STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345478	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harnett Woods Nursing and Rehabilitation Center	604 Lucas Road Dunn, NC 28334

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 13289 Based on record review, staff interview, and physician interview the facility failed to notify the physician when a resident developed pain and bruising in the rib area following a fall. This was for one (Resident # 2) of three sampled residents who had sustained bruising. The findings included: Resident # 2 resided at the facility from 6/1/21 to 11/2/23. The resident's diagnoses in part included dementia, polyosteoarthritis, and dorsalgia (back pain). Resident # 2 had an order for Acetaminophen Extra Strength 500 milligrams three times per day. This order originated on 1/13/23. Resident # 2 also had an order for Cymbalta Capsule Delayed release 60 milligrams daily which originated on 8/24/21. (Cymbalta is an antidepressant used at times to manage pain.) On 7/10/23 at 3:37 PM Nurse # 1 documented the following information in a nursing entry. Resident # 2 had been found sitting on the floor and could not say exactly what had occurred. She was assessed and found to have no bumps, bruises or skin tears. She denied pain. Her neurological checks were within normal limits. Her vital signs were stable. The physician was notified without any new orders. According to staffing records, Nurse # 1 had cared for Resident # 2 from 7 AM to 7 PM on 7/10/23. Review of the facility's investigation into the incident revealed a statement by Nurse # 1 noting the following information about the date of 7/10/23. She and another nurse had assisted Resident # 2 to her chair after the fall. The resident had no pain upon assessment. Nurse # 1 further wrote, A little later [Nurse Aide # 1] let me know she was having some pain under her breast area. I took [Nurse # 2] and we looked at it. It was red and looked yeasty. I put some Nystatin powder on it. She didn't wince in pain or anything. She just said 'Oh that feels better. According to staffing records, Nurse Aide (NA) # 1 had cared for Resident # 2 from 7 AM to 7 PM on 7/10/23. Review of Nurse Aide (NA) # 1's written statement revealed the following information. She had checked on Resident # 2 after the fall, and the resident had complained of a burning sensation under her left breast. She looked and her skin looked like it was a little bit raw. That was not unusual for the resident. She (NA # 1) told the nurse, and the nurse put some sort of powder on the area. The resident did not have any further complaints after that on her shift. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NA # 1 was interviewed on 5/1/24 at 4:40 PM and reported the following information. She recalled Resident # 1 reporting it burned under her breast. Other than the burning under her breast, she did not complain of any other pain on her 7/10/23 shift. Nurse # 1 was interviewed on 5/2/24 at 1:10 PM and reported the following information. The resident was not bruised or had pain when she assessed her on 7/10/23. She did have some redness that was not bright red under her breast. She had an order for a powder to be used PRN (as needed) if she had a yeast infection. She had not called the physician on 7/10/23 when the resident developed the burning sensation under her breast. According to staff records, Nurse # 3 cared for Resident # 2 beginning at 7 PM on 7/10/23 until 7 AM on 7/11/23. Nurse # 3 documented neurological checks were performed on 7/10/23 at 8:24 PM, 7/10/23 at 9:27 PM, and 7/10/23 at 11:26 PM, 7/11/23 at 1:47 AM, and 7/11/23 at 5:32 AM. Each neurological check noted the resident had no apparent distress. Nurse # 3 was interviewed on 5/2/24 at 2:40 PM and reported the following information. She did not recall the specifics of the shift which began on 7/10/23 at 7 PM. If the resident had complained specifically of rib pain, then she would have documented it in the record. The resident routinely received acetaminophen for generalized pain. On 7/11/23 the psychiatric nurse practitioner documented in the medical record she saw Resident # 2, and the resident complained of mild pain. Review of staffing records revealed NA # 2 had cared for Resident # 2 from 7 AM to 7 PM on 7/11/23. Review of a facility's investigative report revealed a written statement by NA # 2 about the occurrences on the date of 7/11/23. NA # 2 wrote the following information. At 9 AM Resident # 2 had complained of pain beneath her breast while NA # 2 bathed and dressed her. At 1 PM Resident # 2 complained of sharp pain to left rib while being turned in bed for incontinent care. At 3 PM NA # 2 answered Resident # 2's call bell, and the resident complained of pain to her left rib. At 6 PM Resident # 2 complained of pain while rolling over to her left side. At each occurrence of pain, NA # 2 reported the resident's pain to Nurse # 1. NA # 2 was interviewed on 5/3/24 at 12:15 PM and reported the following. Every time she cared for Resident # 2 on 7/11/23 the resident complained of pain. She was alert enough to report where the pain was and she would say, My ribs hurt real bad. She had some bruising also. Although she did not recall for sure where the bruising was, she thought it had been on her back rib area. She also had some redness under her breast which the NA thought was a different issue than the bruise. She had told Nurse # 1 the resident was hurting in her ribs. Review of Nurse # 1's written statement about the details of 7/11/23 revealed the following information. On 7/11/23 the CNA reported that the resident was having pain under her left breast around 9 AM. I went to the room to check the resident and pressed the area under her left breast. It was still red and [Resident # 2] denied pain when I pressed on it. I applied Nystatin Powder on it. She gets Tylenol in the AM and at lunch. The CNA reported resident was having sharp pain at 1 PM and again sometime after supper. I went and checked her each time and [she] denied pain when I pushed on it Nurse # 1 further wrote, Other than the yeast area under her breast that [NA # 1] made me aware of she didn't have pain or seem to be in pain. She was rolling in her wheelchair in the hall also. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the interview with Nurse # 1 on 5/2/24 at 1:10 PM, Nurse # 1 reported the resident did not have any excruciating pain when she checked her on both 7/10/23 and 7/11/23 to signal that there was anything wrong further than a yeast rash under her breast. She had not observed bruising to signify an injury and therefore had not called the physician. According to staffing records, Nurse # 4 cared for Resident # 2 from 7 AM to 7 PM on 7/12/23. Nurse # 4 documented in a nursing entry on 7/12/23 at 1:49 PM that the resident complained of left side discomfort and was medicated with Tylenol. On 7/12/23 at 5:51 PM, Nurse # 4 documented the resident had a very small knot like area under the skin below the rib cage. When manipulated the resident did not complain of pain or grimace. Nurse # 4 further noted the physician would be asked to look at the area when the physician was next in the facility, and they would continue to monitor the resident. Resident # 2's Medication Administration Record included a pain assessment was completed at the times when the resident's routine Acetaminophen was administered. On 7/12/23 Resident # 2's pain was documented to be 0 at 8 AM, 6 at 12:00 PM and 0 at 8 PM. Review of a written statement by Nurse # 4 revealed the following information. On 7/12/23 Resident # 2 had wheeled around as per her normal pattern and did not complain of pain. A physical therapist had asked Nurse # 4 to look at an area on the resident's left lower back below the rib cage. She (Nurse # 4) asked Nurse # 5 to look at the knot with her, and the area looked like a cyst below the skin. Occupational therapist # 1 (OT) was interviewed on 5/2/24 at 10:10 AM and reported the following. On 7/12/23 Resident # 2 was in the therapy gym working on reaching activities. She complained of pain, and she (OT # 1) could feel a palpable mass underneath the resident's clothing in the rib area. The resident was in the gym and therefore she did not raise the resident's clothing to look at the area, but she reported it to the resident's nurse. OT # 1 further reported she had worked with Resident # 2 the previous day (7/11/23) and the resident had complained of left sided pain. Nurse # 4 and Nurse # 5 were interviewed together on 5/1/24 at 4:00 PM and reported the following information. Resident # 2 had not been in pain when they checked the area on her left flank on 7/12/23. There was no bruising they saw. It looked like fatty tissue and they did not call the physician that day. On 7/13/23 at 12:47 AM Nurse # 6 documented in a nursing entry that Resident # 2 had no pain. On 7/13/23 at 10:31 AM Nurse # 4 documented in a nursing entry that Resident # 2 voiced no complaints from her 7/10/23 fall. On 7/13/23 at 1:47 PM Nurse # 4 documented in a nursing entry that Resident # 2 was starting to show some signs of bruising to her left rib area and orders were obtained for an x-ray. Interview with the facility's physical therapy assistant on 5/2/24 at 9:10 AM revealed the following information. The PTA had worked with Resident # 2 on 7/13/23 and she had complained of pain in her ribs. The PTA looked at the rib area and saw she had bruising. She alerted Nurse # 4. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the interview with Nurse # 4 on 5/1/24 at 4:00 PM, Nurse # 4 reported she saw bruising for the first time on 7/13/23 when the PTA called it to her attention. That was when she first talked to the physician about the bruising and orders were obtained for the first time to do an x-ray. On 7/13/23 an x-ray was done. The results showed Acute appearing fractures of the left 4th and 5th ribs, with suspicion of occult fracture of the left 6th rib. (An occult fracture is a hidden fracture.) According to the radiology report, the fractures were minimally displaced (out of alignment). Resident # # 2's physician was interviewed on 5/2/24 at 11:50 AM. During the interview, the physician reviewed NA # 2's written statement noting Resident # 2 had complained of pain multiple times per day on 7/11/23 (the day following the fall of 7/10/23). The physician reported the nurses should have contacted him on 7/11/23 when NA # 2 was reporting to Nurse # 1 multiple episodes of pain. There was no treatment for the resident's rib fractures other than to let them heal and offer pain medication. He (the physician) typically liked to try acetaminophen in the elderly but would use codeine if the pain was severe. Further review of Resident # 2's record revealed following the identification of the rib fractures her acetaminophen was increased to 500 mg four times per day on 7/13/23. On 7/14/23 this was discontinued, and she was placed on Acetaminophen-codeine 300 mg-30 mg every six hours as needed for pain. According to Resident # 2's July 2023 Medication Administration Record, she required three doses of this between the dates of 7/14/23 to 7/31/23. The resident also continued to receive Duloxetine delayed release every day as originally prescribed on 8/24/21. During an interview with the Administrator on 5/2/24 at 3:00 PM the Administrator reported the facility had identified issues with physician notification for Resident # 2 through their quality assurance program and completed a corrective action plan. On 5/2/24 the Administrator presented the following corrective action plan. Corrective Action for Resident Involved On 7/10/2023 at approximately 3:00pm Resident #2 was noted on the floor sitting in front of her Geri-chair. The nurse assessed resident who was able to move all extremities and had no complaints of pain or discomfort. Resident #2 has a history of fungal infections under her breasts. Resident # 2's diagnoses include dorsalgia (chronic back pain) and polyosteoarthritis. She also has documented old rib fractures. She is currently on 60mg of Cymbalta daily and 500mg of Extra Strength Tylenol 3x/day, which has proven to be effective. At approximately 3:15pm the CNA went to the resident's room to check on the resident. Resident reported burning sensation under left breast. The nurse assessed the resident to find fungal rash under left breast and Nystatin powder was applied per wound/skin standing order protocol. Resident stated, oh that feels better and had no further complaints. The resident was provided incontinent care, dinner, and preparation for sleep with no complaints of pain, discomfort, or burning on left breast. Resident slept through the night with uninterrupted sleep. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/11/2023 during AM care resident reported to CNA pain under left breast. The nurse performed an assessment including palpation of area and resident denied pain or discomfort. Redness continued under left breast and Nystatin powder applied per wound/skin standing order protocol. At approx. 12:30pm the resident was seen by psych services who noted unspecified mild pain during psych assessment. Resident was provided scheduled Extra Strength Tylenol 500mg and noted to be effective. At approx. 1:00pm during incontinence care, resident complained of sharp rib pain. CNA reported to nurse and nurse assessed resident's pain and resident denied pain. At approx. 4:30pm the resident's dinner tray arrived, and resident sat up in bed to eat without complaints of pain, discomfort, or burning under left breast. On 7/12/2023 at approximately 12:30pm, the physical therapist noted the area to left back and reported to nurse. On assessment, the resident was noted with a small nodule-like area. The Resident had no complaints of pain or discomfort on palpation of the nodule-like area and nurse noted nodule was fatty. The Resident continued with scheduled pain medication with usual pain noted intermittently. However, no pain increase noted from chronic dorsalgia pain. On 7/13/2024 the physical therapist assisted resident with bath and AM care and noted bruising on left back and resident complains of pain on transfer. An order for X-ray was obtained. X-ray results revealed moderate osteoporosis, acute appearing, minimally displaced fractures of lateral aspect of the left 4th and 5th ribs. There is mild deformity of the lateral portion of the left 6th rib, which has the appearance of remote healed fracture. On 7/13/2023 Extra Strength Tylenol straight order was increased to 4x/day. The resident received 3 doses; however, the resident had no complaints of pain. Therefore, on 7/14/2023 Extra Strength Tylenol straight order was discontinued, and order received for Acetaminophen-Codeine 300-30mg every 6 hours as needed for pain. Resident requested only 3 doses from 7/14/2023 to 7/31/2023. Identification and Corrective Action Plan for Other Potentially Impacted Residents On 7/14/23, 100% audit of non-alert residents was completed by the Unit Manager to identify all residents with new bruising, pain, or deformity. On 7/14/23, the Progress notes for the last 14 days were reviewed by the Unit Manager/Director of Nursing (DON) to determine if a resident exhibited a change in condition, to include increased pain, and ensure the practitioner was notified timely. The Director of Nursing will address all areas of concern identified during the audit to include notification of the physician for further instruction. Audit will be completed by 7/17/23. Measures put in Place and Systemic Changes to Ensure the Deficient Practice Will Not Recur On 7/14/2023 an Ad Hoc Quality Assurance Performance Improvement meeting was held with attendance of the Administrator, Director of Nursing, Regional [NAME] President, and Regional Clinical Consultant to review Performance Improvement Plan and put corrective action in place. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/14/23, an in-service was initiated by the Administrative Nursing Team with all nurses regarding Assessment and Notification of Changes, and signs/symptoms of fracture. The nurses were educated on notifying physician with any change in resident condition to include but not limited to new bruising, pain, and/or deformity after a fall with documentation in the electronic record. In-service will be completed by 7/17/23. All newly hired nurses will be in-service during orientation regarding Notification of Changes. No nurse will work after 7/17/23 without receiving the in-service. Monitoring Plan to Make Sure that Solutions are Sustained: IDT Team will review Falls, Change of condition, and pain assessments 5x/week x4 weeks then monthly x1 month to ensure the physician was notified of changes in condition and changes related to new bruising, pain, and deformity. The Unit Managers will address all areas of concern identified during the audit. The DON will review the Notification Audit Tool weekly x4 weeks then monthly x1 month to ensure all areas of concern are addressed. The DON will present the findings of the Notification, Pain, and Change of Condition Audit Tools to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will review the Notification, Pain, and Change of Condition Audit Tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. Resolution Date: 7/17/23 The facility's corrective action was validated by the following actions: Beginning on 5/1/24 at 9:05 AM a tour of the facility was made. Multiple residents were interviewed and reported they were pleased with care and services. None of the residents reported a problem with the staff not communicating with their physician. A family member of a cognitively impaired resident was also interviewed and had no concerns about care and services. Other residents were placed on a sample for review. These additional reviews revealed staff were notifying the physician when a change in condition arose with sampled residents. The facility presented documented evidence of their inservice education and audits per their corrective action plan. On 5/3/24 the facility's plan of correction date of 7/17/23 was validated.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 13289 Based on record review, staff interview, and physician interview the facility failed to ensure a complete assessment was done when Resident # 2 started complaining of rib pain and showing signs of bruising following a fall. This was for one (Resident # 2) out of three sampled residents who sustained bruising and/or injuries. The findings included: Resident # 2 resided at the facility from 6/1/21 to 11/2/23. The resident's diagnoses in part included dementia, polyosteoarthritis, and dorsalgia (back pain). Resident # 2 had an order for Acetaminophen Extra Strength 500 milligrams three times per day. This order originated on 1/13/23. Resident # 2 also had an order for Cymbalta Capsule Delayed release 60 milligrams daily which originated on 8/24/21. (Cymbalta is an antidepressant used at times to manage pain.) Resident # 2's quarterly Minimum Data Set assessment, dated 7/10/23, coded the resident as moderately cognitively impaired. She was also assessed to need extensive assistance with her hygiene needs and transferring. Resident # 2's care plan revealed the resident was at risk for falls. This had been added to the resident's care plan at her original admitted and remained as an active part of her care plan as of 7/10/23. On 7/10/23 at 3:37 PM Nurse # 1 documented the following information in a nursing entry. Resident # 2 had been found sitting on the floor and could not say exactly what had occurred. She was assessed and found to have no bumps, bruises or skin tears. She denied pain. Her neurological checks were within normal limits. Her vital signs were stable. The physician was notified without any new orders. According to staffing records, Nurse # 1 had cared for Resident # 2 from 7 AM to 7 PM on 7/10/23. Review of the facility's investigation into the incident revealed a statement by Nurse # 1 noting the following information about the date of 7/10/23. She and another nurse had assisted Resident # 2 to her chair after the fall. The resident had no pain upon assessment. Nurse # 1 further wrote, A little later [Nurse Aide # 1] let me know she was having some pain under her breast area. I took [Nurse # 2] and we looked at it. It was red and looked yeasty. I put some Nystatin powder on it. She didn't wince in pain or anything. She just said 'Oh that feels better. According to staffing records, Nurse Aide (NA) # 1 had cared for Resident # 2 from 7 AM to 7 PM on 7/10/23. Review of Nurse Aide (NA) # 1's written statement revealed the following information. She had checked on Resident # 2 after the fall, and the resident had complained of a burning sensation under her left breast. She looked and her skin looked like it was a little bit raw. That was not unusual for the resident. She (NA # 1) told the nurse, and the nurse put some sort of powder on the area. The resident did not have any further complaints after that on her shift. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NA # 1 was interviewed on 5/1/24 at 4:40 PM and reported the following information. She recalled Resident # 1 reporting it burned under her breast. Other than the burning under her breast, she did not complain of any other pain on her 7/10/23 shift. Nurse # 1 was interviewed on 5/2/24 at 1:10 PM and reported the following information. The resident was not bruised or have pain when she looked at her on 7/10/23. She did have some redness that was not bright red under her breast. The resident had an order for a powder to be used PRN (as needed) if she had a yeast infection. According to staff records, Nurse # 3 cared for Resident # 2 beginning at 7 PM on 7/10/23 until 7 AM on 7/11/23. Nurse # 3 documented neurological checks were performed on 7/10/23 at 8:24 PM, 7/10/23 at 9:27 PM, and 7/10/23 at 11:26 PM, 7/11/23 at 1:47 AM, and 7/11/23 at 5:32 AM. Each neurological check noted the resident had no apparent distress. Nurse # 3 was interviewed on 5/2/24 at 2:40 PM and reported the following information. She did not recall the specifics of the shift which began on 7/10/23 at 7 PM. If the resident had complained specifically of rib pain, then she would have documented it in the record. The resident routinely received acetaminophen for generalized pain. On 7/11/23 the psychiatric nurse practitioner documented in the medical record she saw Resident # 2, and the resident complained of mild pain. Review of staffing records revealed NA # 2 had cared for Resident # 2 from 7 AM to 7 PM on 7/11/23. Review of a facility's investigative report revealed a written statement by NA # 2 about the occurrences on the date of 7/11/23. NA # 2 wrote the following information. At 9 AM Resident # 2 had complained of pain beneath her breast while NA # 2 bathed and dressed her. At 1 PM Resident # 2 complained of sharp pain to left rib while being turned in bed for incontinent care. At 3 PM NA # 2 answered Resident # 2's call bell, and the resident complained of pain to her left rib. At 6 PM Resident # 2 complained of pain while rolling over to her left side. At each occurrence of pain, NA # 2 reported the resident's pain to Nurse # 1. NA # 2 was interviewed on 5/3/24 at 12:15 PM and reported the following. Every time she cared for Resident # 2 on 7/11/23 the resident complained of pain. She was alert enough to report where the pain was and she would say, My ribs hurt real bad. She had some bruising also. Although she (NA#2) did not recall for sure where the bruising was, she thought it had been on her back rib area. She also had some redness under her breast which the NA thought was a different issue than the bruise. She had told Nurse # 1 the resident was hurting in her ribs. Review of Nurse # 1's written statement about the details of 7/11/23 revealed the following information. On 7/11/23 the CNA reported that the resident was having pain under her left breast around 9 AM. I went to the room to check the resident and pressed the area under her left breast. It was still red and [Resident # 2] denied pain when I pressed on it. I applied Nystatin Powder on it. She gets Tylenol in the AM and at lunch. The CNA reported resident was having sharp pain at 1 PM and again sometime after supper. I went and checked her each time and [she] denied pain when I pushed on it. Nurse # 1 further wrote in her statement, Other than the yeast area under her breast that [NA # 1] made me aware of she didn't have pain or seem to be in pain. She was rolling in her wheelchair in the hall also. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the interview with Nurse # 1 on 5/2/24 at 1:10 PM, Nurse # 1 reported the resident did not have any excruciating pain when she checked her on both 7/10/23 and 7/11/23 to signal that there was anything wrong further than a yeast rash under her breast. She had not identified the bruising which NA # 2 had observed on 7/11/23 when she assessed Resident # 2. According to staffing records, Nurse # 4 cared for Resident # 2 from 7 AM to 7 PM on 7/12/23. Nurse # 4 documented in a nursing entry on 7/12/23 at 1:49 PM that the resident complained of left side discomfort and was medicated with Tylenol. On 7/12/23 at 5:51 PM, Nurse # 4 documented the resident had a very small knot like area under the skin below the rib cage. When manipulated the resident did not complain of pain or grimace. Nurse # 4 further noted the physician would be asked to look at the area when the physician was next in the facility, and they would continue to monitor the resident. Resident # 2's Medication Administration Record included a pain assessment was completed at the times when the resident's routine Acetaminophen was administered. On 7/12/23 Resident # 2's pain was documented to be 0 at 8 AM, 6 at 12:00 PM and 0 at 8 PM. Review of a written statement by Nurse # 4 revealed the following information. On 7/12/23 Resident # 2 had wheeled around as per her normal pattern and did not complain of pain. A physical therapist had asked Nurse # 4 to look at an area on the resident's left lower back below the rib cage. She (Nurse # 4) asked Nurse # 5 to look at the knot with her, and the area looked like a cyst below the skin. Occupational therapist # 1 (OT) was interviewed on 5/2/24 at 10:10 AM and reported the following. On 7/12/23 Resident # 2 was in the therapy gym working on reaching activities. She complained of pain, and she (OT # 1) could feel a palpable mass underneath the resident's clothing in the rib area. The resident was in the gym and therefore she did not raise the resident's clothing to look at the area, but she reported it to the resident's nurse. OT # 1 further reported she had worked with Resident # 2 the previous day (7/11/23) and the resident had complained of left sided pain. Nurse # 4 and Nurse # 5 were interviewed together on 5/1/24 at 4:00 PM and reported the following information. Resident # 2 had not been in pain when they checked the area on her left flank on 7/12/23. There was no bruising they saw. It looked like fatty tissue or a fatty cyst. They did not see a bruise. The nurses were interviewed regarding whether they had looked at the resident's front side of her ribs under her breast and replied they had not done so. She had been in bed at the time they assessed her. The nurses were also interviewed regarding whether they had been aware that NA # 2 had been reporting to Nurse #1 on 7/11/23 that the resident was hurting in her ribs when they were doing their assessment of the knot. Nurse # 4 reported she was aware Resident # 2 had a fall on 7/10/23 but she had not been aware of the resident's complaints of rib pain the previous day (7/11/23). The pain issue had not been passed along in report to her. On 7/13/23 at 12:47 AM Nurse # 6 documented in a nursing entry that Resident # 2 had no pain. On 7/13/23 at 10:31 AM Nurse # 4 documented in a nursing entry that Resident # 2 voiced no complaints from her 7/10/23 fall. On 7/13/23 at 1:47 PM Nurse # 4 documented in a nursing entry that Resident # 2 was starting to show some signs of bruising to her left rib area and orders were obtained for an x-ray. (continued on next page)

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	345478	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harnett Woods Nursing and Rehabilitation Center	604 Lucas Road Dunn, NC 28334

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the facility's physical therapy assistant on 5/2/24 at 9:10 AM revealed the following information. The PTA had worked with Resident # 2 on 7/13/23 and she had complained of pain in her ribs. The PTA looked at the rib area and saw she had bruising. She alerted Nurse # 4. During the interview with Nurse # 4 on 5/1/24 at 4:00 PM, Nurse # 4 reported she saw bruising for the first time on 7/13/23 during her assessment when the PTA called it to her attention. On 7/13/23 an x-ray was done per physician order. The results showed Acute appearing fractures of the left 4th and 5th ribs, with suspicion of occult fracture of the left 6th rib. (An occult fracture is a hidden fracture.) According to the radiology report, the fractures were minimally displaced (out of alignment). Resident # # 2's physician was interviewed on 5/2/24 at 11:50 AM. During the interview, the physician reviewed NA # 2's written statement noting Resident # 2 had complained of pain multiple times per day on 7/11/23 (the day following the fall of 7/10/23). The physician reported the following information. Skin yeast infections typically do not cause pain under the breast. They might cause discomfort or itching. Nurse # 1's action of pressing at one particular point on Resident # 2's ribs may have not elicited a pain response to signal the rib fractures. This was because Nurse # 1 may have not been pressing on the affected ribs. An indicator that might signify rib fractures is generally that residents cannot take a deep breath without experiencing pain. There was no treatment for the resident's rib fractures other than to let them heal and offer pain medication. He (the physician) typically liked to try acetaminophen in the elderly but would use codeine if the pain was severe. Further review of Resident # 2's record revealed following the identification of the rib fractures her acetaminophen was increased to 500 mg four times per day on 7/13/23. On 7/14/23 this was discontinued, and she was placed on Acetaminophen-codeine 300 mg-30 mg every six hours as needed for pain. According to Resident # 2's July 2023 Medication Administration Record, she required three doses of this between the dates of 7/14/23 to 7/31/23. The resident also continued to receive Duloxetine delayed release every day as originally prescribed on 8/24/21. During an interview with the Administrator on 5/2/24 at 3:00 PM the Administrator reported the facility had identified issues with assessment for Resident # 2 through their quality assurance program and completed a corrective action plan. On 5/2/24 the Administrator presented the following corrective action plan. Corrective Action for Resident Involved On 7/10/2023 at approximately 3:00pm Resident #2 was noted on the floor sitting in front of her Geri-chair. The nurse assessed resident who was able to move all extremities and had no complaints of pain or discomfort. Resident #2 has a history of fungal infections under her breasts. Resident # 2's diagnoses include dorsalgia (chronic back pain) and polyosteoarthritis. She also has documented old rib fractures. She is currently on 60mg of Cymbalta daily and 500mg of Extra Strength Tylenol 3x/day, which has proven to be effective. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At approximately. 3:15pm the CNA went to the resident's room to check on the resident. Resident reported burning sensation under left breast. The nurse assessed the resident to find fungal rash under left breast and Nystatin powder was applied per wound/skin standing order protocol. Resident stated, oh that feels better and had no further complaints. The resident was provided incontinent care, dinner, and preparation for sleep with no complaints of pain, discomfort, or burning on left breast. Resident slept through the night with uninterrupted sleep. On 7/11/2023 during AM care resident reported to CNA pain under left breast. The nurse performed an assessment including palpation of area and resident denied pain or discomfort. Redness continued under left breast and Nystatin powder applied per wound/skin standing order protocol. At approx. 12:30pm the resident was seen by psych services who noted unspecified mild pain during psych assessment. Resident was provided scheduled Extra Strength Tylenol 500mg and noted to be effective. At approx. 1:00pm during incontinence care, resident complained of sharp rib pain. CNA reported to nurse and nurse assessed resident's pain and resident denied pain. At approx. 4:30pm the resident's dinner tray arrived, and resident sat up in bed to eat without complaints of pain, discomfort, or burning under left breast. On 7/12/2023 at approx. 12:30pm, the physical therapist noted the area to left back and reported to nurse. On assessment, the resident was noted with a small nodule-like area. The Resident had no complaints of pain or discomfort on palpation of the nodule-like area and nurse noted nodule was fatty. The Resident continued with scheduled pain medication with usual pain noted intermittently. However, no pain increase noted from chronic dorsalgia pain. On 7/13/2024 the physical therapist assisted resident with bath and AM care and noted bruising on left back and resident complains of pain on transfer. An order for X-ray was obtained. X-ray results revealed moderate osteoporosis, acute appearing, minimally displaced fractures of lateral aspect of the left 4th and 5th ribs. There is mild deformity of the lateral portion of the left 6th rib, which has the appearance of remote healed fracture. On 7/13/2023 Extra Strength Tylenol straight order was increased to 4x/day. The resident received 3 doses; however, the resident had no complaints of pain. Therefore, on 7/14/2023 Extra Strength Tylenol straight order was discontinued, and order received for Acetaminophen-Codeine 300-30mg every 6 hours as needed for pain. Resident requested only 3 doses from 7/14/2023 to 7/31/2023. Identification and Corrective Action Plan for Other Potentially Impacted Residents On 7/14/2023 an Ad Hoc Quality Assurance Performance Improvement meeting was held with attendance of the Administrator, Director of Nursing, Regional [NAME] President, and Regional Clinical Consultant to review Performance Improvement Plan and put corrective action in place. On 7/14/23, 100% audit of non-alert residents was completed by the Unit Manager to identify all residents with new bruising, pain, or deformity with no additional concerns identified. On 7/14/23, the Progress notes for the last 14 days were reviewed by the Unit Manager/Director of Nursing (DON) to determine if a resident exhibited a change in condition, to include increased pain, and ensure an assessment was completed if indicated. There were no additional concerns identified. Audit was completed by 7/17/23. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/14/23 Interviews were initiated by the unit manager and social worker with alert residents regarding any pain not addressed to ensure proper pain management and/or any additional treatment or diagnostics needed. Interviews were completed by 7/17/23 with no additional concerns. On 7/14/23, the unit manager, Director of Nursing and Administrator initiated an audit of all falls for the past 30 days to ensure residents were assessed and the physician notified for further recommendations. The audit was completed by 7/17/23 with no additional concerns. On 7/14/23, the unit manager and social worker educated the alert and oriented residents regarding reporting new or worsening pain and/or changes in condition to include falls to ensure the resident is assess and the physician is notified for further recommendation. Measures put in Place and Systemic Changes to Ensure the Deficient Practice Will Not Recur On 7/14/23, an in-service was initiated by the Administrative Nursing Team to include Minimum Data Set Nurse, Unit Manager, Director of Nursing with all nurses regarding Residents' changes of condition including (1) completing a full assessment (2) Notification of Changes to the physician/NP and resident representative (3) signs/symptoms of fracture (4) document the findings of the assessment, notification of the physician/NP/resident representative and entering any new orders in the resident's clinical record. Changes in condition include, but are not limited to falls with injury, new onset or increased complaints of pain, and/or an obvious physical change. All newly hired nurses will be in-service during orientation regarding assessment and notification of physician and resident representative upon change of condition. No nurse will work after 7/17/23 without receiving the in-service. Monitoring Plan to Make Sure that Solutions are Sustained: The IDT Team to include Minimum Data Set Nurse, DON, Administrator and Unit Managers will review incident reports, progress notes for changes in condition, and pain assessments 5 x/week x 4 weeks then monthly x 1 month to ensure a full assessment was completed with provider and RR notification and documentation in the clinical record. This will be documented on the IDT audit tools. The Unit Managers will address all areas of concern identified during the audit. The DON will review the audit tools weekly x4 weeks then monthly x1 month to ensure all areas of concern are addressed. The DON will present the findings of audit tools to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The QAPI Committee will review the audit tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. Resolution Date: 7/17/23 The facility's corrective action was validated by the following actions: Beginning on 5/1/24 at 9:05 AM a tour of the facility was made. Multiple residents were interviewed and reported they were pleased with care and services. None of the residents reported a problem with a lack of medical care or assessment of their medical needs. A family member of a cognitively impaired resident was also interviewed and had no concerns about care and services. (continued on next page)

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