STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345475	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tsali Care Center	55 Echota Church Road Cherokee, NC 28719

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** 39734 Based on record review and staff interview the facility failed to complete a thorough fall investigation to identify root cause(s) and appropriate interventions to prevent future falls for one (1) of three (3) residents (Resident #3). This failure resulted in the resident sustaining a right femoral neck fracture, a type 4 fracture of the sacrum and a rib fracture. The findings include: Resident #3 was admitted on [DATE] and most recently readmitted [DATE] with diagnoses including: unspecified fracture of right femur, dysphasia, type 4 fracture of sacrum, muscle weakness, unspecified dementia and anxiety disorder. Review of the progress notes dated 6/20/24 revealed 2041 (8:41 PM) Resident yelling for help, found res (resident) lying on her left side next [sic] with her walker lying sideways next to the closed door. Res reported 'I fell '. Res c/o (complained) pain to her left arm. BLE (bilateral lower extremities) in proper alignment, able to bear weight BLE denies hitting her head. Res did not have her shoes on when found and the left tennis ball was off her walker when found. Assisted res with her shoes reminded to make sure she has her shoes before walking . On 7/19/24 at 12:00 PM the Nurse Consultant confirmed the facility could not locate the Fall Questionnaire, which was a form the Nurse was to fill out when a fall incident occurred. The Nurse Consultant (NC) stated that the falls questionnaire was what started the incident review and investigation process. On 7/19/24 at 1:14 PM the NC stated that the cause of the fall documented by Nurse #2 was that the resident did not put on her shoes. The NC said that since Nurse #2 made this determination, no further review or investigation was necessary. However, this was not a thorough investigation and determination of cause since the tennis ball slider device that came off the left leg of Resident #3's walker, during the 6/20/24 fall, was not addressed in a root cause review to identify additional interventions to prevent future falls. (continued on next page)

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	Review of the progress notes dated 7/10/24 revealed, 1915 (7:15 PM) CNA (Certified Nursing Assistant) who was sitting at the nurses' station while charting witnessed res. walking up in A hall and fell on her right side and hit her head against the wall. The tennis ball on the bottom of her walker came off causing her to fall. Res c/o right rib cage pain and right leg pain (femur). No external rotation nor shortening observed to RLE (right lower extremity). Redness noted to parietal-occipital area of head, but no hematoma noted post fall. Assisted res up x3 person assist, able to bear weight BLE and took a few steps. Assisted in w/c (wheelchair) then to bed. Skin assessment done. 2 skin tears to RFA (right forearm) with bruising. Area cleansed with NS, xeroform applied and covered with Allevyn dressing. Neurological check initiated. Old walker removed to prevent further fall. Review of the progress notes dated 7/11/24 revealed Resident #3 had been sent to the emergency room and was found to have fractured ribs and a right femoral neck fracture. Review of the Fall Questionnaire dated 7/10/24 revealed the time of the resident's fall was 7:15 PM. Tennis ball came off of walker was written as the Environmental Observation. The resident was wearing her shoes at the time of her fall. Dysfunctional walker removed was written as the Immediate Action. The resident's range of motion was documented as decreased to her right lower extremity and the resident was sent to the emergency room after 2 hours. The incident report for the 7/11/24 fall was reviewed with the Nurse Consultant and Administrator present. The report was not printed by the facility, but sections as requested could be viewed on the computer screen. The information revealed that Certified Nursing Assistant (CNA) #1 witnessed the fall and saw the resident hit her head on the right side near the utility door. No additional information regarding the fall, beyond what was in the Progress Notes, was noted. The Administrator stated that the facility had other tennis ball slider devices for the walkers previously, but they had all been changed out and a new purchase order was just placed for a new tennis ball slider device (brand name Therafin) and another style that was like ski glides. She indicated that the Therapy Manager had been checking the tennis ball slider devices on all the walkers that had them, but confirmed there was no documentation regarding this. During an interview with the Therapy Manager and Physical Therapy Assistant (PTA) on 7/18/24 at 11:45 AM, the PTA stated that there had been one (1) previous incident quite a while ago when the tennis ball device came off Resident #3's walker but the previous Administrator had changed over to the current brand (Therafin) and Resident #3's tennis ball slider device was changed out at that time. This was the same brand she had at the time of her 6/20/24 and 7/10/24 falls. Upon observation this device had a plastic piece that the leg of the walker fit into and a plastic claw that held a tennis ball in place. The Therapy Manager stated she checked the tennis ball slider devices on the walkers periodically for wear and tear and changed them out as needed but confirmed she did not keep any documentation regarding this. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview with Nurse #2 on 7/18/24 at 6:15 PM, she stated she had been passing medications when Resident #3 fell on [DATE]. The resident was complaining of rib pain and the tennis ball and attachment had come off her walker. The whole thing came off; I just didn't know what to call it. She added that CNA #2 witnessed the fall. Nurse #2 confirmed she was also the nurse on shift when Resident #3 fell on [DATE]. She confirmed the tennis ball and plastic attachment came of the resident's walker at that time as well and Nurse #2 said she put the same one back on the walker for the resident. Nurse #2 also confirmed the tennis ball and attachment came off the left side both times. She did not know why the facility could not locate the Fall Questionnaire from 6/20/24, she thought she would have completed the form but added that it was easy to forget. She said the Fall Questionnaires were supposed to be reviewed in the morning meetings the next day and any additional interventions that were needed were to be added at that time. During a telephone interview with CNA #2 on 7/18/24 at 6:50 PM she stated when Resident #3 fell on [DATE] she heard metal clinking and the resident hollered out, then she saw the resident fall and the tennis ball and attachment that came off her walker. She stated the fuzz wasn't worn away on the tennis ball but it looked like there was a problem with the plastic piece that screwed into the walker (the plastic connector on the tennis ball slider devices did not screw into the walkers they were held in place by friction). Review of the 10/1/19 facility policy titled Fall Risk Reduction and Management revealed, Fall management includes the review of fall risk indicators, evaluation of interventions, and care of the resident following a fall, including investigation of possible causes and modifications of interventions. Immediately after a fall an investigation is initiated to attempt to define possible causes for the fall Causes refer to factors that are associated with or that directly result in a fall A root cause analysis should be initiated to determine if intrinsic, environmental, or operational factors or a combination of factors contributed to the fall . Often, multiple factors contribute to a falling problem.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39734 Based on observation, record review, resident, family and staff interview and review of the Facility Assessment, the facility failed to have sufficient nurse staffing to meet activities of daily living needs and preferences of residents for five (5) of seven (7) sample residents (Resident #'s 1, 2, 3, 4, and 5) and failed to meet the facility's planned Certified Nursing Assistant (CNA) staffing ratio of 1:13 on the night shift (7:00 PM - 7:00 AM) on seven (7) of 56 nights. In addition, on the A and D halls the ratio was consistently over 1:13. The facility also failed to meet the planned number of Nurses on night shift for 16 of 56 nights during the period 5/18/24 - 7/20/24. The findings include: During an interview with Resident #2 on 7/16/24 at 7:25 PM, she stated that she liked to receive showers on night shift around 3:00 or 4:00 AM (as care planned) but on Sunday (7/14/24) she was unable get her shower because the CNA (Certified Nursing Assistant) was too busy. She stated that there were not enough staff and she felt that wasn't fair to the residents or the workers. She said the staffing on night shift was a bigger problem and added that 1 CNA per hall and 2 Nurses for 3 halls wasn't enough Resident #2 said staff only came in the room if she rang her call bell because they were too busy, and it made her feel like they didn't care about her. Resident #2 said that she was independent with getting up to the bathroom but needed help with the pull up briefs she wore. Sometimes when she rang the call bell she had to wait 30 minutes for this help. She added that sometimes the CNA wasn't even on her hall because the CNA had to go to the hall on the other side of the nurses' station to help with a resident who needed the assistance of 2 staff. During an observation on 7/16/24 at 7:30 PM Resident #1's call light was on. The resident's room was on A hall. One (1) CNA was assigned to A Hall for the 7:00 PM to 7 AM shift (CNA #1). She was in another resident's room at this time. Continuous observation revealed Nurse #1 went in Resident #1's room at 7:50 PM and told him the CNA was in another room with another resident and said, We'll be back. She then turned off the call light and left the room. At 8:00 PM Nurse #1 and CNA #1 went in Resident #1's room, a second call light was also on when they entered Resident #1's. CNA #1 then assisted Resident #1 to the toilet and Nurse #1 exited. An interview on 7/16/24 at 8:05 PM with Resident #1's family member (FM #1), who had been in the room during this observation, revealed Resident #1 had pressed the call bell for assistance to use the toilet as he needed to void and then waited for 30 minutes to get help with toileting. The call light for another resident's room remained on while CNA #1 assisted Resident #1. The ratio of CNA staff to residents was 1:23 on both A and B hall at this time; there was one (1) CNA assigned to each hall for the 7:00 PM - 7:00 AM shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a confidential interview with Staff #1, she stated that one CNA per hall on night shift (7:00 PM - 7:AM) was not enough and that while she worked hard to try and meet resident care needs there were things that didn't get done as well as they should with only one CNA per hall. She said that on her hall there were 4-5 residents that needed to be assisted to bed, 10 that needed incontinent care rounds every 2 hours (q2h), 4 that needed turning and repositioning up to q2h and 4-5 that required 2-person assistance. She stated that with only one CNA residents were not checked and changed as frequently as they should be. She also confirmed that there was one resident (Resident #2) who liked to be showered on night shift but on 7/14/24 that resident only received a bed bath during the night shift because the staff were too busy to give her a shower. Review of the Staffing Sheet for 7:00 PM - 7:00 AM on 7/14/24 revealed there had been one (1) CNA assigned to Resident #2s Hall that night and one (1) assigned to each of the other two (2) Halls, as well as a float CNA for a total of four (4) CNA staff. During a confidential interview with Staff #2, she stated that Resident #9 did not get her shower on day shift that day as scheduled. During a confidential interview with Staff #3, she confirmed she had worked the 7:00 AM - 7:00 PM shift but had stayed late to give Resident #9 a shower because the resident wasn't happy about not receiving her scheduled shower that day. Staff #3 said another staff member had been assigned to give Resident #9 a shower, but that staff member did not have time to complete the resident's shower before leaving at 3:00 PM, as scheduled. Staff #3 had not been asked or scheduled to stay late or to help the night shift; she said she chose to stay because otherwise the resident would not have received a shower. She had some other work to complete from day shift as well including charting and some cleaning tasks. During a confidential interview with Staff #4, she stated, There are times there are not enough people because they can't find anyone for callouts. During an interview on 7/17/24 at 12:25 PM with a family member of Resident #5 (FM #2), she said the facility had a problem with staffing. As an example, she revealed that the staff were aware Resident #5 liked to be up in her wheelchair to have lunch with Resident #6 in the dinning room. However, a couple of weeks ago on a Saturday, when FM #2 came in at 1:30 PM, Resident #5 was still in bed. Resident #5's brief had been changed but she wasn't dressed, and her hair hadn't been brushed. FM #2 stated that Resident #5 was so upset she was shaking which happened when she was upset about something. FM #2 added that the Nurse apologized and indicated the staff had been unable to get Resident #5 up sooner because they were short staffed and too busy. During an interview on 7/18/24 at 3:17 PM with Resident #5 and Resident #6 present, Resident #5 communicated the following concerns: On 7/17/24 and again on 7/18/24 she wasn't gotten up until late in the afternoon (3:30 PM) and on 7/18/24 she missed the 2:30 PM bingo which she liked to go to because she wasn't assisted to get up until after 3:00 PM. Upon inquiry she confirmed the staff working with her on these two days were aware she wanted to be up for lunch/bingo. Resident #5 indicated that she did get her scheduled showers but the issue with her showers was that the staff rushed too much. She said that often it took two staff to complete her shower and they would rush and not do a thorough job: for example, not rinsing the conditioner out of her hair completely. Resident #5 communicated that she felt insufficient staffing was the reason she was gotten up late and had inadequate showers. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a confidential interview with Staff #5, she confirmed she was aware Resident #5 usually liked to get up before lunch and to attend bingo. She also said Resident #5 was usually gotten up at 11:00 AM but Resident #5 couldn't get up before lunch on 7/17/24 because the residents needing wound care had to be up first. Staff #5 also confirmed that Resident #5 was gotten up after 2:30 on 7/18/24 and needed two-person assistance for care and showers. Upon inquiry she stated that staffing had become a problem more recently and because of short staffing some residents had not gotten their showers. During a confidential interview with Staff #7, she confirmed Resident #5 had expressed concerns about not getting an adequate shower. Staff #7 explained that It takes about an hour to take the time to do it how she wants and often staff rush and she's not getting showers according to her expectations as a young woman. During a confidential interview with Staff #6, she stated that when there were only two (2) nurses it was challenging to carry out charge nurse and hall nurse responsibilities and when things were busy it was easy to forget to do something like fill out the required form when a resident had a fall. During an interview on 7/17/24 at 3:56 PM with the Social Worker, she stated she had been working at the facility since approximately the second week in March. Since then, she received one complaint about care not being provided related to staffing. This was from Resident #4. He reported to her that he didn't get his shower but didn't tell her about it until the day after. She said she didn't investigate further because when she talked to him about it the next day, he said he didn't want to file a grievance. During an interview on 7/18/24 at 2:25 PM with Resident #4, he stated there were not enough CNAs. He was also worried the CNAs they still had would choose to leave because of having to work short staffed or they would be fired for speaking up about it. He said that about 3 or 4 weeks ago he didn't get his shower before having to leave for an appointment in the morning and he was told he couldn't be showered because they were short staffed. Resident #4 confirmed he reported this complaint to the Social Worker. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a confidential interview Staff #7 confirmed Resident #4 was told recently that he couldn't have his shower before leaving the facility for an appointment due to staffing. She stated that the facility had faced challenges with multiple changes in administration over the past 5 years and each time there was an administrator change there was a change in the expectations. Staff # 7 said, with the previous Administrator the expectation was for staff to meet all resident needs, so staffing was increased bringing the staffing ratio above the National average, but the residents were getting quality care. She added that the current administration group was brought in to make the facility more cost effective and one of the first things they did was get rid of the agency staff quickly (except 1 agency staff on nights and 1 on days). The staff we have left are not able to fill in to cover a sufficient staffing level. The staff that are still here really care about these residents and work so hard to make sure residents are getting care but it's concerning because it's not possible to give the residents the attention they really need and so we feel guilty about not being able to give the best care we can. Some really good staff have left because of this and I'm worried were going to lose more. It's not safe to have just one (1) CNA on each unit at night (7:00 PM - 7:00 AM). There's only one staff back there on the memory care unit. Staff #7 stated that in the past the facility had been cited for inadequate supervision on the memory care unit and staffing had been increased but this plan of correction was no longer in place. In addition, she said that full staffing on night shift was 3 nurses, but they often only had two more recently. With only two nurses for 3 halls medications, including those due at specific times such as insulin, sometimes would not be given on time when problems came up such as: needing to send a resident to the hospital, resident falls, change of condition, resident behaviors. Resident Council minutes dated 5/28/24 revealed residents raised the following concern, Not enough staff. During an interview on 7/17/24 at 4:24 PM with the Activity Director, he confirmed residents at the 5/28/24 Resident Council meeting expressed that the facility did not have enough staff, but he did not ask the residents to elaborate further to determine any specifics regarding this concern. He stated that the minutes were provided to the Administrator, but he was unaware of any further follow-up. During an interview on 7/19/24 with the Staffing Coordinator, she confirmed that on 7/15/24 and 7/16/24 there were 3 CNAs and 2 Nurses Scheduled for 7:00 PM - 7:00 AM. She stated she had not called other staff to come in and provide additional coverage for these shifts because she was told no additional staff were needed. The census on 7/15/24 and 7/16/24 was 54 (8 residents on the memory care unit and 23 on both Hall A and Hall B) Review of the Facility assessment dated [DATE] revealed the average census was 54. The Staffing Plan revealed Based on our resident population and their needs, this facility has developed the following staffing plan to ensure sufficient staff is in place to meet the needs of the residents. The average number of staff planned was: Floor Nurse (Registered Nurses and Licensed Practical Nurses): 6 on days, 6 on evenings and 4 on nights. CNA: 7 on days plus 1 restorative aide, 4 on evenings plus 2 medication aides. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Nurse Staffing Sheets dated 5/18/24 - 7/19/24 revealed the Night Shift Staffing Sheet had slots for 3 Nurses and 3 Medication Aides. Typically, three nurses were assigned however on 10 occasions during this time there were 2 Nurses and a Medication Aide but on 16 nights (7:00 PM - 7:00 AM) there were only 2 Nurses for all 3 halls. The census ranged from 50 - 57 on these nights. During an interview with the Administrator and Nurse Consultant (NC) on 7/19/24 at 4:00 PM, the RNC confirmed 3 CNAs and 2 Nurses was not sufficient staffing for night shift. She stated, Our plan is not to be bare minimum. The Administrator indicated that the current Facility Assessment did not reflect the accurate staffing plan and needed to be revised. Both the NC and Administrator confirmed that when there were callouts, they were not always able to ensure the call out was covered by a replacement staff member. They also confirmed they had eliminated the agency staff within the facility other than 2 remaining agency staff. They were in the process of recruiting additional staff. Review of the additional information provided by the facility via email on 7/22/24 revealed the desired staffing ratio for CNAs on nights (7:00 PM - 7:00 AM) was 1:13 and this ratio was not met on seven (7) occasions between 5/18/24 - 7/20/24 with a ratio of 1:14 on two (2) nights, 1:16 on two (2) nights and 1:18 on three (3) nights. However, this additional information provided by the facility did not account for the fact that the memory care unit was consistently staffed by one (1) CNA and that unit typically had approximately eight (8) residents. Therefore, on the remaining two units the night shift CNAs had a ratio of up to 1:23 based on the facility average census of 54 when there were three (3) CNAs scheduled and 1:15 when four (4) CNAs were scheduled on night shift. A revised staffing plan for CNAs on the day shift and for Floor Nurses on the day and night shifts was not provided.