NCHCFA
North Carolina Health Care Facilities Association

Harm and Immediate Jeopardy Issues: First Quarter 2023

NCHCFA has compiled Harm and Immediate Jeopardy data for all facilities surveyed during the first quarter of 2023. There were 16 Harm level deficiencies and 24 Immediate Jeopardies issued to facilities in this quarter. North Carolina Department of Health and Human Services, Division of Health Service Regulation cited 11 of these citations at a severity level G, 5 of those citations at a severity level H, 17 of those citations at a severity level J, and 7 at a severity level K.

There were 21 citations in January, 15 citations in February, and 4 citations in March. The Harm and Immediate Jeopardy citations were as follows:

CITATION CODE	DESCRIPTION	NUMBER OF CITATIONS
E013	Emergency Policy and Procedures	1
F689	Accidents	8
F600	Abuse	4
F550	Dignity	5
F690	Bowel/Bladder/Incontinence	1
F686	Pressure Ulcers	1
F697	Pain	2
F726	Competent Nursing Staff	1
F755	Pharmacy Services	2
F580	Notification	2
F684	Quality of Care	5
F610	Investigate Alleged Violations	2
F760	Significant Medication Error	2
F802	Sufficient Dietary Staff	1
F805	Food in form to meet needs	1
F835	Administration	1
F880	Infection Control	1

Most citations were from complaint surveys. The Division of Health Service Regulation has seen increased complaints, leading to more complaint surveys.

This report is compiled from data available through April 13, 2023, in the Quality Certification and Oversight Reports and the NCDHHS Regulated Facilities and Statement of Deficiencies websites. Summaries of the citations for First Quarter 2023 are below.

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FACILITY A (CENTRAL REGIONAL OFFICE)

E013 (EP), F600 (Neglect), F684 (Quality of Care) and F689 (Accidents)
Immediate Jeopardy was identified when the facility failed to implement emergency procedures, neglected to provide necessary services, failed to identify the seriousness of facial burns, failed to monitor a resident and provide medical intervention after a resident experienced an oxygen explosion and staff did not provide emergency first aid to the resident who sustained second and third-degree flame burns to both sides of his face, both ears, left chest, left upper arm, left forearm, and back of left hand. Facility staff did not position the resident to facilitate an open airway, attempt to provide oxygen to an oxygen dependent resident, or attempt to provide covering for a resident when the recorded low temperature was 29-degrees Fahrenheit. When EMS arrived, they observed the resident slumped over sitting in a wheelchair, unresponsive and without a pulse or respiration. EMS personnel immediately began cardiopulmonary resuscitation (CPR) once inside the ambulance. He went into cardiac arrest twice, was intubated, and became comatose. The resident later expired.

Immediate Jeopardy was also identified when the contracted facility transportation company failed to notify the facility of a resident who was observed to be smoking with an oxygen tank on his wheelchair, was in possession of cigarettes, a lighter, and repeatedly asked the driver to stop for cigarettes and coffee while en route to a physician's appointment. The resident later lit a cigarette in his room with oxygen in use and sustained second- and third-degree flame burns to both sides of his face, both ears, left chest, left upper arm, left forearm, and back of left hand. He went into cardiac arrest twice, was intubated, and became comatose. The resident later expired. In addition, the facility continued to assess a resident as safe to smoke without supervision after he was non-compliant with the facility's smoking policy.

Comments/Suggestions

- Educate all staff on the emergency preparedness plan, specifically the Fire Plan. Ensure all new staff are educated in this as well before beginning work.
- Ensure your facility is completing fire drills to ensure staff are aware of duties and responsibilities in the event of a fire.
- In the event of EMS calls for care, ensure that licensed staff attend resident until EMS arrives, continue to monitor, assess and intervene as needed.
- Educate staff on procedures for delivering emergent care as needed.
- Residents who smoke who also use oxygen must be educated on oxygen use while smoking and staff should monitor for safe smoking practices.
- The facility should ensure all residents who are safe smokers are assessed and care planned for safe smoking.
- Educate staff on smoking policies.
- Assess smoking residents for ability to safely smoke and reassess as needed.
- Facilities should reassess residents for safe smoking when smoking policies are violated. Staff should report breaches of smoking policy immediately.

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FACILITY B (WESTERN REGIONAL OFFICE)

F550 (Dignity) and F690 (Bowel/Bladder/Incontinence)
Harm was identified when the facility failed to provide enough 3x size briefs for residents who required them, resulting in residents experiencing fear of embarrassment, physical discomfort, not participating in activities, feeling upset, bothered, and crying. During this investigation, interviews with Nurse Aides revealed they were aware of the shortage of briefs and had not reported it to the Administration or central supply.

Harm was also identified for this same deficient practice when the deficient practice resulted in pain, discomfort, and reddened areas to residents' body where briefs were secured.

Comments/Suggestions

- When admitting residents, would be good to assess brief sizes to ensure accurate sizes and provide monitoring of brief supplies routinely.
- Educate staff to report any unavailable supplies to your designated staff person.
- The inventory needed supplies and brief sizes for residents and monitor availability of those needed sizes.

FACILITY C (CENTRAL AND EASTERN REGIONAL OFFICE)

F697 (Pain) and F880 (Infection Control)
Harm was identified when the facility failed to obtain and administer a controlled substance medication ordered to treat pain for a resident admitted with a recent fracture and surgical repair of her right lower leg. Failure to receive the pain medication over a 2-day period of time resulted in the resident experiencing pain rated up to "10" on a scale of 0 to 10, resulting in nausea and a significant interference with her sleep. During this investigation, nursing staff were noted to be aware of the resident's pain and aware that the needed pain medication was not available at the facility. The DON and Administrator were not made aware of the medications that were not available to treat the resident's pain.

Immediate Jeopardy was identified when the facility staff failed to disinfect a shared blood glucose meter between residents in accordance with the instructions provided by the manufacturer of the disinfectant wipes. This occurred while there was a resident with a known bloodborne pathogen in the facility. The facility was also found to fail disinfect an individually assigned glucometer for a resident diagnosed with a bloodborne pathogen. This glucometer was stored in a cloth container inside a drawer with other residents' glucometers and placed on surfaces that were not disinfected after contact. Failure to use an Environmental Protection Agency (EPA)-approved disinfectant in accordance with the manufacturer of the glucometer potentially exposes residents to the spread of blood borne infections.

Comments/Suggestions

- Shared glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure. Individual glucometers are a great idea.

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- Have extra glucometers available in your facility if possible.
- Even with individual glucometers, resident glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure.
- Review most common medications that hospitals in your area are discharging residents with. Check with your pharmacy and supplies to determine if common medications used for pain are available in your facilities.
- Have use of a backup pharmacy for needed medications.
- Educate staff on following physician orders and notifying physician and administration of unavailable medications.

FACILITY D (EASTERN REGIONAL OFFICE)

F689 (Accidents)
Harm was identified when the facility failed to provide care safely when a resident was provided with incontinence care by 1 staff assist and fell from the bed during care sustaining a 2.5-centimeter laceration to her head with bleeding and she reported pain in her back and head post fall. Resident was sent to the hospital and required 3 staples to close the laceration. State Agency evidence revealed the resident was totally dependent on two staff members for bed mobility.

Comments/Suggestions

- Educate staff on following resident care guides for needed assistance during care.
- Staff should be monitored to validate and demonstrate safe incontinent care practices.

FACILITY E (EASTERN REGIONAL OFFICE)

F550 (Dignity)
Harm was identified when the facility failed to maintain residents' dignity by failing to provide incontinence care when a nurse aide told a resident he would have to wait for care. This practice made the resident feel "embarrassed" and uncared for. The facility also failed to maintain a residents' dignity by allowing a resident to sit in a soiled brief during her meal. This practice made the resident feel like "poop" and the resident complained of being uncomfortable and burning to her skin.

Comments/Suggestions

- Initiate resident questionnaires with all alert and oriented residents regarding call bell response time and customer service.
- Educate staff on call bell response times and responding to resident request for assistance.
- Educate staff on resident dignity and rights.

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FACILITY F (EASTERN REGIONAL OFFICE)

F689 (Accidents)
Immediate Jeopardy was identified the facility failed to safely transfer a dependent resident. The resident was totally dependent for 2 staff's assistance and a mechanical lift for transfers. The resident was transferred by 2 staff members without the use of a mechanical lift. During this transfer the resident fell, and experienced pain rated a 10 out of 10, she suffered femur fractures to both legs, and she underwent two orthopedic surgeries to address the fractures. During this investigation it was determined that one of the 2 staff was aware of the required mechanical lift for transfers, but the second staff was not. The staff continued with the transfer without the use of the lift which resulted in the fall with significant injuries.

Comments/Suggestions

- Educate staff on following resident care guides for needed assistance during care and for required transfer assistance.
- Staff should be monitored to validate and demonstrate safe transfer practices.

FACILITY G (CENTRAL REGIONAL OFFICE)

F550 (Dignity)
Harm was identified when the facility failed to maintain the dignity of residents by not providing assistance with Activities of Daily Living when requested. The resident indicated she waited over 1 hour for her call bell to be answered and this made her feel ignored, bad, and resulted in the resident being tearful, and mad. State Agency evidence showed interviews with multiple staff that were aware of the residents' complaints of having to wait for long periods for ADL assistance.

Comments/Suggestions

- Initiate resident questionnaires with all alert and oriented residents regarding call bell response time and customer service.
- Educate staff on call bell response times and responding to resident request for assistance.
- Educate staff on resident dignity and rights.

FACILITY H (EASTERN REGIONAL OFFICE)

F686 (Pressure Ulcers), F697 (Pain) and F755 (Pharmacy Services)
Immediate Jeopardy was identified when the facility failed to assess and identify a Stage 4 sacral pressure ulcer. The resident was originally admitted to the facility with no pressure ulcers. At admission the resident was identified as being high risk for pressure ulcers due to immobility, skin integrity and incontinence. The resident had severe cognitive impairment and was totally dependent on staff for activities of daily living. Interventions to prevent pressure development were to do weekly skin checks and provide caution in care with resident. A stage 2 was identified approximately 2 and ½ months after admission. Ordered treatments were found to not always be completed to the wound as ordered. Measurements and skin assessments were found to not have

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been completed as planned. Approximately 4 months after admission the sacral wound was identified as a Stage 4. The sacral wound was documented as a Stage 4 with Osteomyelitis in a facility hospital discharge note. Observations during the days of the survey, the state agency's evidence showed the resident was not turned as scheduled and often was observed in the same position. Interviews with the nurse aides reported they were not always able to turn and reposition the resident as scheduled.

Harm was also identified when the facility failed to obtain and administer ordered pain medication to treat pain for a resident recently admitted with fractures to the upper and lower humerus. The resident was transferred to the hospital on 2 occasions for unmanageable pain and was treated with ordered pain medication. In the first instance, the residents pain medication was not sent to the facility and the facility used and exhausted their back up supply of the needed medication. When the pharmacy had still not sent the pain medication, the resident and family complained of uncontrolled pain for resident and asked he be sent to the emergency room for care. In a second instance, the facility ran out of pain medication and after it was not delivered by the pharmacy to the facility, the resident was sent to emergency room at his request for pain management.

Comments/Suggestions

- Review your resident with pressure ulcers or those assessed as high risk for the development of pressure ulcers to ensure treatments and interventions are provided.
- Facilities should ensure monitoring is in place for residents with wounds to include checks of the skin, changes in size and appearance or change in condition of the wound.
- Educate nurse aid staff on the importance of turning and reposition residents. Staff should be trained to report new wounds or changes in wounds to the physician.
- Educate nursing staff on administering treatments as ordered and notifying the physician of changes in wounds.
- Assess residents with ordered pain medication to ensure medications are available.
- Educate staff to check back up medications for any needed medication not available and to notify the Director of Nursing or designee when back up medications are used to replenish as needed.
- Educate staff to immediately report unavailable medications to the Physician and Administration.
- Ensure pharmacy delivers medications timely and have a plan with a backup pharmacy for medications.

FACILITY I (WESTERN REGIONAL OFFICE)

F580 (Notification), F760 (Significant Medication Error) and F755 (Pharmacy Services)
Immediate Jeopardy was identified when the facility failed to notify the physician when two medications, an intravenous (IV) antibiotic and an antiarrhythmic medication were unable to be delivered to the facility and failed to notify the physician when the medications were unable to be administered. The resident missed three doses of the IV antibiotic and four doses of the antiarrhythmic medications after admission to the facility. Additionally, the facility failed to notify the physician when the resident missed three additional doses of the IV antibiotic due to

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the antibiotic being unavailable. Interviews with nursing staff revealed they were aware of the delayed/missing medications but did not report it to the physician.

Immediate Jeopardy was also identified when the facility failed to have an effective system in place to ensure a physician ordered Intravenous (IV) antibiotic and an antiarrhythmic medication was available to administer for a resident. The resident was ordered an IV antibiotic for bacteremia and did not receive the first three doses of the antibiotic due to the medication being on order from pharmacy and not available at the facility. The resident did not receive another three doses of the IV antibiotic due to the medication being on reorder from the pharmacy and staff not checking the facility back-up safe for the medication. The resident was also ordered an antiarrhythmic medication for atrial fibrillation and did not receive the first four doses of this medication due to the medication being on order from pharmacy and not available at the facility. Interviews with nurses revealed residents not receiving their ordered medications upon admission and having to wait a day or two to receive their medications from the pharmacy was an ongoing issue, especially for residents admitted on the weekends due to the pharmacy not delivering medications on the weekends. Interviews with the nurses also revealed they did not recall checking the facility back up safe for the residents' ordered medications.

Comments/Suggestions

- Educate staff to check back up medications for any needed medication not available.
- Educate staff to immediately report unavailable medications to the Physician and Administration.
- Ensure pharmacy delivers medications timely and have a plan with a backup pharmacy for medications.
- If resident is a weekend admission, may be helpful to call the facility pharmacy in addition to using faxes as a way of communication.

FACILITY J (WESTERN REGIONAL OFFICE)

F600 (Abuse/Neglect) and F684 (Quality of Care)

Immediate Jeopardy was identified when the facility neglected to provide necessary care and services and comprehensive assessment after a resident complained of left lower pain during therapy and was assessed by the Physical Therapist who recommended an x-ray of the residents left lower extremity and spine. The x-ray results noted an acute, transverse, displaced sub capital fracture of the femoral neck. No facility staff followed up on or acknowledged the x-ray results. Two days after the x-ray, the resident continued to report pain in his left lower extremity to therapy daily refused therapy due to the severe pain. No medical evaluation or treatments were initiated until the Nurse Practitioner called the facility near midnight 4 days after the x-ray and reported the x-ray results to staff. The resident reported left hip pain and was transferred to the hospital 5 days after the x-ray and the left hip fracture required surgical intervention for repair.

Comments/Suggestions

- Ensure staff are trained and up to date and abuse and neglect policy and procedures.
- Educate staff on following up on physician orders timely to include review and reporting of any ordered x-ray or service.

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- Ensure system for reviewing x-rays that are faxed into facility for needed interventions.
- Educate staff on ensuring residents' complaints of pain are addressed timely.

FACILITY K (WESTERN REGIONAL OFFICE)

F550 (Dignity)
Harm was identified when the facility failed to maintain residents' dignity by failing to provide incontinence care. This practice made the resident feel sad and as if that had done something wrong to be treated that way. Evidence showed resident had used the call bell for assistance to be changed, a staff answered her call light stated they would be back but had not returned in over an hour.

Comments/Suggestions

- Initiate resident questionnaires with all alert and oriented residents regarding call bell response time and customer service.
- Educate staff on call bell response times and responding to resident request for assistance.
- Educate staff on resident dignity and rights.

FACILITY L (WESTERN REGIONAL OFFICE)

F802 (Sufficient Dietary Staff), F805 (Food in Form to Meet Needs) and F835 (Administration)
Immediate Jeopardy was identified when the facility failed to have effective systems in place to ensure there were dietary staff to prepare meals when dietary staff did not arrive at work. The facility also failed to provide effective leadership and oversight to ensure effective systems were in place to have trained dietary staff available to prepare meals for residents. The Central Supply Clerk and three Nurse Aides prepared breakfast, lunch, and dinner resident meals without checking the internal temperature of cooked foods before serving and did not serve resident mechanically altered diets as ordered. This led to the high likelihood for residents to be at risk of choking or aspiration.

Immediate Jeopardy was also identified when the facility failed to provide pureed foods as ordered by the physician for residents. When dietary staff did not arrive for work, a central supply clerk and three nurse aides prepared and served breakfast, lunch, and dinner to residents on pureed diets by chopping food into small pieces and not smooth consistencies. The staff had not been trained in food production and did not have skills to operate the food processor. This resulted in a high likelihood for residents to choke or aspirate.

Comments/Suggestions

- Review Dietary staff schedules for appropriate staffing.
- Educate Dietary staff on ensuring the dietary department is sufficiently staffed and appropriate food and nutritional competencies have been completed.
- Educate staff working in dietary on use of equipment for mechanically altering residents' food as needed.

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- Ensure resident specific dietary needs are available to any staff working in the kitchen.
- Educate Dietary Manager on reporting calls in to Administrator and/or designee as needed for assistance.

FACILITY M (WESTERN/CENTRAL REGIONAL OFFICE)

F689 (Accidents)
Immediate Jeopardy was identified when the facility failed to provide supervision to a resident who was confused, impulsive, unsafe, with a history of falls and at risk for further falls. The facility failed to observe the condition of the resident after an unwitnessed fall, report the observation to a nurse, provide continuous monitoring after the resident was found with his neck entrapped by a bed control cord and observed that his face was blue. The resident was found prone with his feet on the floor, with his right side against his bed. His neck was entrapped by the bed control cord that was attached to the bed and the siderail. He was found with no pulse. The resident was left in this condition when staff left the room to get help. Emergency Medical Services was called and pronounced his death in the facility.

Comments/Suggestions

- Educate staff regarding safety, resident monitoring and responding to incidents and accidents.
- Educate on the placement of call lights and bed controls to prevent fall-related incidents.
- Monitor bed controls and call light placement for potential accidents.

FACILITY N (EASTERN REGIONAL OFFICE)

F684 (Quality of Care)
Harm was identified when the facility to communicate, follow care plan interventions and physician orders regarding bowel movements. The resident was treated in the hospital for abdominal pain and constipation. State evidence showed the resident was crying, experiencing abdominal pain with distention and ordered medications and interventions were not consistently communicated and completed for the resident.

Comments/Suggestions

- Educate staff on following physician orders.
- Educate staff addressing and assessing residents' pain.
- Monitor residents for needed interventions and care related to bowel management.

FACILITY O (EASTERN/CENTRAL REGIONAL OFFICE)

F600 (Abuse) and F610 (Investigate Allegations of Abuse)
Immediate Jeopardy was identified when the facility to protect a resident's right to be free from a suspicious injury. The facility also failed to report an allegation of abuse to the administrator immediately per policy. The resident told staff he was hit in the eye and was later discovered with a bruise around the left eye. The resident who had cognitive impairment was noted with a

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reddened swollen area to his eye. In conversation with a nurse, the resident reported he was hit in the eye. The nurse did not report this conversation with the supervisor on duty or document it in the resident's chart. The following day the resident was observed with a black eye. During the facility investigation into the black eye, it was found that the resident was found the day before with a red swollen eye and had reported he had been hit. Interviews revealed the resident report of being hit was not reported and addressed until the day after he reported it.

Comments/Suggestions

- Ensure staff are trained to immediately report allegations of abuse and change in resident condition to nursing staff and administration.
- Abuse policy and procedures should be followed to include protection, investigation and reporting of all incidents.
- Ensure all staff are up to date on abuse training and monitor staff interactions with residents.
- Ensure staff are up to date on what to report, when and whom to report abuse concerns to.

FACILITY P (CENTRAL REGIONAL OFFICE)

F689 (Accidents) and F726 (Competent Nursing Staff)

Immediate Jeopardy was identified when the facility failed to transfer a resident safely from her recliner to the bathroom toilet with the assist of one while using a sit-to-stand lift. The facility also failed to provide agency Nurse Aides with orientation and training to meet individual residents' care needs, including education and verification of the NA's competency on the safe use of the facility's mechanical sit-to-stand lift. The resident experienced a fall when the nurse aide did not fasten the sling's chest support strap securely in accordance with the manufacturer's instructions and did not use the leg straps attached to the lift resulting in the resident falling from the lift to the floor. The resident was sent out to the hospital for evaluation / treatment and was found to have a right acetabular roof/iliac bone fracture and 3 lumbar vertebral fractures. The resident reported her pain level after the fall as an "8 to more than 10". Review of state evidence revealed the aid working with the resident during this incident was an agency staff who reported she did not know the specifics of caring for this resident. The evidence further revealed that some of the traps used to secure the residents during transfers were in knots and unable to be used effectively.

Comments/Suggestions

- Audit current residents requiring transfer utilizing lifts for transfer and monitor those lift transfers.
- Educate and in-services all licensed nurses and certified nursing assistants (full time, part time, prn and agency employees) on Mechanical Lift Safety Education which included education on how to use the lift, how many caregivers are required to use the lift, and what to do if there is a problem with the lift.
- Incorporate these in-services into all new hire orientation for nurses, certified nursing assistants and agency staff that are allowed to use the lift.
- Ensure staff are competent to transfer residents using lifts prior to being allowed to transfer residents with lifts.

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- Monitor lifts, slings and straps and ensure all are in good working order.

FACILITY Q (EASTERN REGIONAL OFFICE)

F689 (Accidents) and F684 (Quality of Care)
Immediate Jeopardy was identified when the facility failed to ensure a transportation driver followed emergency protocol after a resident fell from his wheelchair during van transportation. The facility also failed to ensure positioning and securement of a resident during transport was according to manufacturer's recommendations to provide safe contract van transport. The driver failed to request emergency aid and continued driving with the resident on the floor of the van. The resident had bleeding from his below the knee amputation site and pain in his right shoulder.

Comments/Suggestions

- Contact all current van transport companies used to transport facility residents to request training material and documentation of training for all van drivers utilized for facility transports.
- Ensure all transportation staff are educated in wheelchair securement and safe transport procedures.
- Ensure all staff are trained to follow emergency procedures in case of an accident.
- Monitor your facility transportation staff and transportation companies for safe transportation.

FACILITY R (EASTERN REGIONAL OFFICE)

F689 (Accidents)
Harm was identified when the facility failed to provide care in a safe manner resulting in a hematoma and a left ankle fracture for a resident. One staff was bathing the resident and changing his sheets when the resident was turned to the side and fell out of bed.

Comments/Suggestions

- Educate staff on providing supervision to prevent accidents.
- Monitor staff performing activities of daily living for safe practices.

FACILITY S (WESTERN REGIONAL OFFICE)

F550 (Dignity), F580 (Notification) and F760 (Significant Medication Error)
Harm was identified when the facility failed to treat residents in a dignified manner when staff did not provide scheduled bed baths as requested. The resident expressed feelings of being dirty, unhappy, itchy, and unclean. State Agency evidence showed interviews with staff who stated they were aware of the resident's missed baths and the resident had complaint of feeling dirty/nasty. Interviews further revealed staff to state they were often pulled to work in other areas due to staff shortages and could not complete baths as scheduled and as residents preferred. Immediate Jeopardy was identified when the facility failed to prevent a significant medication error and failed to notify the Infectious Disease Provider that was managing a resident's

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intravenous antibiotic which was being used to treat a right subdural empyema and Cerebritis that the residents peripherally inserted central catheter had become dislodged and his antibiotics were not administered as ordered. There was a high likelihood of bacterial regrowth, resistance to antibiotics, sepsis, or return to hospital due to the missed medications.

Comments/Suggestions

- Audit resident with intravenous antibiotic for following physician orders and reporting missed medications or dislodgment of PICC line to the physician immediately.
- Educate staff on requirements to notify physicians when medication cannot be administered as ordered.
- Facilities should ensure that nurses administer all medications following the physician's order.
- Educate staff on resident dignity and preferences.
- Audit residents for satisfaction with bathing activities of daily living.

FACILITY T (WESTERN REGIONAL OFFICE)

F684 (Quality of Care)

Harm was identified when the facility failed to complete a thorough assessment after a resident had an unwitnessed fall and landed on her right side. Resident was found on the floor and assisted back to bed. The resident displayed or voiced no complaints of pain but was unable to bear weight. The next day an x-ray was ordered which showed an acute right intertrochanteric fracture and the resident was transported to the emergency room for evaluation and treatment.

Comments/Suggestions

- Review resident with falls for assessment and care related to fall.
- Educate staff on post fall assessments.
- Educate staff on providing assessment of a resident after a fall even when there are no complaints of pain.

FACILITY U (WESTERN REGIONAL OFFICE)

F600 (Abuse) and F610 (Investigate Allegations of Abuse)

Harm was identified when the facility failed to protect the resident's right to be free of a suspicious injury and failed to complete a thorough investigation to determine the cause of an injury of unknown origin. A resident was discovered to have a red area below her right eye with facial swelling which progressed to bruising under both eyes and bruising in left ear. The resident was assessed as wandering in the facility. State Agency evidence showed resident spoke Spanish and was not interviewed to ask how the red area on her eye occurred. Evidence further showed the family member of the resident later asked what happened to her and the resident indicated someone threw something at her. Further evidence showed a resident reported another resident throwing something at this resident.

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Comments/Suggestions

- Review care plans of any resident who wanders into resident rooms to ensure that there are appropriate interventions in place to prevent resident to resident altercations.
- Interview residents regarding any incidents of injuries of unknown origin, to attempt to determine the cause.
- Educate staff on abuse policy and procedures, specifically investigating injuries of unknown origins.
- Monitor injuries of unknown origin for thorough investigations to determine the cause.

FACILITY V (WESTERN REGIONAL OFFICE)

F689 (Accidents)

Harm was identified when the facility failed to provide supervision to prevent a cognitively impaired resident from attacking another cognitively impaired resident in their shared bathroom which result in one of the residents having a bloody right lower lip, left nostril and left cheek. Her right wrist was swollen, bruised, and painful and required evaluation at the Emergency Room. State Agency evidence showed multiple staff were aware of the possible conflicts with the residents and had asked management not to have the residents in the same area.

Comments/Suggestions

- Complete behavior monitoring as needed for newly identified resident behaviors or any aggressive behaviors.
- Care plan for resident behaviors as appropriate.
- Provide care plan interventions to meet resident behavioral needs.
- Educate staff on de-escalating techniques with residents with aggressive behaviors.
- Monitor resident behavior assessments.

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If you have an adverse occurrence in your facility, NCHCFA recommends that the incident be immediately and thoroughly investigated and reviewed by the QA Committee. The facility should implement a QAPI plan even if the facility believes that there is no non-compliance evidence, and the facility has followed all facility policies and procedures. If a survey team identifies an instance of non-compliance, implementing the appropriate and thorough action plan may limit the time frame that the facility is determined to be out of compliance. A timely and comprehensive action plan may demonstrate that the alleged non-compliance is fully corrected and serve as evidence of past non-compliance in an immediate jeopardy situation.