

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/08/2024
NAME OF PROVIDER OR SUPPLIER  Coon Memorial Home		STREET ADDRESS, CITY, STATE, ZIP CODE  210 Texas Blvd Dalhart, TX 79022	

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)
<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 26515</p> <p>Based on interviews and record reviews, the facility failed to immediately notify the resident's physician and family when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental or psychosocial status in either life threatening conditions or clinical complications) for 1 of 5 residents (Resident #1) reviewed for change in condition.</p> <p>LVN E failed to notify the DON, the Administrator, the physician, and the family member when Resident #1 was assisted to the floor on 10/24/24.</p> <p>These failures could place residents at risk of a delay in treatment, decline in physical, mental, and/or psychosocial status, hospitalization, and even death.</p> <p>On 11/7/24 at 4:35 p.m. an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 11/8/24 at 11:50 a.m., the facility remained out of compliance at a scope of isolated for more than minimal harm that was not immediate Jeopardy due to the facility's continuing need to monitor the implementation and effectiveness of their Plan of Removal.</p> <p>Findings included:</p> <p>Record review of Resident #1's Face Sheet documented an [AGE] year-old female was admitted to the facility on [DATE] with the following diagnoses: dementia, congestive heart failure, allergic rhinitis, vitamin deficiency, long term use of aspirin, type 2 diabetes, hyperlipidemia (high levels of fat particles in the blood), hypokalemia (low potassium levels in the blood), major depressive disorder, hypertension, age-related physical debility and non-verbal.</p> <p>-Resident #1's Care Plan, dated 10/1/24, documented Transfers: Resident #1 requires assistance by two staff to move between surfaces, bed mobility, turning and repositioning.</p> <p>-Resident #1's quarterly MDS resident assessment, dated 9/27/24, documented the resident had unclear speech, sometimes understood, and sometimes understands others, unable to complete interview for cognitive awareness, long and short-term memory problems, severely impaired cognitive skills for daily decision making, requires two staff for bathing/showering, bed mobility, dressing, eating and transfers, incontinent, 61 inches tall and 168 pounds.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Resident #1's Nurses Notes documented the following:</p> <p>10/24/24 at 8:30 p.m. - When putting resident to bed, staff stated that resident's legs gave out and assisted her to the floor. Staff then asked nurse to assist putting resident into bed. Resident was assisted to bed by staff and nurse. Upon assessing resident, there is edema present in both lower extremities, no pain, bruising, or apparent injuries note.</p> <p>10/25/24 at 1:46 p.m. - When CNA placed resident back to bed after lunch, reported to this nurse (RN D) that resident can't bear weight during transfer. Assessment done with DON, noted left knee with reddish-purplish tender bruise with swelling. Further noted nonverbal signs of pain upon assessment, referred to PA with order to do x-ray of left hip, left femur and left knee. Notified Resident #1's POA and voiced understanding.</p> <p>10/25/24 at 1:46 p.m. - addendum - CNA B and C were the staff who transferred Resident to bed after lunch.</p> <p>10/25/24 at 3:00 p.m. - x-ray of the left hip, left femur and left knee done via portable x-ray machine. Resident tolerated the procedure.</p> <p>10/25/24 at 4:00 p.m. - notified PA of the result of the x-ray of the said sites with order to send resident to ER for further management of the findings and for CT scan of the affected parts. Notified POA again about the treatment plan and voiced understanding.</p> <p>10/25/24 at 5:00 p.m. Report given to RN, ER nurse, Resident to ER via EMS.</p> <p>Record reviewed of the Incident/Accident Report filled out by the Administrator, dated 10/31/24, reflected Resident #1, who was a two-person transfer, was transferred from her wheelchair to her bed by CNA A on 10/24/24 at approximately 8:30 p.m. Resident #1's legs gave out and she was lowered to the ground on her knees. No pain or visible injuries at that time. On 10/25/24 after lunch, the DON was notified by LVN D that Resident #1 could not bear weight on her left leg, her left knee was swollen with a large bruise on her knee and the knee was tender. X-rays were ordered and found a distal fracture of the left femur.</p> <p>During an interview on 11/6/24 at 11:00 a.m., the Administrator stated from their investigation, they determined that CNA A was transferring Resident #1 on 10/24/24 from her wheelchair to her bed and the resident's knees gave out and she was assisted to the floor. The Administrator stated when Resident #1 was put to bed on 10/25/24 by CNA B and CNA C, she was unable to bear weight on her legs and the nurse was informed of that. The Administrator stated RN D assessed her, and x-rays were ordered for Resident #1's knees and hips and a fracture was found in the distal femur of her left leg. The Administrator stated when she interviewed CNA A, the CNA said that if Resident #1 was awake, she could be a one person assist, and that was when the DON yelled at her. The Administrator stated the DON informed CNA A that Resident #1 was always a two person assist. The Administrator stated LVN E was fired because she did not report the fall to the DON or physician, did not fill out an Incident/Accident Report and did not call the family about the assisted fall. The Administrator stated Resident #1's family was not informed of the assisted fall until Resident #1 was sent to the hospital for evaluation. The Administrator stated LVN E was responsible for reporting the assisted fall to the physician, the DON, and the family.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/6/24 at 2:25 p.m., the DON stated Resident #1 had an assisted fall on 10/24/24 but it was not reported to her until around 11:00 a.m. on 10/25/24. The DON stated there was only one CNA (CNA A) transferring Resident #1 at the time and she said it was a gentle fall to her knees. The DON stated she was told that LVN E went to the room and assessed Resident #1 and they put her to bed and did small assessments during the night. The DON stated when she became aware of the assisted fall around 11:00 a. m., the following day, staff said to come to Resident #1's room and look at her legs. The DON stated Resident #1's knee on her left leg was swollen and there was a bruise as big as her knee. The DON stated that was the moment she learned the Resident #1 had an assisted fall the night before. The DON stated she palpated Resident #1's left knee and Resident #1 grimaced in pain. The DON stated she tried to reposition Resident #1 to take some pressure of the left knee and Resident #1 was grimacing in pain, so she got orders for an x-ray. The DON stated the x-ray results found a distal femur fracture close to the knee so Resident #1 was sent to the hospital for further evaluation. The DON stated she was so upset with CNA A for transferring Resident #1 by herself because no one needs to be in a hurry and staff can always wait on someone to help them transfer if the resident was a two-person transfer. The DON stated LVN E, who was an agency LVN, was given a Do Not Return (DNR) and the facility was referring her nursing license because she failed to call her, did not call the family, and did not call the doctor.</p> <p>During a telephone interview on 11/6/24 at 2:35 p.m., RN D stated she was told in report when she came on shift, CNA A was transferring Resident #1 from a wheelchair to her bed, her knees gave out and she was assisted to the floor. RN D stated LVN E told her Resident #1 had a little bruise on her left leg and she had the CNA put TED (prevent blood clots and swelling) hose on her. RN D stated after lunch, she knew something was out of alignment because Resident #1's left knee was swollen and bruised, and she was grimacing in pain. RN D stated the doctor was called, they got x-rays and sent Resident #1 to the hospital because of a distal fracture in her left knee.</p> <p>During a telephone interview on 11/6/24 at 2:45 p.m., CNA A stated she was putting Resident #1 to bed. CNA A stated she made sure Resident #1's feet were flat on the ground before she lifted her up. CNA A stated she had Resident #1 stand next to the bed and her knees buckled, she heard a crack and Resident #1 started going down. CNA A stated she had already started to pivot with Resident #1, and she felt the best thing was to slowly put her down on the floor. CNA A knew that Resident #1 was a two person assist but it was easier to put Resident #1 to bed by herself and she had been doing that all the time.</p> <p>During a telephone interview on 11/6/24 at 3:10 p.m., Resident #1's PA stated Resident #1 had several underlying comorbidities as she had severe dementia, non-verbal, high blood pressure, diabetic, and did not ambulate. The PA stated Resident #1 had a regular clinic visit on 10/22/24 and she was at her baseline. The PA stated Resident #1 was assisted to the floor on 10/24/24 but she was not made aware of Resident #1 being assisted to the floor until 10/25/24. The PA stated she was informed Resident #1 was not wanting to bear weight on her left leg. The PA stated she gave orders for Resident #1 to have her left hip, left leg and left lower leg x-rays. The PA stated there was a suspected pelvic fracture for Resident #1, but a CT scan was conducted and there was no fracture. The PA stated she needed to be contacted for any incident, fall or injury to a resident so they can get the medical attention they need right away The PA stated if Resident #1 did not have all underlying health issues, the outcome might be different. The PA stated Resident #1 has not had any changes in the past year and was always a two-person transfer or assist for everything as she was totally dependent of staff for all her care. The PA stated the fracture could have been prevented if the CNA used two people for the transfer.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of the facility policy titled, Fall Protocol, undated, documented the following:</p> <p>The established purpose of this program is to provide the highest quality of care and life attainable through the interdisciplinary efforts of the [NAME] Memorial Nursing Home Staff.</p> <p>After a fall occurs, the following protocol is to be followed:</p> <ol style="list-style-type: none"> <li>4. The charge nurse will fill out an incident report and fax to the attending physician.</li> <li>c. Notify the family,</li> <li>d. Notify the DON/ADON</li> <li>5. DON/ADON will review report,</li> <li>6. The DON/ADON will review the fall and recommend action to the nursing staff. The attending physician will be notified of recommended evaluations needed.</li> <li>6. Unwitnessed or witnessed falls:</li> </ol> <p>All falls that occur and the resident has a change of condition (such as cannot bear weight, onset of pain, etc. ) notify the attending physician by phone immediately (within 2 hours).</p> <p>This was determined to be an Immediate Jeopardy (IJ) on 11/7/24 at 4:35 p.m. The Administrator and the DON were notified. The Administrator was provided with the IJ templates on 11/7/24 at 4:35 p.m. and a request was made for a Plan of Removal.</p> <p>The following Plan of Removal was submitted by the facility and was accepted on 11/8/24 at 7:30 a.m.</p> <p>The Removal Plan for F 689</p> <p>6. Scenario: On 10/24/24 approximately around 8:30 p.m., CNA A was assisting Resident #1 from her wheelchair to the bed. CNA A stated Resident #1's knees buckles, she heard a crack, and CNA A gently lowered her to the ground on her knees. CNA A stated she was able to get Resident #1 on to her back and went to get the nurse. LVN E stated upon initial assessment, Resident #1 did not show any signs of distress, pain, or bruising. LVN E stated Resident #1 had no limited ROM to bilateral lower extremities. LVN E stated at Midnight, Resident #1's left knee had a dime size bruise. LVN E stated she palpated it and did not feel any abnormalities and Resident #1 did not grimace or show signs of pain. At 5:00 a.m., on 10/25/24, LVN E stated Resident #1 felt warm and her temperature was 99 degrees, she was given Tylenol, but continued to show no signs of pain and was resting comfortably. RN D stated after lunch on 10/25/24, she was alerted by CNA B and CNA C that Resident #1 could not bear weight on her left leg. RN D assessed Resident #1, finding swelling and a bruise approximately quarter size on her left knee, reddish-slightly purplish in color, tender with improper alignment of the left leg. RN D immediately notified DON. X-rays were ordered, finding a closed fracture of the left femur. Resident #1 was sent to the ER for further evaluation and treatment. Resident #1 was transferred to the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>7. Root Cause Analysis:</p> <p>Problem Statement: CNA A transferred Resident #1 without assistance.</p> <p>*Noncompliance with training and plan of care</p> <p>*Lack of teamwork</p> <p>-Lack of supervision</p> <p>-Lack of communication with supervisors and physician</p> <p>-Documentation issues</p> <p>*Compliance with standards</p> <p>Five Why's:</p> <p>-Why did the problem occur?</p> <p>*CNA A failed to follow plan of care and established training protocol. LVN E failed to notify DON and physician.</p> <p>*CNA A got in a hurry to perform job duties. LVN E did not think the lowering of the resident was considered a fall.</p> <p>*CNA A chose to perform the task without waiting for help to quickly be done with her duties. LVN E lack of in depth of review and assessment of what actually happened.</p> <p>*CNA A did not want to have a heavy night. LVN E chose to ignore the incident due to other duties.</p> <p>*CNA A desired down time. LVN E did not realize the severity of the incident.</p> <p>Root Cause Analysis:</p> <p>-Problem Statement: CNA A transferred Resident #1 without assistance. LVN E did not notify DON and Physician.</p> <p>* Noncompliance with training and plan of care</p> <p>*Complacency</p> <p>-Lack of supervision</p> <p>-Lack of communication and supervisors and physicians</p> <p>-Documentation Issues</p> <p>(continued on next page)</p>

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>c. CNAs and LVNs will be supervised. Charge nurses and the ADON/DON will supervise. Supervision will be continuous throughout all shifts. CNAs will follow the plan of care for each resident will utilize a second nursing staff member for 2 person transfers. LVNs will notify the DON and physician on all falls.</p> <p>d. The DON and Administrator will evaluate. The CNAs and the LVNs will be evaluated. CNAs will follow the plan of care for each resident and will utilize a second nursing staff member for 2 person transfers. LVNs will notify the DON and physician on all falls. The evaluation will occur twice a week. The changed structures and processes have been effective and efficient.</p> <p>On 11/8/24 at 8:00 a.m., the State surveyor confirmed the Plan of Removal was sufficiently implemented by:</p> <p>1. During interviews that occurred on 11/8/24 starting at 8:00 a.m. and ending at 11:30 a.m. - staff were able to describe what steps to follow when a resident was assisted to the floor. Report the assisted fall to the nurse on duty so the nurse can assess the resident for any injuries. Nursing staff stated the Administrator, the DON, and the family needed to be contacted and informed of all falls, documentation of incident will be documented in nurses' notes and an incident report for all falls. All staff stated they had been in-serviced over the Fall Protocol Policy, individual care plans are to be always followed and assisted falls were still considered falls. CNA A was contacted after the DON was notified of the assisted fall as she was not working, informed that she was suspended due to a pending investigation and was terminated the following day.</p> <p>2. Interviews conducted with staff that were working in the facility on 11/8/24: DON, ADON, CNAs B, C, G, H, and I; LVNs F, J and K.</p> <p>Telephone interviews with staff on 11/8/24:</p> <p>NA L,</p> <p>CNAs M, Q, R, S and U,</p> <p>Med Aide V,</p> <p>RNs D and N.</p> <p>LVN O and T,</p> <p>GN P (All roles and shifts were covered)</p> <p>NOTE: The following staff were contacted via email to read in-services over assisted falls, following care plans, always using two staff for 2 person transfers, Administrator and DON are notified of all falls and acknowledge that it was read and understood. Staff were scheduled off or could not get to the facility due to the severe winter weather or sickness in family.</p> <p>CNAs W, X, Y, Z, AA, BB and CC.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 26515</p> <p>Based on interviews and record review, the facility failed to ensure residents remained free from accidents, hazards and each resident received adequate supervision and assistance when being transferred for 1 of 5 residents (Resident #1) reviewed for accidents and hazards,</p> <p>CNA A failed to transfer Resident #1 using two employees as required by her care plan, which caused Resident #1 to be assisted to the floor when her legs gave out. Resident #1's assisted fall resulted in a fracture of the distal femur in the left knee.</p> <p>This deficient practice has the potential to affect all residents in the building who require assistance with transfers by 2 staff members by causing resident injuries, such as falls, fractures, and even death.</p> <p>On 11/7/24 at 4:35 p.m. an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 11/8/24 at 11:50 a.m., the facility remained out of compliance at a scope of isolated for more than minimal harm that was not Immediate Jeopardy due to the facility's continuing to monitor the implementation and effectiveness of their Plan of Removal.</p> <p>Findings included:</p> <p>Record review of Resident #1's Face Sheet documented an [AGE] year-old female was admitted to the facility on [DATE] with the following diagnoses: dementia, congestive heart failure, allergic rhinitis, vitamin deficiency, long term use of aspirin, type 2 diabetes, hyperlipidemia (high levels of fat particles in the blood), hypokalemia (low potassium levels in the blood), major depressive disorder, hypertension, age-related physical debility and non-verbal.</p> <p>-Resident #1's Care Plan, dated 10/1/24, documented Transfers: Resident #1 required assistance by two staff to move between surfaces, bed mobility, turning and repositioning.</p> <p>-Resident #1's quarterly MDS resident assessment, dated 9/27/24, documented the resident had unclear speech, sometimes understood, and sometimes understands others, unable to complete interview for cognitive awareness, long and short-term memory problems, severely impaired cognitive skills for daily decision making, requires two staff for bathing/showering, bed mobility, dressing, eating and transfers, incontinent, 61 inches tall and 168 pounds.</p> <p>-Resident #1's Nurses Notes documented the following:</p> <p>10/24/24 at 8:30 p.m. - When putting resident to bed, staff stated that resident's legs gave out and assisted her to the floor. Staff then asked nurse to assist putting resident into bed. Resident was assisted to bed by staff and nurse. Upon assessing resident, there is edema present in both lower extremities, no pain, bruising, or apparent injuries note at this time.</p> <p>10/24/24 at 8:30 p.m. - upon assessment of resident, resident shows no signs of pain, no grimacing upon palpation of extremity. No signs of bruising or injuries at this time.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>10/25/24 at 12:40 a.m. - upon assessment, resident has edema in both lower extremities. Edema from thigh to feet bilaterally. Resident voices no pain at this time. Site of edema is not warm or red at this time.</p> <p>10/25/24 at 3:51 a.m. - upon reassessment, resident continues to have edema bilaterally and now has a small bruise on the left knee. No pain, heat or redness of the extremities noted at this time.</p> <p>10/25/24 at 5:15 a.m. - upon reassessment, resident has bilateral edema. Voices no pain at this time. Resident does feel warm all over body at this time. Blood pressure within normal limits, temp 99.4, Tylenol administered. Resident does not express pain at this time.</p> <p>10/25/24 at 1:46 p.m. - When CNA placed resident back to bed after lunch, reported to this nurse (RN D) that resident can't bear weight during transfer. Assessment done with DON, noted left knee with reddish-purplish tender bruise with swelling. Further noted nonverbal signs of pain upon assessment, referred to PA with order to do x-ray of left hip, left femur and left knee. Notified Resident #1's POA and voiced understanding.</p> <p>10/25/24 at 1:46 p.m. - addendum - CNA B and C were the staff who transferred Resident to bed after lunch.</p> <p>10/25/24 at 3:00 p.m. - x-ray of the left hip, left femur and left knee done via portable x-ray machine. Resident tolerated the procedure.</p> <p>10/25/24 at 4:00 p.m. - notified PA of the result of the x-ray of the said sites with order to send resident to ER for further management of the findings and for CT scan of the affected parts. Notified POA again about the treatment plan and voiced understanding.</p> <p>10/25/24 at 5:00 p.m. Report given to RN, ER nurse, Resident to ER via EMS.</p> <p>Record reviewed of the Incident/Accident Report filled out by the Administrator, dated 10/31/24, reflected Resident #1, who was a two-person transfer, was transferred from her wheelchair to her bed by CNA A on 10/24/24 at approximately 8:30 p.m. Resident #1's legs gave out and she was lowered to the ground on her knees. No pain or visible injuries at that time. On 10/25/24 after lunch, the DON was notified by LVN D that Resident #1 could not bear weight on her left leg, her left knee was swollen with a large bruise on her knee and the knee was tender. X-rays were ordered and found a distal fracture of the left femur.</p> <p>Record review of Resident #1's emergency room notes, dated 10/25/24, revealed Resident #1 had left knee x-rays which revealed an acute fracture of the distal femoral fracture with a prior total knee arthroplasty. Resident #1 was transferred to Hospital for higher level of care.</p> <p>Record review of the receiving hospital notes, dated 10/26/24, revealed Resident #1 was an [AGE] year-old female who presented to the ER after being dropped while being moved in a nursing home that resulted in a fracture of the left femur. After discussion with the MPOA, the family decided that the patient would not be able to tolerate surgery. Family did not want her to suffer any longer and have chosen to put her in Hospice.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/6/24 at 11:00 a.m., the Administrator stated from their investigation, they determined that CNA A was transferring Resident #1 from her wheelchair to her bed and the resident's knees gave out and she was assisted to the floor. The Administrator stated LVN E assessed Resident #1 before she was moved off the floor and there were no apparent injuries at that time. The Administrator stated around midnight, a dime size bruise appeared on Resident #1's left knee, LVN E palpated it and there were no abnormalities and Resident #1 did not show any signs of pain. The Administrator state around 5:00 a.m., Resident #1 felt warm, temperature was 99.0 and LVN E gave her Tylenol. The Administrator stated at shift change, Resident #1 was not showing any signs of pain and was comfortable. The Administrator stated when Resident #1 was put to bed later that day by CNA B and CNA C, she was unable to bear weight on her legs and the nurse was informed of that. The Administrator stated RN D assessed her, and x-rays were ordered for Resident #1's knees and hips and a fracture was found in the distal femur of her left leg. The Administrator stated the emergency room felt there was a pelvic fracture, but a CT scan was conducted which ruled out the fracture. The Administrator stated when she interviewed CNA A, the CNA said that if Resident #1 was awake, she could be a one person assist, and that was when the DON yelled at her. The Administrator stated the DON informed CNA A that Resident #1 was always a two person assist. The Administrator stated LVN E was fired because she did not report the fall to the DON or physician, did not fill out an Incident/Accident Report and did not call the family about the assisted fall. The Administrator stated Resident #1's family was not informed of the assisted fall until Resident #1 was sent to the hospital for evaluation. The Administrator stated they were referring LVN E's license to the Board of Nursing.</p> <p>On 11/6/24 at 12:00 p.m., a call was placed to Resident #1's PA but the call was unsuccessful. A detailed message was left along with a call back number.</p> <p>On 11/6/24 at 12:10 p.m., a call was placed to CNA A, the CNA who transferred Resident #1 by herself, but the call was unsuccessful. A detailed message was left along with a call back number.</p> <p>On 11/6/24 at 12:15 p.m., a call was placed to LVN E, the nurse who assessed Resident #1 after her assisted fall, but the call was unsuccessful. A detailed message was left along with a call back number.</p> <p>NOTE: A call back was never received from LVN E. Record review of a Statement made by LVN E, dated 10/26/24, documented the following:</p> <p>At about 7:30 p.m. (on 10/24/24), CNA A came and got me from the nurses' station and asked if I could go help her with Resident #1. When I got to the room, CNA reported that she was helping Resident #1 to bed from wheelchair and resident's legs buckled and she guided her to her knees on the floor. The resident was lying supine on the floor. I assessed Resident #1 at bedside, and she had no bruises, no skin tears or abrasions, no markings on head. Resident #1 had no limited Range of Motion to bilateral lower extremities at this time. Resident did not show any signs of pain. Post fall assessment was completed.</p> <p>-Resident #1 did have some swelling to her lower extremities, but I also knew that she has a history of edema, so I was going to continue to monitor.</p> <p>-I assessed resident throughout the night and noticed a round midnight that she had developed a dime size bruise to her left knee. I palpated it and didn't feel any abnormalities and resident didn't grimace or show signs of pain when I touched it.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>When I did rounds about 5:00 a.m., Resident #1 felt kind of warm. She did have lots of blankets on her. I took temp and it was 99 something. We took the blankets off and I gave her Tylenol. But at this time, Resident #1 still did not show any signs of pain and was resting comfortably.</p> <p>I did not do an incident report because I honestly thought we didn't have to if it was an assisted fall and I thought as long as I continued to monitor her, I could take action if I saw a significant change in her. I did ask CNA A if she transferred Resident #1 by herself and CNA A said yes. I educated CNA A that they are never to move a two person assist resident alone.</p> <p>On 11/6/24 at 12:20 p.m., a call was placed to RN D, the nurse who found Resident #1 with a swollen and bruised left knee, but the call was unsuccessful. A detailed message was left along with a call back number.</p> <p>During an interview on 11/6/24 at 1:40 p.m., CNA B stated she took care of Resident #1 on 10/25/24, the morning after she was assisted to the floor. CNA B stated she learned in report from CNA A that she had stood Resident #1 up and her legs gave out and she was lowered to the floor. CNA B stated she was informed that LVN E had assessed Resident #1 and she did not have any injury. CNA B stated Resident #1 was always a two-person transfer with a gait belt. CNA B stated she went to Resident #1's room with CNA C to get her up for the day. CNA B stated when they pulled the covers back, Resident #1 had bruising on both of her knees, and they were slightly swollen. CNA B stated LVN E said Resident #1 was just fine. CNA B stated they got Resident #1 up and when they stood her up, Resident #1 could not bear any weight on her legs so she reported that to RN D, the nurse on duty. CNA B stated she knew something was wrong with Resident #1 when she could not stand up.</p> <p>During an interview on 11/6/24 at 2:25 p.m., the DON stated Resident #1 had an assisted fall on 10/24/24 but it was not reported to her until around 11:00 a.m. on 10/25/24. The DON stated there was only one CNA (CNA A) transferring Resident #1 at the time and she said it was a gentle fall to her knees. The DON stated she was told that LVN E went to the room and assessed Resident #1 and they put her to bed and did small assessments during the night. The DON stated when she became aware of the assisted fall around 11:00 a. m., the following day, staff said to come to Resident #1's room and look at her legs. The DON stated Resident #1's knee on her left leg was swollen and there was a bruise as big as her knee. The DON stated that was the moment she learned the Resident #1 had an assisted fall the night before. The DON stated Resident #1 always had edema to her lower extremities. The DON stated she palpated Resident #1's left knee and Resident #1 grimaced in pain. The DON stated she tried to reposition Resident #1 to take some pressure of the left knee and Resident #1 was grimacing in pain, so she got orders for an x-ray. The DON stated the x-ray results found a distal femur fracture close to the knee so Resident #1 was sent to the hospital for further evaluation. The DON stated she was so upset with CNA A for transferring Resident #1 by herself because no one needed to be in a hurry and staff can always wait on someone to help them transfer if the resident was a two-person transfer. The DON stated LVN E, who was an agency LVN, was given a Do Not Return (DNR) and the facility was referring her nursing license because she failed to call her, did not call the family, and did not call the doctor. The DON stated she felt it was funny LVN E kept assessing lower leg edema that Resident #1 always has.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 11/6/24 at 2:35 p.m., RN D called back. RN D stated she was told in report when she came on shift, CNA A was transferring Resident #1 from a wheelchair to her bed, her knees gave out and she was assisted to the floor. RN D stated LVN E told her Resident #1 had a little bruise on her left leg and she had the CNA put TED (helps prevent blood clots and swelling) hose on her. RN D stated after lunch, she knew something was out of alignment because Resident #1's left knee was swollen and bruised, and she was grimacing in pain. RN D stated the doctor was called, they got x-rays and sent Resident #1 to the hospital because of a distal fracture in her left knee.</p> <p>During a telephone interview on 11/6/24 at 2:45 p.m., CNA A, called back. CNA A stated she was putting Resident #1 to bed. CNA A stated she made sure Resident #1's feet were flat on the ground before she lifted her up. CNA A stated she had Resident #1 stand next to the bed and her knees buckled, she heard a crack and Resident #1 started going down. CNA A stated she had already started to pivot with Resident #1, and she felt the best thing was to slowly put her down on the floor. CNA A stated she got LVN E, told her what had happened, and she assessed Resident #1, who was not in pain at that time. CNA A knew that Resident #1 was a two person assist but it was easier to put Resident #1 to bed by herself and she had been doing that all the time. CNA A stated she was constantly checking on Resident #1 throughout the night and did not notice a change in her, and Resident #1 never showed any signs of pain.</p> <p>During a telephone interview on 11/6/24 at 3:10 p.m., Resident #1's PA called back. The PA stated Resident #1 had several underlying comorbidities as she had severe dementia, non-verbal, high blood pressure, diabetic, and did not ambulate. The PA stated Resident #1 had a regular clinic visit on 10/22/24 and she was at her baseline. The PA stated Resident #1 was assisted to the floor on 10/24/24 but she was not made aware of Resident #1 being assisted to the floor until 10/25/24. The PA stated she was informed Resident #1 was not wanting to bear weight on her left leg. The PA stated she gave orders for Resident #1 to have her left hip, left leg and left lower leg x-rays. The PA stated there was a suspected pelvic fracture for Resident #1, but a CT scan was conducted and there was no fracture. The PA stated she needed to be contacted for any incident, fall or injury to a resident so they can get the medical attention they need right away. The PA stated Resident #1 was stable with all her underlying health issues. The PA stated if Resident #1 did not have all underlying health issues, the outcome might be different. The PA stated Resident #1 has not had any changes in the past year and was always a two-person transfer or assist for everything as she was totally dependent of staff for all her care. The PA stated the fracture could have been prevented if the CNA used two people with the transfer.</p> <p>Record review of the facility policy titled, Accidents and Incidents - Investigating and Reporting,, revised 2017, documented the following:</p> <p>All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator.</p> <p>Record review of the facility policy titled, Fall Protocol, undated, documented the following:</p> <p>The established purpose of this program is to provide the highest quality of care and life attainable through the interdisciplinary efforts of the [NAME] Memorial Nursing Home Staff.</p> <p>After a fall occurs, the following protocol is to be followed:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>1. The charge nurse will fill out an incident report and fax to the attending physician.</p> <p>a. Notify the family,</p> <p>b. Notify the DON/ADON</p> <p>2. DON/ADON will review report,</p> <p>3. The DON/ADON will review the fall and recommend action to the nursing staff. The attending physician will be notified of recommended evaluations needed.</p> <p>6. Unwitnessed or witnessed falls:</p> <p>All falls that occur and the resident has a change of condition (such as can not bear weight, onset of pain, etc.) notify the attending physician by phone immediately (within 2 hours).</p> <p>This was determined to be an Immediate Jeopardy (IJ) on 11/7/24 at 4:35 p.m. The Administrator and DON were notified. The Administrator was provided with the IJ template on 11/7/24 at 4:35 p.m.</p> <p>The following Plan of Removal was submitted by the facility and was accepted on 11/8/24 at 7:30 a.m.</p> <p>The Removal Plan for F 689</p> <p>1. Scenario: On 10/24/24 approximately around 8:30 p.m., CNA A was assisting Resident #1 from her wheelchair to the bed. CNA A stated Resident #1's knees buckles, she heard a crack, and CNA A gently lowered her to the ground on her knees. CNA A stated she was able to get Resident #1 on to her back and went to get the nurse. LVN E stated upon initial assessment, Resident #1 did not show any signs of distress, pain, or bruising. LVN E stated Resident #1 had no limited ROM to bilateral lower extremities. LVN E stated at Midnight, Resident #1's left knee had a dime size bruise. LVN E stated she palpated it and did not feel any abnormalities and Resident #1 did not grimace or show signs of pain. At 5:00 a.m., on 10/25/24, LVN E stated Resident #1 felt warm and her temperature was 99 degrees, she was given Tylenol, but continued to show no signs of pain and was resting comfortably. RN D stated after lunch on 10/25/24, she was alerted by CNA B and CNA C that Resident #1 could not bear weight on her left leg. RN D assessed Resident #1, finding swelling and a bruise approximately quarter size on her left knee, reddish-slightly purplish in color, tender with improper alignment of the left leg. RN D immediately notified DON. X-rays were ordered, finding a closed fracture of the left femur. Resident #1 was sent to the ER for further evaluation and treatment. Resident #1 was transferred to the hospital.</p> <p>2. Root Cause Analysis:</p> <p>Problem Statement: CNA A transferred Resident #1 without assistance.</p> <p>*Noncompliance with training and plan of care</p> <p>*Lack of teamwork</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Lack of supervision</p> <p>-Lack of communication with supervisors and physician</p> <p>-Documentation issues</p> <p>*Compliance with standards</p> <p>Five Why's:</p> <p>-Why did the problem occur?</p> <p>*CNA A failed to follow plan of care and established training protocol. LVN E failed to notify DON and physician.</p> <p>*CNA A got in a hurry to perform job duties. LVN E did not think the lowering of the resident was considered a fall.</p> <p>*CNA A chose to perform the task without waiting for help to quickly be done with her duties. LVN E lack of in depth of review and assessment of what actually happened.</p> <p>*CNA A did not want to have a heavy night. LVN E chose to ignore the incident due to other duties.</p> <p>*CNA A desired down time. LVN E did not realize the severity of the incident.</p> <p>Root Cause Analysis:</p> <p>-Problem Statement: CNA A transferred Resident #1 without assistance. LVN E did not notify DON and Physician.</p> <p>* Noncompliance with training and plan of care</p> <p>*Complacency</p> <p>-Lack of supervision</p> <p>-Lack of communication and supervisors and physicians</p> <p>-Documentation Issues</p> <p>*Compliance with standards</p> <p>3. Necessary Changes:</p> <p>- Facility immediately suspended CNA A pending investigation.</p> <p>- Facility removed CNA A from working at the nursing facility.</p> <p>(continued on next page)</p>

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 11/8/24 at 8:00 a.m., the State surveyor confirmed the Plan of Removal was sufficiently implemented by:</p> <ol style="list-style-type: none"> <li>During interviews that occurred on 11/8/24 starting at 8:00 a.m. and ending at 11:30 a.m. - staff were able to describe what steps to follow when a resident was assisted to the floor. Report the assisted fall to the nurse on duty so the nurse can assess the resident for any injuries. Nursing staff stated the Administrator, DON and the family needed to be contacted and informed of all falls, documentation of incident will be documented in nurses' notes and an incident report for all falls. All staff stated they had been in-serviced over the Fall Protocol Policy, individual care plans are to be always followed and assisted falls were still considered falls. CNA A was contacted after the DON was notified of the assisted fall as she was not working, informed that she was suspended due to a pending investigation and was terminated the following day.</li> <li>Interviews conducted with staff that were working in the facility on 11/8/24: DON, ADON, CNAs B, C, G, H, and I; LVNs F, J and K.</li> </ol> <p>Telephone interviews with staff on 11/8/24:</p> <p>NA L,</p> <p>CNAs M, Q, R, S and U,</p> <p>Med Aide V,</p> <p>RNs D and N.</p> <p>LVN O and T,</p> <p>GN P, (All roles and shifts were covered)</p> <p>NOTE: The following staff were contacted via email to read in-services over assisted falls, following care plans, always using two staff for 2 person transfers, the Administrator and the DON are notified of all falls and acknowledge that it was read and understood. Staff were scheduled off or could not get to the facility due to the severe winter weather or sickness in family.</p> <p>CNAs W, X, Y, Z, AA, BB and CC.</p> <ol style="list-style-type: none"> <li>Record review of the in-service sheets reflected all staff had been trained on the facility's Plan of Removal, Fall Protocol, Policy: Lifting, Transfer, and Repositioning Policy, and Accidents and Incidents - Investigating and Reporting.</li> </ol> <p>The Administrator was informed the Immediate Jeopardy was removed on 11/8/24 at 11:50 a.m., the facility remained out of compliance at a scope of isolated for more than minimal harm that [NAME] not immediate jeopardy due to the facility's need to evaluate the effectiveness of its corrective systems.</p>		