| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 425100 | A. Building<br>B. Wing | 05/14/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Heritage at Lowman Rehab and Healthcare | 201 Fortress Drive<br>White Rock, SC 29177 |

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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46934<br><br>Based on interviews, record review, and review of facility policy, the facility failed to maintain resident safety from harm for 1 of 1 resident. Specifically, while providing incontinent care to Resident (R)1 on 04/01/24, staff walked away from R1, resulting in R1 falling to the floor and suffering a hematoma of the scalp, skin tear and hematoma over the right elbow/forearm, and acute closed fracture of the tibia and fibula.<br><br>Findings include:<br><br>Review of the facility policy titled Falls with a revision date of 04/04/22 revealed, the facility will identify each patient/resident who is at risk for falls and develop and implement a plan of care. Qualified staff will complete a Fall Risk Evaluation to determine if the patient/resident is a fall risk. Fall risk evaluation assists in identifying the appropriate preventative interventions that will be recorded in the resident's medical record/care plan.<br><br>Review of R1's Face Sheet revealed that R1 was admitted to the facility on [DATE] with diagnoses to include but not limited to: bed confinement status, encephalopathy, encounter for palliative care, muscle weakness, unsteadiness on feet, abnormalities of gait and mobility, and major depressive disorder.<br><br>Review of R1's Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/10/24, revealed a Brief Interview for Mental Status (BIMS) score of 4 out of 15, indicating the resident is severely cognitively impaired. Further review of R1's MDS revealed that R1 is dependent for all Activities of Daily Living (ADL)s including personal hygiene and toileting.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of R1's Care Plan revealed, FALLS: Potential for falls and injuries related to imbalance, muscle weakness, and chronic pain. GOALS- will be free of fall-related injuries through the next review. Interventions- Frequent safety checks when in the room alone. Keep the call light in a consistent place and answer it as promptly as possible. Assist with ADLs as needed: see ADL care plan. Keep room/walkways free from clutter and spills. Toilet on a frequent and routine basis and as requested by residents to keep continent as possible. Observe for increased confusion, sedation, and lethargic behavior. Intervene as needed. Labs as MD ordered. Report abnormal results. 12/23/21 Have 2 staff members for transfers, toileting, dressing, bathing, and providing care. Further review of the Care Plan revealed, ADLs: Self-care deficit related to sepsis, hypotension, Vitamin deficiency, anemia, DM2, HTN, GERD, depression, encephalopathy, and muscle weakness. Requires assist x 1-2 persons with ADL's. hospitalized [DATE] left fib/tib fracture and hematoma. Goal- needs will be always anticipated and met by staff. Interventions-Observe for pain that may interfere with ADL progress/status. Allow residents to rest and assist with positioning/meds. Document pain site and intensity/effectiveness of medications/document effectiveness of medication. Allow time for self-performance of ADL regardless of level of assistance. Check resident for incontinence on a frequent and routine basis or PRN request. Use adult briefs/pull-ups/pads for containment and dignity. 12/23/21 Have 2 staff members for transfers, toileting, dressing, bathing, and providing care. Coordinate care with hospice services at all times.<br><br>Review of R1's Progress Note dated 04/01/24 at 2:11 PM, revealed, Resident had fallen out of bed while being provided incontinence care by 2 [Certified Nursing Assistant] CNAs this am at 5:30 am. It was stated by the CNAs that she had fallen out the bed and landed on her stomach. When I entered the room, the resident was on her back lying next to her bed. Upon evaluation, she had obtained two skin tears to her right elbow that were cleaned, and a dressing was put into place. Upon further evaluation resident LE [lower extremity] appeared to be broken. She also had a hematoma on the right side of her head and a bruise under her right eye. She was also holding her left hip. She was grimacing and vocalizing that she was in pain. A cardboard box, sheets, and tape were used to stabilize resident LLE. Resident's vitals were BP: 173/84, Temp 97.5, Resp 18, SP02 on 2L 92, Pulse was 75. Hospice, Son, and [Director of Nursing] DON were notified of the incident. 911 was called and in route. When EMS arrived, they suggested after they did their assessment of the resident that she be transferred to [local hospital]. Son and Hospice was notified as she was originally going to [local hospital]. The resident left the facility at 5:45 am and was transported to [local hospital]. Both CNAs that were taking care of the resident wrote a detailed statement as requested by DON which was given to the Administrator.<br><br>Review of R1's Hospital Discharge Summary dated 04/03/24, states, discharge diagnosis: Closed fracture of left tibia and fibula. Hematoma of the right parietal scalp. HPI- 89 y.o. female with past medical history to include hypothyroidism, chronic hypoxic respiratory failure on supplemental oxygen at 2-3 Lpm baseline, and bed-bound on hospice care who had a fall after being dropped at her nursing facility today with resultant hematoma of the scalp, skin tear and hematoma over the right elbow/forearm, and acute closed fracture of the tibia and fibula.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of a Witness Statement written by Certified Nursing Assistant (CNA)1 on 04/01/24 at 5:25 AM, revealed, This CNA with the Assistance of [CNA2] went into 413 to start round on resident. The resident was turned on her left side as resident had a bowel movement and was being cleaned. This CNA turned away to dispose of wipes in the garbage as I turned back resident was on the floor before I could do anything else. The resident was face down. This CNA looked her over as (CNA2) went to inform the nurse. This CNA stayed with the resident making sure she was responsive, due to her falling face down. The nurse entered and checked the resident as this CNA could see the resident leg appeared to be broken. This CNA stayed at the resident's side to stabilize as the nurse assessed the resident.<br><br>Review of a Witness Statement written by CNA2 on 04/01/24, revealed, Approximately between 0525 and 0530, [CNA1] and [CNA2] started our final round in room [ROOM NUMBER]. The resident turned on her left side primarily to be cleaned. As she was on her left side she remained in the center of the bed. When [CNA1] turned away to dispose of her soiled items, [R1] abruptly turned and fell off her bed before either of us could proceed to watch her. When the resident fell , it sounded as if her body flopped. [CNA1] and I turned her over because she was face first. After flipping her over, [CNA1] checked her for additional injuries as I went down the hall to find the nurse. The nurse came into the room and also evaluated the resident for injuries. After briefly assessing the resident, she contacted the hospice and the resident's [Power of Attorney] POA, The POA instructed the nurse to send her to [local hospital]. The nurse stabilized her leg because it appeared to be broken and also wrapped her arms as she sustained skin tears. Between 0615 and 0630 the ambulance arrived to further assist.<br><br>During an interview on 05/14/24 at 2:09 PM, CNA1 revealed she was providing care to the resident along with CNA2. CNA1 stated she turned the resident on her left side and thought the resident was in a stable position and was not holding on to anything for support. CNA1 stated she turned around to throw the soiled brief and used wipes in the trash, and when she turned around, the resident was on the floor face down. CNA1 further stated she was unsure of what CNA2 was doing while she turned her back to discard the brief. CNA1 stated she and CNA2 turned the resident on her back, and CNA2 went to get the nurse. CNA1 concluded the nurse came in, assessed the resident, and Emergency Medical Services (EMS) came and transferred the resident to a local hospital.<br><br>An attempt to interview CNA2 on 05/14/24 at 2:03 PM, was unsuccessful, a message for a return phone call was left.<br><br>During a phone interview on 05/14/24 at 2:54 PM, R1's Representative (RR) revealed that he was informed the resident had a fall, which he stated he doesn't believe happened. The RR stated the facility staff dropped his mother during incontinent care. He was told that two CNAs were in the room providing care to his mother because she had a bowel movement, one CNA turned around to discard the brief, and the resident fell . The RR stated that the staff who called him could not tell him what the other CNA was doing and why she didn't prevent the fall from occurring since she was supposed to be on the other side of the bed. The RR further stated the nurse told him that his mother's leg was flopping around and she was getting sent out to a local hospital. The RR revealed the resident had a tibia broken in half, a Fibula fracture in 2 places, and a head contusion the size of a baseball. The RR stated he spoke with the DON and Administrator and requested staff to be available at all times, he also requested bed rails. The RR concluded he just wants his mom to live her last days in peace.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 05/14/24 at 4:18 PM, the Administrator and DON both confirmed they recalled the resident, her level of care, along with being familiar with the resident's care plan. The DON stated she got a call from the nurse telling her that the resident had a fall and it looked like the resident may have fractured her leg. The DON stated that the staff was providing care, specifically a brief change, and one of the two CNAs turned around to throw wipes and brief in the trash, when one of the CNAs turned around, the resident was on the floor face down. The DON stated CNA2 stated she was on the other side of the bed, and the resident rolled over too quickly and didn't have time to prevent the fall. The DON revealed the resident sustained fractures to the tibia and fibula, along with head trauma. |