed in beds. Interviews were conducted with alert residents and staff. There was no deficient practice identified regarding accidents/hazards at the time of survey or since the allegation of compliance.

No further information was provided.