STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115403	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quinton Mem Hc & Rehab Center	1115 Professional Blvd Dalton, GA 30720

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19186 Based on interviews, record review, and review of the facility policy titled Falls, the facility failed to provide the necessary supervision to prevent falls to the extent possible for one of three sampled residents (R) (R3) reviewed for falls. R3 sustained six falls at the facility from [DATE] through February 2024 when attempting to get out of bed unassisted and/or ambulating without assistance, with four of the first five falls resulting in injuries to the head. The facility documented contributing factors for the falls but failed to identify and address the need for increased supervision related to the resident's declining cognition and failed to conduct and document a root cause analysis for each fall to facilitate the ability to develop specific fall prevention interventions that would address the causative factors of the falls. Harm was identified to have occurred on [DATE], when R3 fell and was sent out to the hospital. The fall resulted in R3 sustaining a fractured ankle. The resident was hospitalized and diagnosed with a traumatic brain injury due to recurrent falls with multiple head injuries. Findings included: A facility policy titled Falls with a revised date of [DATE], revealed that the facility's management of falls focuses on resident-centered assessment to aid in the prevention of falls. The policy also specified that the care plan is used as the facility's resident-centered tool that lists the specific interventions that the IDT (interdisciplinary team) discussed and that adjustments can be made to interventions based on the effectiveness of these interventions. Interventions are based on each resident's needs. The policy indicated the facility interventions for fall risk or post-fall may include but were not limited to an IDT review and care plan review and revisions. A review of the Electronic Medical Record (EMR) revealed that R3 was admitted to the facility on [DATE] with diagnoses of mild cognitive impairment, insomnia, macular degeneration, peripheral vascular disease, age-related osteoporosis, an incomplete rotator cuff tear or rupture of an unspecified shoulder, and long-term use of anticoagulants. (continued on next page)

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.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the Significant Change Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of [DATE], revealed that R3 presented with a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment; that R3 used a walker and wheelchair for mobility in the last seven days; that R3 required substantial/maximal assistance to move from a sitting to lying position and to move from a lying position to sitting on side of the bed; that R3 required partial/moderate assistance to move from a sitting to standing position, chair/bed-to-chair transfers, and toilet transfers; that R3 required supervision or touching assistance to walk 10 feet and that walking 50 or 150 feet was not attempted due to a medical condition or safety concerns; that R3 was frequently incontinent of urine and bowel; and that R3 had fallen in the last month, had fallen in the last two to six months prior to admission/reentry, but had not experienced falls since the prior assessment/reentry. A review of a nursing Progress Note dated [DATE] revealed the nurse heard yelling from R3's room and that R3 was found lying on the floor against the air-conditioner. A review of the Fall Event report dated [DATE] revealed that R3 sustained a fall while ambulating and was found on the floor on [DATE] at 9:30 pm. The report documented that the resident stated they were reaching for the bathroom door but could not get it to open, lost their balance, and hit their head on the air conditioning unit. According to the report, the contributing factors for the fall were Distractions. The report revealed R3 sustained a small, soft-tissue injury to the top of the head and an ice pack was applied. A review of the nursing Progress Notes dated [DATE] at 10:00 am revealed R3 had blue/purple bruising to the eyes, forehead, and the back of the head from the fall on [DATE]. The note documented that, per the resident's family member, the resident was having episodes of confusion. The note revealed new physician orders were obtained for a computed tomography (CT) scan and laboratory testing. A review of the ED [Emergency Department] Note dated [DATE] revealed that R3 had fallen from the standing position on [DATE]. Per the note, the resident hit their head, had bruising to the face, and had confusion after the fall. The note revealed during the ED visit, the resident complained of visual disturbances in the left eye and decreased hearing in the left ear with a roaring sensation and pain. The note revealed, per the resident's family, the previous CT scan was normal. According to the note, R3 had purplish facial bruising surrounding both eyes, the forehead, and the posterior occipital areas (back of the head). The notes revealed the resident was diagnosed with facial contusions and was transferred back to the facility. A review of the Fall Event report dated [DATE] revealed R3 fell from bed on [DATE] at 5:05 am. According to the report, a Certified Nursing Assistant (CNA) was called to R3's room, and the resident was found on the floor beside the bed. The report revealed that R3 stated they hit their head, arm, leg, and hip. The report documented a large baseball-sized bruise on the left side of the resident's forehead and that R3 was transferred to the ED. The report revealed the contributing factor to the fall was Action by Patient/Resident. The report revealed immediate actions included the implementation of fall prevention strategies, neurological checks, a referral to the ED, and Risk for falls noted on chart/care plan. The report did not specify what fall prevention strategies were implemented after this fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the hospital ED History and Physical Report dated [DATE] at 12:33 pm revealed R3 was being seen for a post-fall evaluation after the resident fell out of bed and hit their head. The report documented the resident had a hematoma to the forehead, bruising to the upper left arm, and bruising and a skin tear to the right shin. According to the History and Physical, it was reported the resident's feet got caught underneath their blankets and the resident fell out of bed hitting their head on a side table. According to the report, R3's family member reported the resident hit their head when they fell in [DATE] and since that time, the resident had rapidly declined in function and mentation and was much more confused. The report revealed the resident had also had recent dizziness that the resident described as the room spinning. A hospital Discharge Documentation form, dated [DATE], revealed that R3's discharge diagnoses included frequent falls and a closed head injury without concussion. A Fall Event, report dated [DATE] revealed at approximately 6:50 am, the nurse heard R3 yelling for help. According to the report, the resident fell from the bed. The report revealed R3 was found lying flat on their back to the left side of the bed, barefoot. The report documneted that R3 stated, Help when asked what happened. According to the report, the resident had a 1.5-inch skin tear on the left elbow and had bruising and an indention to the left cheekbone and was transferred to the ED. According to the report, the contributing factors to the fall were, Action by Patient/Resident and Confused/Disoriented. A review of the ED After Visit Summary dated [DATE], revealed R3 was diagnosed with a closed head injury. A review of the nursing Progress Notes dated [DATE] at midnight revealed R3 was yelling, and when staff entered the room, the resident was on their knees at the door wearing no socks. The report documented that R3 stated he was going to the bathroom and was using the rollator walker when they fell . A review of the nursing Progress Notes, dated [DATE] at 11:00 am revealed staff were following up on R3 after the unwitnessed fall. According to the notes, R3 had been more confused in the last two days. The notes documented that staff instructed the resident to use the call light if needed, the bed was in the lowest position, and staff placed the call light and bedside table within the resident's reach. A review of the physician's Office Visit note dated [DATE] revealed the resident had been confused the entire weekend with increased delusions and on this date, the resident had increased speech difficulty and was unable to keep their eyes open. The note revealed the physician explained to the family that this could be the progression of underlying dementia, which was now rapidly progressing since the resident's head injury in [DATE]. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the Fall Event report dated [DATE] revealed that R3 sustained another fall on [DATE] at 12:30 am while standing. The report revealed staff found the resident on the floor at the foot of the bed with the rollator walker at the resident's feet. According to the report, contributing factors included confusion/disorientation, current diagnosis/condition, inability to understand, lost/impaired balance, and mental status/capacity. The immediate actions listed on the report indicated the care plan was reviewed/revised, equipment was removed, fall prevention strategies were implemented, neurological checks, that the resident was assessed, the resident's representative was notified, and that the risk for falls was noted on the chart/care plan. The report did not specify what revisions were made to the care plan, what equipment was removed, or what fall prevention strategies were implemented as a result of this fall. A review of the nursing Progress Notes dated [DATE] revealed the resident's family did not want to send R3 to the ED for an evaluation. A review of the Fall Event report dated [DATE] documented that on [DATE] at 7:45 pm, staff found R3 on the floor, yelling that they had broken their foot. The report revealed R3 was holding the right foot in the air and telling staff not to touch the foot. The report documented the right ankle was swollen and the resident had a dislocation/fracture to the right ankle. According to the report, the resident fell from the bed and the contributing factors included confusion/disorientation, inability to understand, inadequate/improper footwear, and lost/impaired balance. Per the report, immediate actions included a care plan review/revision, fall prevention strategies, a footwear review, neurological checks, and a resident assessment. A review of the hospital history and physical report dated [DATE] at 12:33 am revealed the resident had been having repeated falls since [DATE] (approximately five to six) and the majority resulted in head injuries. The report revealed anticoagulation medications were discontinued on Tuesday of the previous week as a precaution and hospice was initiated earlier in the week. The report documented the resident had a closed, right ankle fracture from the fall from a bed at the facility. According to the report, the fracture was reduced and splinted. In addition, the report revealed the resident had a history of traumatic brain injury due to recurrent falls with multiple head injuries since [DATE], likely secondary to dementia. A review of the Discharge Summary dated [DATE] revealed the resident was deceased and the preliminary cause of death was cardiopulmonary arrest. A review of the [state] Death Certificate, dated [DATE], revealed that R3 expired on [DATE] at 12:25 pm. The death certificate documented the immediate causes of death were cardiopulmonary arrest, acute kidney injury on chronic kidney disease, acute delirium, and an ankle fracture. During an interview on [DATE] at 5:09 pm, CNA4 stated that R3 had dementia, and got up unassisted, and tried to walk without the rollator walker. The CNA stated she checked on the resident frequently, usually every hour, and the resident's room was close to the nurses' station. CNA4 stated R3 did not sustain any falls while she was working. During an interview on [DATE] at 2:27 pm, CNA5 stated that R3's health declined and that toward the end, the resident would get up unassisted. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 2:56 pm, Licensed Practical Nurse (LPN)6 stated that R3 had a strong will and was independent before declining. LPN6 indicated that R3 would get up unassisted, and before their health declined, the resident was using a rollator. LPN6 revealed that the resident would frequently walk without the rollator walker and that after each fall, interventions were put in place to prevent falls. During an interview on [DATE] at 9:30 am, the Rehabilitation (Rehab) Director stated that falls were discussed in morning meetings. She indicated that depending on the fall, the nurse manager completed a screening for the rehab department. The Rehab Director stated that R3 was seen by the physical therapy (PT) department from [DATE] through [DATE] for muscle weakness and balance issues. The Rehab Director indicated that R3 also had cognitive decline and confusion. According to the Rehab Director, R3 initially used a rollator walker but was no longer safe to use one and began using a wheelchair. During a telephone interview on [DATE] at 11:55 am, the Director of Hospice stated that R3 started receiving hospice services 48 hours before going to the hospital. She indicated that R3 was admitted to hospice for heart failure, had poor safety awareness, and was known to get up unassisted. She stated that the family revoked hospice when the resident went to the hospital in February 2024 and the resident had surgery on the ankle. During a telephone interview on [DATE] at 4:24 pm, Medical Director (MD)3 stated that R3 frequently forgot to use the walker and fell . MD3 revealed that he did not think an ankle fracture would be the cause of the resident's death unless it was an open fracture that caused an embolism (blood clot). MD3 stated the family chose hospice care for end-stage dementia with delirium, he believed the facility implemented interventions that included moving the resident closer to the nurse's station, and the CNAs checked the resident frequently. During an interview on [DATE] at 3:35 pm, the Director of Nursing (DON) stated that she expected resident falls to be minimized/reduced with the appropriate interventions. The DON stated that she expected a root cause analysis to be completed and that interventions to address falls be added to the care plan. During an interview on [DATE] at 11:37 am, the Administrator stated falls were discussed during daily morning meetings, but there was no written/documented information regarding the root cause for falls. During a follow-up interview on [DATE] at 3:40 pm, the Administrator stated she expected staff to assess the resident after a fall, implement necessary interventions, and put them on the care plan. The Administrator indicated that she expected a root cause analysis to be documented and that interventions to address the falls be documented on the care plan. The Administrator stated that this was discussed during the IDT meetings every morning.