STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215230	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allegany Health Nursing and Rehab	730 Furnace Street Cumberland, MD 21502

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 18819 Based on reviews of the facility investigation and all pertinent administrative documents, a closed clinical record, and staff interview, it was determined that the facility failed to ensure that a resident remained free of abuse. This was true for 1 (Residents #901) of 11 facility reported incidents reviewed during an annual recertification survey. The facility implemented effective and thorough corrective measures following this incident prior to the start of this survey. The facilitie's plan and action were verified during this survey, therefore this deficiency was found to be past noncompliance with a compliance date of 09/10/20. The findings include: The facility's investigation related to the facility reported the incident MD00157948 in which GNA2 was witnessed kicking Resident #901 on the right lower leg on 09/04/2020. This incident was reviewed by the survey team on 01/21/2025 at 1 PM. In the investigation, the facility substantiated through witnesses that GNA2 kicked Resident #901 on the right lower leg and created a skin tear. Resident #901 was attempting to remove food and meal trays from the food cart located at the third-floor nurses' station. The facility suspended GNA2 immediately upon report of the incident and began the investigation that substantiated the allegation. GNA2 was terminated by the facility on 09/04/2020. A review of LPN5's witness statement revealed that staff were wheeling residents to their rooms for the dinner meal. LPN5 witnessed GNA2 speak to Resident #901 and told her/him that S/he had already eaten his/her meal and to go back to his/her room. Resident #901 moved forward towards GNA2. That is when GNA2 became verbally aggressive and stated, I told you to move you already ate. Resident #901 then told GNA2 to leave her/him alone. GNA2 was then holding Resident #901's wheelchair handles trying to move Resident #901 backwards and kicked Resident #901 and attempted to move Resident #901. Resident #901 screamed out you kicked me, get away from me now and leave me alone. Resident #901 wheeled him/herself down the hall. LPN5 indicated S/he followed Resident #901 and when S/he approached LPN5 witnessed Resident #901 crying and observed the skin tear to the right lower leg. LPN5 indicated that S/he informed the supervisor of the incident. GNA2 was asked to leave the facility and later terminated. During an interview that took place with the Director of Nurses (DON) on 01/24/25 at 4:35 PM, the DON stated that all staff received abuse education, other residents were interviewed, and that this abuse incident was reviewed during the October 2020 QAPI meeting.

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 18819 Based on an anonymous complaint, reviews of closed medical records and pertinent administrative policies and records, and staff interview, it was determined that facility administrative staff failed to implement the facility's existing abuse policy and procedures when an allegation of sexual abuse was reported by 2 staff members. This was evident for 1 (Resident #911) of 6 complaints reviewed during an annual recertification survey. The findings include: Review of anonymous complaint MD00194310 on 01/21/2025 at 1 PM, revealed an allegation that Resident #911 was observed sexually assaulting Resident #911's on or around July 12, 2023. The anonymous complaint also listed allegations that included: the facility administration requiring the licensed nurse to take back their nursing documentation about the incident and the facility did not report the allegation of resident-to-resident sexual abuse to the State Survey Agency. In an interview with the facility Director of Social Work on 01/21/25 at 3:55 PM, the Director of Social Work was asked if there ever was an allegation of sexual abuse regarding Resident #913. The Director of Social Work stated yes. The Director of Social Work then stated that a GNA reported an allegation of sexual abuse regarding Resident's #913 and #911. The Director of Social Work reported that the GNA #1 stated that she/he observed Resident #913 with his hands inside Resident #911's brief touching Resident #911's genitals. The Social Work Director stated that she/he had not heard of this occurring in the past. The Director of Social Work stated she/he informed the facility Administrator and the Director of Nurses right away on the day the allegation was reported to him/her. The Director of Social Work stated that he/she and the other facility Social Worker initiated an investigation into the allegation of sexual abuse but could not recall the exact day of the allegation. In an interview with the facility Administrator on 01/21/25 at 4:35 PM, the nurse surveyor requested the facility investigative documents into the staff witnessed allegation of sexual abuse that allegedly occurred between Residents #911 and #913 on or around July 12, 2023. In an interview with the facility Administrator, DON, Director of Social Work, and the Corporate Nurse on 01/22/2025 at 10:45 AM, the facility Administrator stated a staff nurse documented in Resident #913's medical record an incident between Residents #913 and #911 which occurred on 06/30/23. The time of the note was 3:43 PM. The medical record indicated that the 06/30/23, 3:43 PM nursing progress note was changed to read Invalid. The facility Administrator stated that only the staff nurse that wrote the progress note can change the progress note to read as Invalid. The facility Administrator stated that there were no administrative documents or investigative records regarding the alleged resident sexual abuse between Resident's #911 and #913 from 06/30/23. The facility Administrator also stated that there were no staff or other resident witness statements. The local police and the State Survey Agency were not notified either. The facility Administrator and DON stated that the staff were aware that Resident #913's had a history of intrusive behaviors while residing in the facility. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LPN #3 on 01/22/25 at 2:52 PM, LPN #3 stated that S/he was the nurse who reported the allegation of resident-to-resident sexual abuse to the nursing supervisor (RN #4) on 06/30/23. LPN #3 stated that S/he documented the incident in Resident #913's, the alleged perpetrator's medical record. LPN #3 stated that S/he was not aware of how the 06/30/23, 3:43 PM progress note was labeled Invalid. LPN #3 stated that on 06/30/23 S/he was informed by GNA #1 that S/he witnessed sexual abuse between Residents #911 and #913 on 06/30/23. LPN #3 stated that GNA #1 was a new GNA and was observed in a frantic state and could hardly inform her/him of the S/he witnessed. LPN #3 stated that after being informed by GNA #1, LPN #3 went immediately to Resident #911's room and separated Resident #911 and #913. LPN #3 also stated that S/he was not asked to formally write a witness statement or was interviewed by any administrative staff regarding the 06/30/23 alleged resident to resident sexual abuse. A review of the facility abuse, neglect, exploitation, or mistreatment policy on 01/22/25 revealed that: 1) the facility's leadership ensures that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, 2) the facility's leadership shall report immediately, but not later than 2 hours, after the allegation received of suspected abuse to the State Survey Agency, 3) the facility's leadership will conduct a prompt investigation of any allegation received of suspected abuse and will implement immediate action to safeguard resident, and 4) the facility's leadership will provide notification to the proper authorities.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 18819 Based on an anonymous complaint, reviews of closed medical records and pertinent administrative policies and records, and staff interview, it was determined that facility administrative staff failed to report an allegation of resident to resident sexual abuse to the State Survey Agency. This was evident for 1 (Resident #911) of 6 complaints reviewed during an annual recertification survey. The findings include: Review of anonymous complaint MD00194310 on 01/21/2025 at 1 PM, revealed an allegation that Resident #913 was observed sexually assaulting Resident #911's on or around July 12, 2023. The anonymous complaint also listed allegations that included: the facility administration requiring the licensed nurse to take back their nursing documentation about the incident and the facility did not report the allegation of resident-to-resident sexual abuse to the State Survey Agency. In an interview with the facility Director of Social Work on 01/21/25 at 3:55 PM, the Director of Social Work was asked if there ever was an allegation of sexual abuse regarding Resident #913. The Director of Social Work stated yes. The Director of Social Work then stated that a GNA reported an allegation of sexual abuse regarding Resident's #913 and #911. The Director of Social Work reported that the GNA #1 stated that she/he observed Resident #913 with his/her hands inside Resident #911's brief touching Resident #911's genitals. The Social Work Director stated that she/he had not heard of this occurring in the past. The Director of Social Work stated she/he informed the facility Administrator and the Director of Nurses right away on the day the allegation was reported to him/her. The Director of Social Work stated that he/she and the other facility Social Worker initiated an investigation into the allegation of sexual abuse but could not recall the exact day of the allegation. In an interview with the facility Administrator on 01/21/25 at 4:35 PM, the nurse surveyor requested the facility investigative documents into the staff witnessed allegation of sexual abuse that allegedly occurred between Residents #911 and #913 on or around July 12, 2023. In an interview with the facility Administrator, DON, Director of Social Work, and the Corporate Nurse on 01/22/2025 at10:45 AM, the facility Administrator stated a staff nurse documented in Resident #913's medical record an incident between Residents #913 and #911 which occurred on 06/30/23. The time of the note was 3:43 PM. The nursing progress noted the 06/30/23 was Invalid. The facility Administrator stated that the nurse that wrote the progress note can indicate that the progress note is Invalid. The facility Administrator stated that there were no administrative documents or investigative records regarding the alleged resident to resident sexual abuse from 06/30/23. There were no staff or resident witness statements. The local police and the State Survey Agency were not notified either. The facility Administrator and DON stated that the staff were aware of Resident #913's intrusive behaviors through the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LPN #3 on 01/22/25 at 2:52 PM, LPN #3 stated that s/he was the nurse who reported the allegation of resident-to-resident sexual abuse to the facility administrative staff on 06/30/23. LPN #3 stated that s/he documented the incident in Resident #913's, alleged perpetrator's, medical record. LPN #3 stated that s/he was not aware of how the 06/30/23, 3:43 PM progress note was labeled Invalid. LPN #3 stated s/he was informed by GNA #1 of the alleged sexual abuse between Residents #911 and #913 on 06/30/23. LPN #3 stated that GNA #1 was a new GNA and was observed in a frantic state and could hardly inform her/him of the witnessed incident. LPN #3 stated that after being informed by GNA #1, LPN #3 went immediately to Resident #911's room and separated Resident #911 and #913. LPN #3 also stated that s/he was not asked to formally write a witness statement or was interviewed by any administrative staff regarding the 06/30/23 alleged resident to resident sexual abuse. A review of the facility abuse, neglect, exploitation, or mistreatment policy on 01/22/25 revealed that: 1) the facility's leadership ensures that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, 2) the facility's leadership shall report immediately, but not later than 2 hours, after the allegation received of suspected abuse to the State Survey Agency, 3) the facility's leadership will conduct a prompt investigation of any allegation received of suspected abuse and will implement immediate action to safeguard resident, and 4) the facility's leadership will provide notification to the proper authorities.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 18819 Based on an anonymous complaint, reviews of closed medical records and pertinent administrative policies and records, and staff interview, it was determined that facility administrative staff failed to investigate an allegation of resident to resident sexual abuse when it was reported by staff members. This was evident for 1 (Resident #911) of 6 complaints reviewed during an annual recertification survey. The findings include: Review of anonymous complaint MD00194310 on 01/21/2025 at 1 PM, revealed an allegation that Resident #913 was observed sexually assaulting Resident #911's on or around July 12, 2023. The anonymous complaint also listed allegations that included: the facility administration requiring the licensed nurse to take back their nursing documentation about the incident and the facility did not report the allegation of resident-to-resident sexual abuse to the State Survey Agency. In an interview with the facility Director of Social Work on 01/21/25 at 3:55 PM, the Director of Social Work was asked if there ever was an allegation of sexual abuse regarding Resident #913. The Director of Social Work stated yes. The Director of Social Work then stated that a GNA reported an allegation of sexual abuse regarding Resident's #913 and #911. The Director of Social Work reported that the GNA #1 stated that she/he observed Resident #913 with his/her hands inside Resident #911's brief touching Resident #911's Genitals. The Social Work Director stated that she/he had not heard of this occurring in the past. The Director of Social Work stated she/he informed the facility Administrator and the Director of Nurses right away on the day the allegation was reported to him/her. The Director of Social Work stated that he/she and the other facility Social Worker initiated an investigation into the allegation of sexual abuse but could not recall the exact day of the allegation. In an interview with the facility Administrator on 01/21/25 at 4:35 PM, the nurse surveyor requested the facility investigative documents into the staff witnessed allegation of sexual abuse that allegedly occurred between Residents #911 and #913 on or around July 12, 2023. In an interview with the facility Administrator, DON, Director of Social Work, and the Corporate Nurse on 01/22/2025 at10:45 AM, the facility Administrator stated a staff nurse documented in Resident #913's medical record an incident between Residents #913 and #911 which occurred on 06/30/23. The time of the note was 3:43 PM. The nursing progress noted the 06/30/23 was Invalid. The facility Administrator stated that the nurse that wrote the progress note can indicate that the progress note is Invalid. The facility Administrator stated that there are no administrative documents or investigative records regarding the alleged resident to resident sexual abuse from 06/30/23. There were no staff or resident witness statements. The local police and the State Survey Agency were not notified either. The facility Administrator and DON stated that the staff were aware of Resident #913's intrusive behaviors through the facility. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LPN #3 on 01/22/25 at 2:52 PM, LPN #3 stated that s/he was the nurse who reported the allegation of resident-to-resident sexual abuse to the facility administrative staff on 06/30/23. LPN #3 stated that s/he documented the incident in Resident #913's, alleged perpetrator's, medical record. LPN #3 stated that s/he is not aware of how the 06/30/23, 3:43 PM progress note was labeled Invalid. LPN #3 stated s/he was informed by GNA #1 of the alleged sexual abuse between Residents #911 and #913 on 06/30/23. LPN #3 stated that GNA #1 was a new GNA and was observed in a frantic state and could hardly inform her/him of the witnessed incident. LPN #3 stated that after being informed by GNA #1, LPN #3 went immediately to Resident #911's room and separated Resident #911 and #913. LPN #3 also stated that s/he was not asked to formally write a witness statement or was interviewed by any administrative staff regarding the 06/30/23 alleged resident to resident sexual abuse. A review of the facility abuse, neglect, exploitation, or mistreatment policy on 01/22/25 revealed that: 1) the facility's leadership ensures that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, 2) the facility's leadership shall report immediately, but not later than 2 hours, after the allegation received of suspected abuse to the State Survey Agency, 3) the facility's leadership will conduct a prompt investigation of any allegation received of suspected abuse and will implement immediate action to safeguard resident, and 4) the facility's leadership will provide notification to the proper authorities.

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F 0678 Level of Harm - Actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18819 Based on reviews of a facility-reported incident, a closed medical record and all pertinent information and staff interview, it was determined that the facility staff failed to identify a newly admitted Resident who was admitted without clear physician's order for end-of-life care and failed to follow the facility policy to initiate Cardiopulmonary Resuscitation (CPR). This was evident for 1 (Resident #902) of 11 facility-reported incidents reviewed during an annual recertification survey. The facility implemented effective and thorough corrective measures following this incident and prior to the start of this survey. The facilities plan and action were verified during this survey, therefore this deficiency was found to be past noncompliance with a compliance date of [DATE]. The findings include: Review of facility-reported incident (FRI) MD00174662 on [DATE] revealed allegations that Resident #902 was admitted to the facility from the community on [DATE] at 1:15 PM. Resident #902 was being evaluated in the emergency room earlier in the day. On [DATE], Resident #902 was assessed by his/her physician and deemed incapable of understanding any information and that a third party should make the decisions for Resident #902. Reviews of the facility investigation and Resident #902's closed medical record revealed that on [DATE] at 1:30 AM, Resident #902 was observed lying on a floor mat by the bed with nonskid socks on. Resident #902 was assessed by the nursing staff with no evidence of injury and placed back in bed. At 3:40 AM on [DATE], a GNA staff member alerted LPN #4 that Resident #902 had changes in his/her breathing pattern. LPN #4 assessed Resident #902 and notified RN #5 that Resident #902's eyes were observed rolled back into his/her head and Resident #902 was not breathing. LPN #4 alerted 911/EMS and applied oxygen by non-rebreather mask to Resident #902. No other life-sustaining procedures were started at this time. In an interview with LPN #4 on [DATE] at 11:30 AM, LPN4 stated that s/he was alerted by a staff member that Resident #902 was not breathing well and also had trouble finding a pulse. LPN #4 stated that s/he notified 911/EMS and the RN supervisor (RN #5). LPN #4 stated that s/he asked RN #5 what to do. LPN #4 stated that s/he and RN #5 both looked at Resident #902's medical record and could not find a completed MOLST form. LPN #4 stated s/he then asked RN #5 what should they do and RN #5 stated to wait for 911/EMS to arrive. LPN #4 then stated that s/he stayed with Resident #902 until 911/EMS arrived. LPN #4 stated that CPR was not performed on Resident #902 and that 911/EMS pronounced Resident #902 at that time. LPN #4 stated that s/he has had education in the past regarding CPR/MOLST forms and what staff should do if a resident does not have a completed MOLST form and codes. LPN #4 stated that if s/he identified a resident now without any vital signs and without a completed MOLST form, that s/he would start CPR immediately. (continued on next page)

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F 0678 Level of Harm - Actual harm Residents Affected - Few	In an interview with the former Social Work Director on [DATE] at 9:05 AM, the former Social Work Director stated that S/he first visits a newly admitted resident to complete a social history. Also, during the first interview the former Social Work Director stated that S/he speaks to the residents and or the family members about advance directives and reviews the MOLST form. The former Social Work Director stated that if a resident is admitted to the facility without a complete Maryland Order for Life Sustaining Treatment (MOLST) form the resident would be considered a full code in an emergency. The Maryland MOLST form is a portable and enduring medical order form covering options for cardiopulmonary resuscitation and other life-sustaining treatments. The nurse surveyor reviewed the former Social Work Directors' [DATE] 6 PM progress note with him/her. The former Social Work Director was asked why there was nothing documented about a set of advanced directives or a MOLST status in the [DATE] 6 PM progress note. The former Social Work Director stated that s/he could not recall why there was nothing in the [DATE] 6 pm progress note about advance directives or the resident's code status or MOLST form. A review of the facility's Social Services Policies and Procedures on [DATE] revealed a statement that indicated: In the absence of appropriate DNR identification or orders, the Facility Staff will respond to medical emergencies with CPR measures and a full code will be instituted. On [DATE], a total of 18 residents closed and active medical records were audited by the nurse surveyor. In these audits, a completed MOLST form was located. All of the MOLST forms clearly indicated whether or not CPR should be performed if the resident was found in an emergency situation. The Director of Nursing (DON) was interviewed on [DATE]. During the interview, the DON demonstrated and provided Quality Assurance (QA) material that s/he maintained in which the entire nursing staff were educated on [DATE] on ensuring the resident had a completed MOLST form, what to do if the resident is not admitted with a completed MOLST form, and what to do if a resident codes in the facility and does not have a completed MOLST form or physician order for CPR. Also, the facility medical director had given Resident #902's primary care physician education on the timeliness of completing a resident's end of life wishes on the MOLST form and if a resident is admitted without a completed MOLST form the resident will be a full code. An Ad Hoc Quality Assurance Performance Improvement meeting was held on [DATE] regarding the contents of the plan. Data was to be reviewed monthly in QAPI for 3 months. Based on the above actions taken by the facility and verified by the nurse surveyor on site, it was determined that the facility's deficient practice was past noncompliance with a compliance date of [DATE].

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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** 18819 Based on reviews of a facility-reported incident, a closed medical record and all pertinent information, and staff interviews, it was determined the facility staff failed to provide adequate supervision and follow the resident's plan of care to: 1) prevent a fractured humerus during a transfer, and 2) to prevent a cognitively and functionally impaired resident from sliding out of bed onto the floor and receiving bilateral fractured hips. This was evident for 2 (Residents #909, #906) out of 11 facility-reported incidents resulting in harm to both residents reviewed during the survey. The facility implemented effective and thorough corrective measures following this incident and prior to the start of this survey. The facilities plan and action were verified during this survey, therefore this deficiency was found to be past noncompliance with a compliance date of 07/11/23. The findings include: 1) A review of the facility-reported incident MD00178281 was reviewed on 01/23/2025 at 1 PM. The facility's investigation revealed that on 05/14/22 at 9:30 PM Resident #906 had fallen out of bed during care and that subsequent assessments and X-rays determined that Resident #906 had suffered bilateral femoral neck fractures. Resident #906 had been admitted to the facility on [DATE] with cognitive impairment and was totally dependent upon the staff for all aspects of his/her care needs. The facility investigation indicated that on 05/14/22 GNA #5 entered Resident #906's room to provide incontinence care. The investigation indicated that GNA #5 informed staff that S/he turned Resident #906 onto his/her left side, away from him/her, and then Resident #906 rolled out of bed. GNA #5 then informed the nurse. A review of Resident #906's activities of daily living care plan on 01/23/25 revealed nursing interventions dated 06/11/21 that instructed staff members to use two staff members when performing for bed mobility (turning and repositioning) for Resident #906. In an interview with GNA #5 on 01/24/25 at 5:15 PM, GNA #5 stated that prior to the start of Resident #906's bed bath on 07/09/24, GNA #5 stated S/he obtained all the equipment and clean linen supplies to provide Resident #906's bed bath. GNA #5 stated that S/he then raised Resident #906's bed up to his/her hip level. During the bed bath, GNA #5 stated that S/he turned Resident #906 away from him/her, onto Resident 906's left side, which placed Resident #906 closer to the edge of the bed away from him/her. GNA #5 stated that this was when S/he realized that S/he needed more incontinent wipes. GNA #5 stated that S/he then turned away from Resident #906 lying in bed to ask another staff member if they could bring him/her more incontinent wipes. GNA #5 stated that this is when Resident #906 jerked up and rolled out of bed onto the floor. After the Resident #906's fall, GNA #5 stated that other staff members had informed him/her that Resident #906 was a one-staff member assist for baths. GNA #5 stated that S/he had reviewed Resident #906's plan of care that day but could not say why S/he performed the bed bath by himself/herself. The facility administrator and director of nurses were made aware of the findings at the exit conference on 01/24/25 at 6 PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215230	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allegany Health Nursing and Rehab	730 Furnace Street Cumberland, MD 21502

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F 0689 Level of Harm - Actual harm Residents Affected - Few	2) The facility's investigation of the reported incident MD00194149 was reviewed on 01/23/2025 at 10:00 AM. The facility's investigation revealed that on 07/09/23 Resident #909 was being transferred by 2 GNA's to a shower chair during the evening shift when they heard a pop and called the floor nurses for assistance. Resident #909 was sent to the local emergency room via 911 for evaluation. The 2 GNA's were suspended pending the investigation. Resident #909 was scheduled for a shower on 07/09/23. Resident #909 was admitted to the facility on [DATE] with a history of a fractured hip, dementia, and metabolic encephalopathy. Resident #909 is alert to person only and has a BIM's score of 7. Resident #909 was scheduled for a shower on 07/09/23. A review of the facility investigation revealed that GNA #3 requested assistance from GNA #4 to transfer Resident #909 from the bed to the shower chair. GNA #3 and GNA #4 stated that they each got under one arm of Resident #909 and were transferring him/her to the shower chair when they heard a popping sound. GNA #3 and GNA #4 then lowered #909 to the floor. While GNA #3 stayed with Resident #909, GNA #4 alerted the nurse to the incident. Upon assessment by the nurse, Resident #909 was noted to have an abnormal range of motion in the left arm. Resident #909's physician and family were notified of the incident and orders to transfer Resident #909 to the emergency room for eval and treat. The hospital obtained an X-ray of Resident #909's left arm which revealed a fracture of the left humerus with osteopenia/osteoporosis. Resident #909 was sent back to the facility with an order for a splint to the left arm until seen by an Orthopedic physician for a possible cast. The Medical Director and Resident #909's family were made aware of plan of care and both were in agreement. The facility investigation determined that Resident #909 obtained a fracture to his/her left humerus as a result of GNA #3 and GNA #4 failure to follow the plan of care for Resident #909. Both GNA #3 and GNA #4 received counseling and were educated on checking a resident's profile for safe transfer status and plan of care. The facility staff were educated to review a residents' profile for safe transfer status and plan of care. All resident care plans were reviewed and updated. A review of Resident #909's admission fall and injury prevention care plan dated 07/20/21 revealed a nursing intervention that indicated to transfer Resident #909 by the use of lifting device as ordered. In a telephone interview with GNA #3 on 01/24/25 at 3:43 PM, GNA #3 stated that S/he recalled the incident with Resident #909. GNA #3 stated that Resident #909 was to receive a shower that day had asked GNA #4 for assistance transferring Resident #909 from the bed to the shower chair. GNA #3 stated S/he thought Resident #909 was a 2-person assist for transfers. GNA #3 stated that during the transfer both S/he and GNA #4 grabbed Resident #909 under each arm. GNA #3 stated S/he was on the left side of Resident #909 during the transfer. GNA #3 stated that we heard a snap and immediately stopped the transfer and lowered Resident #909 to the ground. When asked, GNA #3 stated that S/he had transferred Resident #909 under his/her arms frequently in the past. GNA #3 stated that S/he had not reviewed Resident #909's plan of care for transfers. GNA #3 stated that after the incident S/he then learned that Resident #909 was to be a Hoyer transferred. GNA #3 stated that S/he was not aware that Resident #909's care plan had been changed regarding transfer status to a Hoyer lift. GNA #3 stated that S/he received education after the incident to check a resident's transfer status prior to the transfer. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview with GNA #4 on 01/24/25 at 3:52 PM, GNA #4 stated that S/he recalled the incident and that GNA #3 had asked for assistance to get Resident #909 out of bed. GNA #4 stated that S/he was not assigned to Resident #909 on 07/09/23. GNA #4 stated that S/he did not review Resident #909's care plan regarding transfer status prior to assisting GNA #3. GNA #3 stated that S/he was standing on Resident #909's right side before the transfer. GNA #4 stated both S/he and GNA #3 grabbed Resident #909 under the arms and lifted the resident up from the bed and this was when they heard Resident #909's arm snap. GNA #4 then stated to GNA #3 they needed to lower Resident #909 down. GNA #4 stated that S/he went and got the nurse. GNA #4 stated that S/he and GNA #3 were suspended after the incident. GNA #4 stated that S/he received education on how to determine a resident's transfer status. The Director of Nursing (DON) was interviewed on 01/24/25. During the interview, the DON demonstrated and provided Quality Assurance (QA) material that s/he maintained in which the entire nursing staff were educated on 07/11/23 on how to access a resident's care plan and correctly identify the number of staff needed to provide care to each resident. The QA plan was to be reviewed monthly in QAPI for 3 months. Based on the above actions taken by the facility and verified by the nurse surveyor on site, it was determined that the facility's deficient practice was past noncompliance with a compliance date of 07/11/23.