STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015128	A. Building B. Wing	11/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, Moulton	300 Hospital Street Moulton, AL 35650

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44165 Based on record review, interviews, and review of a facility policy titled Patient Protection and Response Policy for Allegations/Incidents of Abuse, Neglect, Misappropriation of Property and Exploitation, the facility failed to ensure two allegations of resident-on-resident abuse were reported to the State Agency within two hours: 1) On 07/06/2022 Resident Identifier (RI) #4 was witnessed by staff slapping his/her roommate, RI #3, on the face and arm. The altercation was reported to the Director of Nursing (DON) and Abuse Coordinator/Administrator, but was not reported to the State Agency; and 2) On 07/24/2022 staff witnessed a resident-on-resident altercation between RI #4 and RI #5. This incident was also reported to the DON and Administrator/Abuse Coordinator, but was not reported to the State Agency. This deficient practice was noted with two of two abuse allegations identified while reviewing Progress Notes for three of six sampled residents reviewed for reporting requirements. Findings include: Review of a facility policy titled Patient Protection and Response Policy for Allegations/Incidents of Abuse, Neglect, Misappropriation of Property and Exploitation, revised 12/11/2017, revealed the following: . 5. IDENTIFICATION POLICY Policy Any patient event that is reported to any partner by patient, family, other partner, or any other person will be considered an allegation of . abuse . if it meets any of the following criteria: 1. Any allegation (or) indication of possible willful infliction of injury . 3. Any patient or family complaint of physical or verbal harm . resulting from the actions of others . (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	. 6. REPORTING POLICY Policy Any partner having either direct or indirect knowledge of any event that might constitute abuse . must report the event immediately, but no later than 2 hours after forming the suspicion if the events that cause the suspicion involve abuse . It is the policy of this facility that abuse allegations . are reported per Federal and State law not later than 2 hours after the allegation is made . 1) RI #3 was admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses including Alzheimer's Disease, Dementia with Behavioral Disturbance, Psychotic Disorder with Hallucinations, Psychotic Disorder with Delusions, Anxiety, Parkinson's Disease, and Neurocognitive Disorder. RI #4 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Dementia, and Adjustment Disorder with Mixed Anxiety. Review of RI #3's Progress Notes revealed the following documentation about a resident-on-resident altercation involving RI #3 and RI #4: .07/06/2022 4:28 PM cna (Certified Nursing Assistant) reported that pt (patient) and room mate (RI #3 and RI #4) . started arguing and then pt (RI #4) . slapped pt (RI #3) in the face and on the arm. DON/ ADM (Administrator) notified immediately . This entry was made by Employee Identifier (EI) #5, Registered Nurse (RN)/Charge Nurse. During an interview on 10/31/2022 at 2:52 PM, EI #5, RN/Charge Nurse, was asked if she recalled the incident on 07/06/2022 when RI #4 slapped his/her roommate, RI #3, on the face and arm. EI #5 said yes, she did recall that day, that EI #20, a Certified Nursing Assistant (CNA) told her about the altercation. EI #5 said the incident was reported to the DON (EI #4) and the Administrator/Abuse Coordinator (EI #3). EI #4, the DON, was interviewed on 10/31/2022 at 4:37 PM. When asked if she recalled the resident-on resident altercation on 07/06/2022 involving RI #3 and RI #4, EI #4 said yes, she did. EI #4 confirmed the nurse had reported the incident to her, and indicated the two residents were arguing and RI #4 hit RI #3. EI #4 stated this incident would be considered an allegation of physical abuse. When asked if the allegation of physical abuse was reported to the State Agency, EI #4 said no, but after discussing it with the surveyors, she agreed it should have been reported within two hours. EI #4 reported that EI #3, the Administrator/Abuse Coordinator, was also aware of the resident-on-resident altercation involving RI #3 and RI #4. EI #3, the Administrator/Abuse Coordinator, was interviewed on 10/31/2022 at 5:06 PM. EI #3 stated EI #5, the RN/Unit Manager, had reported the 07/06/2022 resident-on-resident altercation involving RI #3 and RI #4. EI #3 said it was reported to her that one of the residents slapped the other one on the face and arm. When asked what type of abuse this allegation would be considered, EI #3 said physical abuse. EI #3 said the allegation had not been reported to the State Agency. When asked what the facility policy said regarding the reporting of alleged abuse, EI #3 said the policy indicated allegations of abuse should be reported within no later than two hours. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) RI #4 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Dementia, and Adjustment Disorder with Mixed Anxiety. RI #5 was admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses including Alzheimer's Disease, Dementia with Behavioral Disturbance, Anxiety Disorder, Mood Disorder with Depressive Features, and Unspecified Psychosis. Review of an Event Report for RI #5 revealed the following note: 7/24/2022 . 3:15 PM I was in room next door to pt's (patient's) (RI #5's) and heard a loud noise of screaming coming from next door . Entered room . and witnessed (RI #5) slamming (his/her) rollator into (RI #4's side of w/c (wheelchair). Both were screaming at each other making verbal threats . EI #3, the Administrator/Abuse Coordinator, was interviewed on 10/31/2022 at 5:06 PM. When asked about RI #5's note dated 07/24/2022, EI #3 stated that this would be considered an allegation of abuse; however, EI #3 said they had not reported it to the State Agency. EI #3 said according to their policy, allegations of abuse should be reported within no later than two hours.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44165 Based on record review, interviews, review of the facility's Fall Prevention Program, and review of the facility's Nursing Care Policies, the facility failed to ensure Resident Identifier (RI) #1's comprehensive care plans were implemented on 09/26/2022. RI #1's plan of care for falls had an approach that guided staff to assist with transfer and locomotion. RI #1 also had a BIMS score of 9, indicating moderate cognitive impairment, and was care planned for communication problems and cognition deficits. On 9/26/2022 at approximately 1:00 PM, Employee Identifier (EI) #6, the Dietitian (RD), and EI #15, a Certified Nursing Assistant (CNA), took residents outdoors in wheelchairs while EI #9, a Registered Nurse (RN), held the door open. RI #1 self-propelled out the exit door with them. The RD told RI #1, a cognitively impaired resident with communication deficits and the need for assistance, to wait. The intent was to take the residents down a sloped sidewalk to a patio area. RI #1 wheeled him/her self out the door as the RN held the door open. RI #1 wheeled around the RD, who had another resident in a wheelchair, and down a sloped sidewalk unassisted. RI #1's wheelchair rolled down the slope, the left wheel of the wheelchair rolled off the sidewalk and overturned off the edge of the sidewalk, propelling RI #1 onto the ground face first on his/her left side on the ground. EI #6, the RD who initiated taking residents outside, did not know the level of supervision/assistance required for the residents before taking them outside an exit with a sloped sidewalk. EI #9, the RN who held open the door, said she was new, and she thought the RD was supervising the resident since she was wheeling another resident outside and asked the RN to hold the door open for them as she was returning from her lunch break. RI #1 was pronounced dead on the scene on 09/26/2022 at 1:02 PM, after being assessed by EI #16, the Medical Director, who was present at the facility when the incident occurred. This deficient practice placed RI #1, one of six sampled residents for whom care plans were reviewed, in immediate jeopardy, as it was likely to result in serious injury, serious harm, serious impairment, or death. On 11/3/2022 at 3:17 PM, the facility's Administrator (Employee Identifier (EI) #3); the Regional Administrator of the South Central Region for NHC Healthcare and member of the Governing Body (EI #1); the facility's Director of Nursing (DON, EI #4); and a Regional Nurse for NHC Healthcare (EI #2) were given a copy of the Immediate Jeopardy (IJ) template and were notified of the immediate jeopardy findings in the area of Develop/Implement Comprehensive Care Plans, F656. Findings include: Cross reference F689, F837, and F867. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The State Agency received a complaint on 10/21/2022 that alleged the complainant was a witness to an accident that caused the death of a resident of the facility, RI #1. RI #1 was witnessed on 9/26/2022, outside, rolling down an incline in a wheelchair. The complainant alleged hearing someone calling out RI #1's name over and over and that was what caught the complainant's attention. The complainant reported that RI #1's wheelchair, while rolling down the incline, went off the edge of the concrete, and RI #1's wheelchair flipped over, throwing RI #1 onto concrete, face down, about three feet from the sidewalk. Review of an undated facility document titled Fall Prevention Program revealed the following: . PURPOSE: To reduce patient's risk of falling. 3. Apply fall risk interventions as appropriate for the patient . The facility provided for review, Patient Care Policies, page 13, which documented . 4.0 NURSING POLICIES . B. The care plan serves as a guide for care decisions and is made available for use by all patient care personnel. RI #1 was admitted to the facility on [DATE] and had diagnoses to include: Epilepsy, Dementia, Osteoarthritis, Kyphosis, Contracture of the Right Hand/Second Finger, Hallux Valgus of the Left and Right foot, Presence of Artificial Eye, and History of Falling. RI #1's Care Plan for being at risk for falls related to balance problems, fall history, visual and hearing impairment, incontinence, weakness, and multiple medical problems, with a start date of 03/15/2021, documented approaches to assist with transfers and locomotion and to observe for unsafe actions and intervene. RI #1's Care Plan for cognitive deficits documented an approach dated 04/02/2021, to allow adequate time to answer and respond. RI #1's Care Plan for being at risk for having difficulty communicating related to a hearing and visual impairment, with a problem start date of 10/25/2021, documented approaches to observe for signs and symptoms of difficulty communicating and anticipate any unmet needs and to speak slowly, clearly, and to face RI #1 when talking, changing the tone of voice or repeating information as needed. Review of RI #1's most recent quarterly Minimum Data Set (MDS) assessment, dated 7/25/2022, revealed RI #1 had a Brief Interview for Mental Status (BIMS) score of nine, which indicated moderate cognitive impairment. RI #1's MDS also documented the resident required extensive, two-person assistance with bed mobility and transfer, one-person physical assistance with locomotion on the unit (his/her room and adjacent corridor on the same floor). Per this assessment, locomotion off the unit did not occur. This assessment also indicated RI #1 used a wheelchair for mobility. Review of a Patient Care Report for RI #1 from Emergency Medical Services (EMS), dated 09/26/2022, revealed EMS arrived on the scene at 1:00 PM. This report documented Cardiac Arrest prior to EMS arrival, patient dead at the scene. The report also indicated a witness at the scene said the resident fell from his/her wheelchair and lost consciousness. Per the EMS report, RI #1 had a formal DNR (Do Not Resuscitate order) and EI #16, the Medical Director, was present. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RI #1's progress note dated 9/26/2022 documented . This nurse was notified at 12:55 pm that patient had fallen out of wheelchair in back sitting area. Upon arrival and assessing patient (he/she) was found to be absent of vital signs, . Dr. (EI #16) present . A typed facility statement from EI #6, the RD, dated 9/26/2022 at 4:21 PM documented the following: On 9-26-22, . (RI #6 and another resident) told me, . (EI #6's name), that they wanted to go sit outside. I asked . (EI #4, DON), if I was allowed to take patients outside by myself. She confirmed that I could take patients outside. after lunch. I took . (RI #6 and the other resident) downstairs via the elevator. I asked a CNA to help me take one of them outside. (RI #1) was sitting inside at the doorway to the exit where the patio is located. (He/She) told me that .(he/she) wanted to go outside as well. I told . (him/her) yes . but we have to wait on someone to help you. I looked back for additional help. A nurse came to the door and offered to help us. The nurse held the door open while I exited the building with .(RI #6). As I rounded the corner about to take .(RI #6) to the patio, .(RI #1) rolled up beside me at a continual roll. I asked . (him/her) to stop and to wait just a second and that I would take . (him/her).(He/She) did not respond to me.(He/She) kept rolling forward. I could not let go of . (RI #6), because .(he/she) would have rolled forward down the hill. I again told . (RI #1) to stop . (He/She) did not respond to me. I told the CNA in front of me that . (he/she) was rolling . She was in the process of moving . (the other resident) and could not reach . (RI #1) . (RI #1) kept rolling forward down the sidewalk. The left side wheel on . (his/her) wheel chair went off the side of the side walk tipping the wheel chair over . (RI #1) fell out of the wheelchair onto . (his/her) knees and then onto . (his/her) front side of . (his/her) body. Nursing immediately came to . (his/her) side at that time. A handwritten statement dated 9/26/2022, signed by EI #9, Registered Nurse (RN), documented the following: Upon arrival back from lunch . (at approximately 12:48 PM, EI #6, RD) . was taking several pts (patients) outside to sit . (RI #1) exited door . (with EI #6) . behind . pushing a . resident . (RI #1) using . (his/her) feet began self propelling down Ramp . (EI #6) instructed pt to stop but at that time pt had fallen. I didn't witness the actual fall. Upon arrival to pt, lying face down angled on .(left) shoulder. Shallow Respirations, Non Responsive. Multiple staff arrived . A handwritten statement dated 9/26/2022, signed by EI #15, CNA, documented the following: I was rolling a patient down to the pavilion outside, and as we got to the pavilion I heard someone scream at me catch . (him/her)! Stop .(him/her)! When I turned around I saw . (RI #1) rolling rapidly down the ramp. I ran as fast as I could . by the time I got to . (him/her) . (his/her) wheelchair had already went off the side walk and lunged . (him/her) forward causing . (him/her) to land hard face first on the ground, and cause . (him/her) to fall on . (his/her) side . A typed facility statement, signed by EI #4, DON, dated 9/26/2022, documented the following: I received a phone call on my cell phone at 12:55pm from downstairs CNA . she stated I needed to hurry and come to back parking lot area . (RI #1) had fallen out of . (his/her) chair and seemed to be unresponsive. I made it downstairs at 12:58 pm, patient was laying on . (his/her) back, Paramedic on scene. I stated patient was DNR. Patient had no pulse or respirations noted . (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A facility statement, signed by EI #16, the Medical Director, dated 9/26/2022, documented the following: On 9/26/22, I was notified by DON of . (RI #1) being unresponsive and apneic after falling out of wheelchair near back patio . On arrival . (RI #1) was unresponsive no respirations/pulse . patient was noted to be DNR . rhythm checked. Rhythm was PEA . (Pulseless Electrical Activity), no spontaneous respirations, no palpable pulse, and no reflexes elicited. Patient pronounced by me at 1:02pm . A facility POST INVESTIGATION OF INCIDENTS form, with an incident date of 09/26/2022, documented RI #1 was sitting in a wheelchair at the back door leading up to the incident. The document indicated staff were inserviced to use an alternate exit when taking patients to the gazebo/pavilion area. EI #4, the DON, signed the form as complete. RI #1's care plan and approaches not being followed was not identified as a contributing factor in the incident. On 10/25/2022 at 10:29 AM, EI #6, the RD, was asked to explain the incident on 9/26/2022 involving RI #1. EI #6 stated EI #9, RN, was holding the door open while EI #15, CNA, took a resident out the door and EI #6 took RI #6. EI #6 said RI #1 was sitting inside the door looking outside. According to EI #6, the CNA and the other resident went down first and she was pushing RI #6 in a wheelchair. EI #6 said when she got to the area just at the top where it sloped down, RI #1 rolled up beside her and at that point she realized RI #1 was rolling on his/her own. EI #6 said she asked RI #1 to wait until they got the others down to the patio, and continued to call out to RI #1, but RI #1 did not acknowledge her and kept rolling down the sidewalk toward the patio. EI #6 said, she could not let go of RI #6 because RI #6 would have rolled down too. EI #6 said, EI #9 was behind her somewhere, as she was looking forward and did not exactly know where EI #9 was. EI #6 said RI #1 moved the wheelchair with his/her feet. EI #6 said, she called out to EI #15, the CNA ahead of her, but she could not get to RI #1 before the left wheel went off the side of the sidewalk and tipped the wheelchair over to the left and RI #1 fell forward onto the sidewalk, knees hitting first and RI #1 fell forward. A phone interview was conducted on 10/25/2022 at 2:22 PM with EI #9, RN. EI #9 was asked about the incident with RI #1 on 9/26/2022. EI #9 said that she was coming back from her lunch break and opened the door for EI #6 and the residents she was taking to the gazebo. She stated that EI #1 rolled himself/herself out of the door while she held the door open. She stated that she turned and went into the facility and heard EI #6 say RI #1's name and stop and she stated that was when he/she fell out of the wheelchair. RI #9 was asked, when did EI #6 ask her to assist with the residents. EI #9 stated, EI #6 did not ask her to help, EI #6 just asked her to hold the door. EI #9 was asked, who assisted RI #1 out the door. EI #9 replied, no one. EI #9 was asked, what should have happened. EI #9 replied, RI #1 should have been assisted. EI #9 was asked, what was the risk of a resident wheeling themselves down an inclined sidewalk. EI #9 replied, the risk of falls. A follow-up interview was conducted with EI #6, the RD, on 10/25/2022 at 5:35 PM. EI #6 was asked, when she was taking the residents outside did she know she would need assistance. EI #6 replied, yes that is why she asked for assistance. EI #6 was asked, why would she need assistance. EI #6 replied, to get the residents to the patio because she would not want to leave one resident on the patio by themselves and go back and get another resident. EI #6 was asked, how would other staff assist her. EI #6 replied, to help safely push them down to the patio area until she could get down there to them. EI #6 was asked, what was the risk of someone wheeling themselves down a sidewalk slope. EI #6 replied, losing control of their wheelchair. EI #6 was asked, should RI #1 have been wheeling himself/herself down the sidewalk slope by himself/herself. EI #6 replied, she did not know RI #1's abilities. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/25/2022 at 6:28 PM EI #15, CNA, was asked about the incident on 9/26/2022 with RI #1. EI #15 said, EI #6 was pushing a resident and juggling her laptop in her other hand, and she offered to help. EI #15 said EI #6 told her they were going to the patio. EI #15 said, RI #1 was sitting at the door when she went through the door outside with another resident. EI #15 said EI #9 opened the door, and she went down to the patio. EI #15 said she then heard catch him/her, catch him/her, stop him/her, stop him/her, and she looked around toward the door and saw RI #1 coming down the ramp rapidly. EI #15 said, she ran as fast as she could, but the left wheel went off of the sidewalk, and RI #1 fell face first on his/her side. On 10/27/2022 at 9:41 AM, EI #6, RD, was interviewed with follow-up questions. EI #6 was asked how she determined the risk factors for each of the residents she was taking outside. EI #6 said she did not determine individual risk factors, but more overall risk factors and she needed three staff members to get all three of them to the patio. EI #6 said she did not know the supervision requirement for RI #1 but knew the three residents she was taking outside would need supervision to go outside. EI #6 was asked when she asked EI #9 to assist RI #1 down the sloped sidewalk. EI #6 said, she never directly asked EI #9 to assist RI #1 down the slope. EI #6 also said she did not ask anyone if she could take RI #1 outside, but the nurse manager, EI #9, assisted with the door, and she knew RI #1 was going outside. When asked who she communicated with about the level of supervision required for them to go outside, EI #6 said, no one really told her a level of supervision that they needed. On 10/30/2022 at 1:12 PM, EI #16, the attending physician for RI #1, was interviewed. When asked what his understanding was of what RI #1 was doing in that area on 9/26/2022 just prior to the incident, EI #16 said, something out on the patio because it was a really nice day. EI #16 did not know who was responsible for the resident in that area at that time. EI #16 said, what could have been done differently to prevent the accident was to not use that particular exit door and to have a better way of identifying residents' assistance needs. On 11/01/2022 at 12:58 PM, a follow-up interview was conducted with EI #16. EI #16 said if RI #1 was not left unattended the fall could have been avoided. EI #16 also stated if someone was controlling the wheelchair or if someone had locked RI #1's wheelchair wheels, RI #1 would not have rolled down the sidewalk alone. When asked what should have been done differently for RI #1 in this incident, EI #16 said, clarity of communication, better organization, and dietary should be clear on the status of assistance the residents need before taking them outside. On 11/03/2022 at 8:10 AM, EI #6, the RD, was asked how she knew what assistance RI #1 needed for locomotion. EI #6 said, from general daily observations that she had observed throughout the facility. EI #6 reviewed RI #1's care plan and said, RI #1 was limited to extensive assistance with Activities of Daily Living (ADLs) related to balance problems. EI #6 said, RI #1 was assist with transfers and locomotion with assistance of one person and that meant RI #1 would need someone to assist with locomotion. EI #6 said the risk of not following the care plan to assist with locomotion was the lack of maintaining RI #1's safety at all times. On 10/31/2022 at 10:15 AM, EI #4, DON, was asked what should have been done differently when taking residents out the east exit door. EI #4 said, they should have ensured that they had the proper number of staff needed to ensure resident safety. EI #4 said, before going out the door, they should have had a staff member assisting each resident when exiting the building. EI #4 clarified that each resident should have had someone holding onto their wheelchairs. When asked what she thought caused the incident, EI #4 said, the level of assistance RI #1 required was not provided. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A follow up interview was conducted with EI #4 on 11/02/2022 at 5:41 PM. EI #4 was asked, what was the assistance level on the care plan for RI #1. EI #4 replied, limited to extensive assist. EI #4 was asked, what did limited to extensive assistance mean. EI #4 replied, assistance times one at the minimum. EI #4 was asked, why was the care plan not followed that stated to assist RI #1 with locomotion on 09/26/2022. EI #4 replied, miscommunication between two staff members. EI #4 was asked, how staff should have assisted RI #1 with locomotion on 09/26/2022. EI #4 replied, assist times one. When asked what would have assisting RI #1 with the wheelchair prevented, EI #4 said, possibly going off the sidewalk and the tipping of his/her wheelchair. EI #4 was asked, what was the risk of not following the care plan to assist with locomotion. EI #4 replied, falling. On 11/02/2022 at 4:26 PM, EI #3, the Administrator, was asked what might have gone differently if staff had followed RI #1's care plan. EI #3 said, RI #1's wheelchair might not have tipped over. EI #3 said, RI #1's care plan was not followed and there was a miscommunication between two staff members on 09/26/2022. This deficient practice was cited as a result of the investigation of complaint/report number AL00042123. ********** On 11/04/2022 at 6:55 PM, the facility submitted the following acceptable Removal Plan addressing F656: F656-Care plan 10/30/22 MDS Coordinator began in-servicing all nursing partners on how to access the care plan and to utilize it for level of assistance required for patients. 11/3/22 RN trained MDS coordinator to ensure she was competent to train partners on how to access the care plan and to utilize it for level of assistance required for patients comprehensive care plan. 11/3/22 MDS Coordinator/designee all nursing partners in-service on how to access the care plan and to utilize it for level of assistance required for patients. This in-service was provided by the MDS Coordinator . 11/3/22 Regional Nurse in-serviced DON on Patient communication tool process and identified this system to communicate individualized patient requirements related to comprehensive plan of care to ensure staff provides needed assistance/supervision to patients. 11/3/22 4pm DON trained the following designees (DHIM, WCC, UM, ADON, RN) on Patient communication tool process this is a system to communicate individualized patient requirements related to comprehensive plan of care to ensure staff provides needed assistance/supervision to patients. The DON and designees (DHIM WCC, UM, ADON, RN) immediately began in-servicing all partners on utilizing PCT/Care plan to provide care based on patients' requirements - person centered care. This training will be provided by the next worked shift for all partners prior to the next shift worked. (continued on next page)

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	015128	A. Building B. Wing	11/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, Moulton	300 Hospital Street Moulton, AL 35650

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Inservice included: The PCT should contain the following information ACL, developmental age comparison, BATF, preferred name, interests, care approaches, and abilities considering activities from all disciplines i.e. feeding, dressing, ambulation, transfers, communication. All partners have access to the patient communication tool. This tool provides all partners with the ability to know what type of assistance, cognitive abilities, and equipment the patient requires. Be sure to utilize this tool to assist patients or to notify the nurse should you notice a change in the patient. If you have questions, please see the nurse. If you do not know or have questions about the needs of a patient, ask the nurse prior to assisting any patient. 11/3/22 Reviewed/revised all patient care plans to ensure patients locomotion and transfer assistance was reflected in care plan. This was completed by Regional Nurse and Assistant Regional nurse by 10pm (11/3/22). 11/3/22 Administrator designated nursing leadership to review/update all patients' PCTs according to the PCT process . completed 11/3/22 10pm Contents will be completed and immediacy will be removed on 11/3/22 After reviewing the facility's information provided in their Removal Plan and verifying the immediate actions had been implemented, the scope/severity level of F656 was lowered to a D level on 11/03/2022, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44165 Based on observation, record review, interviews, review of the facility's investigative file related to a fall involving Resident Identifier (RI) #1, review of Patient Care Policies and review of the facility's policy titled SUBJECT: Incident and Accident Process, the facility failed to provide needed assistance and/or supervision to RI #1, a resident in a wheelchair, to prevent an accident outdoors at the facility on 09/26/2022. RI #1's plan of care for falls had an approach that guided staff to assist with transfer and locomotion. RI #1 also had a BIMS score of 9, indicating moderate cognitive impairment, and was care planned for communication problems and cognition deficits. On 9/26/2022 at approximately 1:00 PM, Employee Identifier (EI) #6, the Dietitian (RD), and EI #15, a Certified Nursing Assistant (CNA), took residents outdoors in wheelchairs while EI #9, a Registered Nurse (RN), held the door open. RI #1 self-propelled out the exit door with them. The RD told RI #1, a cognitively impaired resident with communication deficits and the need for assistance, to wait. The intent was to take the residents down a sloped sidewalk to a patio area. RI #1 wheeled him/her self out the door as the RN held the door open. RI #1 wheeled around the RD, who had another resident in a wheelchair, and down a sloped sidewalk unassisted. RI #1's wheelchair rolled down the slope, the left wheel of the wheelchair rolled off the sidewalk and overturned off the edge of the sidewalk, propelling RI #1 onto the ground face first on his/her left side on the ground. EI #6, the RD who initiated taking residents outside, did not know the level of supervision/assistance required for the residents before taking them outside an exit with a sloped sidewalk. EI #9, the RN who held open the door, said she was new, and she thought the RD was supervising the resident since she was wheeling another resident outside and asked the RN to hold the door open for them as she was returning from her lunch break. RI #1 was pronounced dead on the scene on 09/26/2022 at 1:02 PM, after being assessed by EI #16, the Medical Director, who was present at the facility when the incident occurred. This deficient practice placed RI #1, one of three sampled residents reviewed for accidents, in immediate jeopardy, as it was likely to result in serious injury, serious harm, serious impairment, or death. On 11/3/2022 at 3:17 PM, the facility's Administrator (Employee Identifier (EI) #3); the Regional Administrator of the South Central Region for NHC Healthcare and member of the Governing Body (EI #1); the facility's Director of Nursing (DON, EI #4); and a Regional Nurse for NHC Healthcare (EI #2) were given a copy of the Immediate Jeopardy (IJ) template and were notified of the findings of substandard quality of care at the IJ level in the area of Accident Hazards/Supervision/Devices, F689. Findings include: Cross reference F656, F837, and F867. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The State Agency received a complaint on 10/21/2022 that alleged the complainant was a witness to an accident that caused the death of a resident of the facility, RI #1. RI #1 was witnessed on 9/26/2022, outside, rolling down an incline in a wheelchair. The complainant alleged hearing someone calling out RI #1's name over and over and that was what caught the complainant's attention. The complainant reported that RI #1's wheelchair, while rolling down the incline, went off the edge of the concrete, and RI #1's wheelchair flipped over, throwing RI #1 onto concrete, face down, about three feet from the sidewalk. Review of an undated facility document titled Fall Prevention Program revealed the following: . PURPOSE: To reduce patient's risk of falling. 3. Apply fall risk interventions as appropriate for the patient . The facility provided for review, Patient Care Policies, page 13, which documented . 4.0 NURSING POLICIES . B. The care plan serves as a guide for care decisions and is made available for use by all patient care personnel. RI #1 was admitted to the facility on [DATE] and had diagnoses to include: Epilepsy, Dementia, Osteoarthritis, Kyphosis, Contracture of the Right Hand/Second Finger, Hallux Valgus of the Left and Right foot, Presence of Artificial Eye, and History of Falling. RI #1's Care Plan for being at risk for falls related to balance problems, fall history, visual and hearing impairment, incontinence, weakness, and multiple medical problems, with a start date of 03/15/2021, documented approaches to assist with transfers and locomotion and to observe for unsafe actions and intervene. RI #1's Care Plan for cognitive deficits documented an approach dated 04/02/2021, to allow adequate time to answer and respond. RI #1's Care Plan for being at risk for having difficulty communicating related to a hearing and visual impairment, with a problem start date of 10/25/2021, documented approaches to observe for signs and symptoms of difficulty communicating and anticipate any unmet needs and to speak slowly, clearly, and to face RI #1 when talking, changing the tone of voice or repeating information as needed. Review of RI #1's most recent quarterly Minimum Data Set (MDS) assessment, dated 7/25/2022, revealed RI #1 had a Brief Interview for Mental Status (BIMS) score of nine, which indicated moderate cognitive impairment. RI #1's MDS also documented the resident required extensive, two-person assistance with bed mobility and transfer, one-person physical assistance with locomotion on the unit (his/her room and adjacent corridor on the same floor). Per this assessment, locomotion off the unit did not occur. This assessment also indicated RI #1 used a wheelchair for mobility. Review of a Patient Care Report for RI #1 from Emergency Medical Services (EMS), dated 09/26/2022, revealed EMS arrived on the scene at 1:00 PM. This report documented Cardiac Arrest prior to EMS arrival, patient dead at the scene. The report also indicated a witness at the scene said the resident fell from his/her wheelchair and lost consciousness. Per the EMS report, RI #1 had a formal DNR (Do Not Resuscitate order) and EI #16, the Medical Director, was present. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RI #1's progress note dated 9/26/2022 documented . This nurse was notified at 12:55 pm that patient had fallen out of wheelchair in back sitting area. Upon arrival and assessing patient (he/she) was found to be absent of vital signs, . Dr. (EI #16) present . A typed facility statement from EI #6, the RD, dated 9/26/2022 at 4:21 PM documented the following: On 9-26-22, . (RI #6 and another resident) told me, . (EI #6's name), that they wanted to go sit outside. I asked . (EI #4, DON), if I was allowed to take patients outside by myself. She confirmed that I could take patients outside. after lunch. I took . (RI #6 and the other resident) downstairs via the elevator. I asked a CNA to help me take one of them outside. (RI #1) was sitting inside at the doorway to the exit where the patio is located. (He/She) told me that .(he/she) wanted to go outside as well. I told . (him/her) yes . but we have to wait on someone to help you. I looked back for additional help. A nurse came to the door and offered to help us. The nurse held the door open while I exited the building with .(RI #6). As I rounded the corner about to take .(RI #6) to the patio, .(RI #1) rolled up beside me at a continual roll. I asked . (him/her) to stop and to wait just a second and that I would take . (him/her).(He/She) did not respond to me.(He/She) kept rolling forward. I could not let go of . (RI #6), because .(he/she) would have rolled forward down the hill. I again told . (RI #1) to stop . (He/She) did not respond to me. I told the CNA in front of me that . (he/she) was rolling . She was in the process of moving . (the other resident) and could not reach . (RI #1) . (RI #1) kept rolling forward down the sidewalk. The left side wheel on . (his/her) wheel chair went off the side of the side walk tipping the wheel chair over . (RI #1) fell out of the wheelchair onto . (his/her) knees and then onto . (his/her) front side of . (his/her) body. Nursing immediately came to . (his/her) side at that time. A handwritten statement dated 9/26/2022, signed by EI #9, Registered Nurse (RN), documented the following: Upon arrival back from lunch . (at approximately 12:48 PM, EI #6, RD) . was taking several pts (patients) outside to sit . (RI #1) exited door . (with EI #6) . behind . pushing a . resident . (RI #1) using . (his/her) feet began self propelling down Ramp . (EI #6) instructed pt to stop but at that time pt had fallen. I didn't witness the actual fall. Upon arrival to pt, lying face down angled on .(left) shoulder. Shallow Respirations, Non Responsive. Multiple staff arrived . A handwritten statement dated 9/26/2022, signed by EI #15, CNA, documented the following: I was rolling a patient down to the pavilion outside, and as we got to the pavilion I heard someone scream at me catch . (him/her)! Stop .(him/her)! When I turned around I saw . (RI #1) rolling rapidly down the ramp. I ran as fast as I could . by the time I got to . (him/her) . (his/her) wheelchair had already went off the side walk and lunged . (him/her) forward causing . (him/her) to land hard face first on the ground, and cause . (him/her) to fall on . (his/her) side . A typed facility statement, signed by EI #4, DON, dated 9/26/2022, documented the following: I received a phone call on my cell phone at 12:55pm from downstairs CNA . she stated I needed to hurry and come to back parking lot area . (RI #1) had fallen out of . (his/her) chair and seemed to be unresponsive. I made it downstairs at 12:58 pm, patient was laying on . (his/her) back, Paramedic on scene. I stated patient was DNR. Patient had no pulse or respirations noted . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A facility statement, signed by EI #16, the Medical Director, dated 9/26/2022, documented the following: On 9/26/22, I was notified by DON of . (RI #1) being unresponsive and apneic after falling out of wheelchair near back patio . On arrival . (RI #1) was unresponsive no respirations/pulse . patient was noted to be DNR . rhythm checked. Rhythm was PEA . (Pulseless Electrical Activity), no spontaneous respirations, no palpable pulse, and no reflexes elicited. Patient pronounced by me at 1:02pm . A facility POST INVESTIGATION OF INCIDENTS form, with an incident date of 09/26/2022, documented RI #1 was sitting in a wheelchair at the back door leading up to the incident. The document indicated staff were inserviced to use an alternate exit when taking patients to the gazebo/pavillion area. EI #4, the DON, signed the form as complete. RI #1's care plan and approaches not being followed was not identified as a contributing factor in the incident. On 10/25/2022 at 10:29 AM, EI #6, the RD, was asked to explain the incident on 9/26/2022 involving RI #1. EI #6 stated EI #9, RN, was holding the door open while EI #15, CNA, took a resident out the door and EI #6 took RI #6. EI #6 said RI #1 was sitting inside the door looking outside. According to EI #6, the CNA and the other resident went down first and she was pushing RI #6 in a wheelchair. EI #6 said when she got to the area just at the top where it sloped down, RI #1 rolled up beside her and at that point she realized RI #1 was rolling on his/her own. EI #6 said she asked RI #1 to wait until they got the others down to the patio, and continued to call out to RI #1, but RI #1 did not acknowledge her and kept rolling down the sidewalk toward the patio. EI #6 said, she could not let go of RI #6 because RI #6 would have rolled down too. EI #6 said, EI #9 was behind her somewhere, as she was looking forward and did not exactly know where EI #9 was. EI #6 said RI #1 moved the wheelchair with his/her feet. EI #6 said, she called out to EI #15, the CNA ahead of her, but she could not get to RI #1 before the left wheel went off the side of the sidewalk and tipped the wheelchair over to the left and RI #1 fell forward onto the sidewalk, knees hitting first and RI #1 fell forward. A phone interview was conducted on 10/25/2022 at 2:22 PM with EI #9, RN. EI #9 was asked about the incident with RI #1 on 9/26/2022. EI #9 said that she was coming back from her lunch break and opened the door for EI #6 and the residents she was taking to the gazebo. She stated that EI #1 rolled himself/herself out of the door while she held the door open. She stated that she turned and went into the facility and heard EI #6 say RI #1's name and stop and she stated that was when he/she fell out of the wheelchair. RI #9 was asked, when did EI #6 ask her to assist with the residents. EI #9 stated, EI #6 did not ask her to help, EI #6 just asked her to hold the door. EI #9 was asked, who assisted RI #1 out the door. EI #9 replied, no one. EI #9 was asked, what should have happened. EI #9 replied, RI #1 should have been assisted. EI #9 was asked, what was the risk of a resident wheeling themselves down an inclined sidewalk. EI #9 replied, the risk of falls. A follow-up interview was conducted with EI #6, the RD, on 10/25/2022 at 5:35 PM. EI #6 was asked, when she was taking the residents outside did she know she would need assistance. EI #6 replied, yes that is why she asked for assistance. EI #6 was asked, why would she need assistance. EI #6 replied, to get the residents to the patio because she would not want to leave one resident on the patio by themselves and go back and get another resident. EI #6 was asked, how would other staff assist her. EI #6 replied, to help safely push them down to the patio area until she could get down there to them. EI #6 was asked, what was the risk of someone wheeling themselves down a sidewalk slope. EI #6 replied, losing control of their wheelchair. EI #6 was asked, should RI #1 have been wheeling himself/herself down the sidewalk slope by himself/herself. EI #6 replied, she did not know RI #1's abilities. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/25/2022 at 6:28 PM EI #15, CNA, was asked about the incident on 9/26/2022 with RI #1. EI #15 said, EI #6 was pushing a resident and juggling her laptop in her other hand, and she offered to help. EI #15 said EI #6 told her they were going to the patio. EI #15 said, RI #1 was sitting at the door when she went through the door outside with another resident. EI #15 said EI #9 opened the door, and she went down to the patio. EI #15 said she then heard catch him/her, catch him/her, stop him/her, stop him/her, and she looked around toward the door and saw RI #1 coming down the ramp rapidly. EI #15 said, she ran as fast as she could, but the left wheel went off of the sidewalk, and RI #1 fell face first on his/her side. On 10/27/2022 at 9:41 AM, EI #6, RD, was interviewed with follow-up questions. EI #6 was asked how she determined the risk factors for each of the residents she was taking outside. EI #6 said she did not determine individual risk factors, but more overall risk factors and she needed three staff members to get all three of them to the patio. EI #6 said she did not know the supervision requirement for RI #1 but knew the three residents she was taking outside would need supervision to go outside. When asked why she chose to use that particular exit, EI #6 said, it was the only exit she had used to get to the patio. EI #6 was asked when she asked EI #9 to assist RI #1 down the sloped sidewalk. EI #6 said, she never directly asked EI #9 to assist RI #1 down the slope. EI #6 also said she did not ask anyone if she could take RI #1 outside, but the nurse manager, EI #9, assisted with the door, and she knew RI #1 was going outside. When asked who she communicated with about the level of supervision required for them to go outside, EI #6 said, no one really told her a level of supervision that they needed. On 10/28/2022 at 3:00 PM, observations and measurements were made outside of the East exit door that was used at the time of the incident. From the exit door to the right side, where the sidewalk began to slope was measured to be nine feet. The sloped section of the sidewalk was measured to be 288 inches long, with a drop in elevation of 10.5 inches over that distance. On 10/30/2022 at 1:12 PM, EI #16, the attending physician for RI #1, was interviewed. When asked what his understanding was of what RI #1 was doing in that area on 9/26/2022 just prior to the incident, EI #16 said, something out on the patio because it was a really nice day. EI #16 did not know who was responsible for the resident in that area at that time. EI #16 said, what could have been done differently to prevent the accident was to not use that particular exit door and to have a better way of identifying residents' assistance needs. On 11/01/2022 at 12:58 PM, a follow-up interview was conducted with EI #16. EI #16 said if RI #1 was not left unattended the fall could have been avoided. EI #16 also stated if someone was controlling the wheelchair or if someone had locked RI #1's wheelchair wheels, RI #1 would not have rolled down the sidewalk alone. When asked what should have been done differently for RI #1 in this incident, EI #16 said, clarity of communication, better organization, and dietary should be clear on the status of assistance the residents need before taking them outside. On 11/03/2022 at 8:10 AM, EI #6, the RD, was asked how she knew what assistance RI #1 needed for locomotion. EI #6 said, from general daily observations that she had observed throughout the facility. EI #6 reviewed RI #1's care plan and said, RI #1 was limited to extensive assistance with Activities of Daily Living (ADLs) related to balance problems. EI #6 said, RI #1 was assist with transfers and locomotion with assistance of one person and that meant RI #1 would need someone to assist with locomotion. EI #6 said the risk of not following the care plan to assist with locomotion was the lack of maintaining RI #1's safety at all times. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/31/2022 at 10:15 AM, EI #4, DON, was asked what should have been done differently when taking residents out the east exit door, EI #4 said, they should have ensured that they had the proper number of staff needed to ensure resident safety. EI #4 said, before going out the door, they should have had a staff member assisting each resident when exiting the building. EI #4 clarified that each resident should have had someone holding onto their wheelchairs. EI #4 said, the difference in East and South exits was that the East exit had an incline in the sidewalk and South did not have an incline. When asked what should have been done to keep RI #1 from rolling down the sidewalk, EI #4 said, someone holding the wheelchair. When asked what she thought caused the incident, EI #4 said, the level of assistance RI #1 required was not provided. A follow up interview was conducted with EI #4 on 11/02/2022 at 5:41 PM. EI #4 was asked, what was the assistance level on the care plan for RI #1. EI #4 replied, limited to extensive assist. EI #4 was asked, what did limited to extensive assistance mean. EI #4 replied, assistance times one at the minimum. EI #4 was asked, why was the care plan not followed that stated to assist RI #1 with locomotion on 09/26/2022. EI #4 replied, miscommunication between two staff members. EI #4 was asked, how staff should have assisted RI #1 with locomotion on 09/26/2022. EI #4 replied, assist times one. When asked what would have assisting RI #1 with the wheelchair prevented, EI #4 said, possibly going off the sidewalk and the tipping of his/her wheelchair. EI #4 was asked, what was the risk of not following the care plan to assist with locomotion. EI #4 replied, falling. On 11/02/2022 at 5:59 PM, EI #4 was asked to clarify what she meant by miscommunication between two staff members. EI #4 said, EI #9 thought EI #6 was assisting RI #1, and EI #6 assumed RI #9 was assisting RI #1 on 9/26/2022 at the time they went outside. On 11/02/2022 at 4:26 PM, EI #3, the Administrator, was asked what might have gone differently if staff had followed the care plan to assist RI #1 with locomotion. EI #3 said, RI #1's wheelchair might not have tipped over. EI #3 said, RI #1's care plan was not followed and there was a miscommunication between two staff members on 09/26/2022. This deficient practice was cited as a result of the investigation of complaint/report number AL00042123. ********** On 11/04/2022 at 6:55 PM, the facility submitted the following acceptable Removal Plan addressing F689: F689 9/26/22 Incident occurred at 12:55pm 9/26/22 Administrator assessed the East Hall exit to begin the investigation into what happened. Administrator immediately stopped use of east hall exit for patient use. Administrator notified all partners in building at the time not to use door on east hall downstairs. 9/26/22, RN- RD, CNA sent home at 2:18pm pending an investigation by the Administrator after discussion with the Regional Administrator and Regional Nurse. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	9/26/22 POC was written by DON to include supervision of patients with cognitive impairments with a BIMS below 12. As DON/administrators immediate investigation indicated that this patient's BIMS was a risk. Identified patient had not been supervised and implemented immediate action to prevent patients requiring supervision to be left unattended. DON began inservicing all partners regarding patients with cognitive impairments are to be supervised when taken outside. 9/26/22 4pm DON (director of nursing) completed in-servicing with partners regarding patients with cognitive impairments are to be supervised when taken outside. 100% of partners in-serviced regarding cognitive impaired patients being supervised while outdoors and not utilizing East Hall exit door by 10/3/22. 9/27/22 Untoward event completed by DON to initiate the QAPI process for root cause analysis related to the incident. 9/27/22- RN-, RD, & CNA from incident, were individually in-serviced before start of next shift by the DON regarding supervising patients with cognitive impairments when assisting them outside. 9/28/22 DON initiated QA monitors on partners that had completed the training since 9/26/22 to ensure they knew what patients needed assistance to go outside. This began weekly starting 9/28/22 to 10/18/2022 this QA monitor was completed to ensure training on 9/26 (ended 10/3) was effective and was part of the POC to monitor 2 partners per week for 4 weeks. 10/18/22 100% of partners monitored were able to verbalize correct procedure regarding cognitively impaired patients being supervised outside and not using the east hall door. 10/20/22 QAPI meeting held. Discussion included incident and presented plan of correction. 10/30/22 began to 11/3/22 (completed) MDS Coordinator began an in-service for all nursing partners on how to access the care plan and to utilize it to provide the level of assistance required. 11/3/22 MDS Coordinator & DON completed all nursing partners in-services on how to access the care plan and to utilize it to provide the level of assistance required . 11/3/22 Regional Nurse in-serviced DON on Patient communication tool process and identified this system to communicate individualized patient requirements related to comprehensive plan of care to ensure facility staff provides needed assistance/supervision to residents. 11/3/22 All patients will be reviewed by DON or designee to ensure they have a PCT that accurately states level of assistance/supervision and locomotion including but not limited to when in hazardous areas of the facility premises 11/3/22. (continued on next page)

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	015128	A. Building B. Wing	11/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, Moulton	300 Hospital Street Moulton, AL 35650

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	11/3/22 4pm DON/designee(DHIM, WCC, UM, ADON, RN) began in-servicing all partners/all disciplines on utilizing PCT/care plan to provide care based on patient requirements - person centered care. This training will be provided for all facility staff before the start of the next scheduled shift. The inservice provides the partners information to provide patient centered care including what level of cognition and assistance the patient requires to prevent incidents of this nature from occurring again. This included training on regarding ensuring needs are communicated properly and thoroughly to other staff when working together to provide care for patients. Ensure that every patient has adequate supervision to accomplish needs tasks through thorough communication. Patient needs and supervision levels can be found on the care plan, PCT or by asking their nurse. This was completed 11/3/22 100% of all disciplines received this training. Inservice included: The PCT should contain the following information ACL, developmental age comparison, BATF, preferred name, interests, care approaches, and abilities considering activities from all disciplines i.e. feeding, dressing, ambulation, transfers, communication. All partners have access to the patient communication tool. This tool provides all partners with the ability to know what type of assistance, cognitive abilities, and equipment the patient requires. Be sure to utilize this tool to assist patients or to notify the nurse should you notice a change in the patient. If you have questions, please see the nurse. If you do not know or have questions about the needs of a patient, ask the nurse prior to assisting any patient. 11/3/22 RD was inserviced by administrator regarding ensuring needs are communicated properly and thoroughly to other staff when working together to provide care for patients. Ensure that every patient has adequate supervision to accomplish needs tasks through thorough communication. Patient needs and supervision levels can be found on the care plan, PCT or by asking their nurse. 11/4/22 10am bright yellow sign posted on East Hall exit door at standing eye level as well as seated eye level by Administrator that patients do not use this door. 11/4/22 2:30pm Administrator or designee (ADON, RD, ICP, UM) providing education to all patients regarding not using East Hall downstairs exit. 11/4/22 ADON, RD, UM, ICP called all family members of patients who are not cognitively intact to notify them that the East hall door should not be used for patients and to use the south hall entrance. A copy of the sign and map showing what door not to use and what door to use to enter downstairs was placed in all patient rooms. Ongoing purposes this will be placed in admission packet starting 11/4/22 Contents will be completed and immediacy will be removed on 11/4/2022 After reviewing the facility's information provided in their Removal Plan and verifying the immediate actions had been implemented, the scope/severity level of F689 was lowered to a D level on 11/04/2022, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44165 Based on interviews and review of the facility's Quality Assurance and Performance Improvement (QAPI) Manual, Subject: COMMITTEE MEMBERSHIP and Subject: GOVERNANCE AND LEADERSHIP, the governing body failed to provide oversight to the facility on the investigation and plans of action developed in QAPI, addressing Resident Identifier (RI) #1's accident on 9/26/2022 when RI #1's plans of care were not followed, and RI #1 was not provided assistance or supervision in accordance with his/her care plan. On 9/26/2022 at approximately 1:00 PM, Employee Identifier (EI) #6, the Dietitian (RD), and EI #15, a Certified Nursing Assistant (CNA), took residents outdoors in wheelchairs while EI #9, a Registered Nurse (RN), held the door open. RI #1 self-propelled out the exit door with them. The RD told RI #1, a cognitively impaired resident with communication deficits and the need for assistance, to wait. The intent was to take the residents down a sloped sidewalk to a patio area. RI #1 wheeled him/her self out the door as the RN held the door open. RI #1 wheeled around the RD, who had another resident in a wheelchair, and down a sloped sidewalk unassisted. RI #1's wheelchair rolled down the slope, the left wheel of the wheelchair rolled off the sidewalk and overturned off the edge of the sidewalk, propelling RI #1 onto the ground face first on his/her left side on the ground. EI #6, the RD who initiated taking residents outside, did not know the level of supervision/assistance required for the residents before taking them outside an exit with a sloped sidewalk. EI #9, the RN who held open the door, said she was new, and she thought the RD was supervising the resident since she was wheeling another resident outside and asked the RN to hold the door open for them as she was returning from her lunch break. RI #1 was pronounced dead on the scene on 09/26/2022 at 1:02 PM, after being assessed by EI #16, the Medical Director, who was present at the facility when the incident occurred. This deficient practice placed all 114 residents residing in the facility in immediate jeopardy, as it was likely to result in serious injury, serious harm, serious impairment, or death. On 11/3/2022 at 3:17 PM, the facility's Administrator (Employee Identifier (EI) #3); the Regional Administrator of the South Central Region for NHC Healthcare and member of the facility's Governing Body (EI #1); the facility's Director of Nursing (EI #4); and a Regional Nurse for NHC Healthcare (EI #2) were given a copy of the Immediate Jeopardy (IJ) template and were notified of the immediate jeopardy findings in the area 483. 70 Administration, at F837-Governing Body. Findings include: During the survey it was found that RI #1, a cognitively impaired resident with communication deficits and the need for staff assistance, sustained an accident on 09/26/2022 while going outside with facility staff unassisted. RI #1 was pronounced dead on the scene on 09/26/2022 at 1:02 PM, after being assessed by EI #16, the Medical Director, who was present at the facility when the incident occurred. Cross Reference F656, F689, and F867. Review of the facility's QAPI Manual, Subject: COMMITTEE MEMBERSHIP, dated 01/01/2006, revealed the following: (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	.COMMUNICATION TO GOVERNING BODY: The Administrator and Medical Director are to review and approve each month's committee minutes. In addition, copies of the Quality Assurance and Process Improvement Committee minutes are to be sent to the Regional QAPI Coordinator to review and discuss on a regional level . Regional QAPI Coordinators should forward to the NHC Quality Review Committee those reports which indicated the need for policy revision, practice change or other issues requiring attention . Further review of the facility's QAPI Manual, Subject: GOVERNANCE AND LEADERSHIP, revised 09/13/2022, revealed the following: . The QAPI Committee will report to the following groups as indicated: Regional staff monthly Corporate staff through established routes monthly . Copies of the QAPI Committee Minutes with all attachments are to be forwarded to the Regional Nurse . On 11/03/2022 at 10:54 AM an interview was conducted with EI #1, Regional Administrator of the South Central Region of NHC Healthcare and a member of the facility's governing body. EI #1 was asked when he was notified about the incident involving RI #1. EI #1 replied, he was notified per phone by EI #3, the Administrator, on 09/26/2022. EI #1 did not recall the exact time. EI #1 was asked what conversations he had and what feedback he provided to the facility regarding their investigation into the incident. EI #1 said they discussed it during the phone call on 09/26/2022, and he knew they had developed an action plan as a result of the incident. When asked where their conversation would be documented, EI #1 said he had not documented anything. EI #1 said the documentation would be up to EI #3, the Administrator, since she was the one responsible for the day-to-day operations of the facility. EI #1 went on to say that during the survey process, he became aware of a gap in the facility's investigation into the incident. EI #1 was asked, why following the care plan was not addressed in QAPI or in the action plan developed by the facility. EI #1 replied, he could not say. EI #1 was asked, why he did not identify not following the care plan as a causal factor during the facility's initial investigation into the incident. EI #1 replied, he could not say why it was not identified in the initial investigation. He was relying on the information provided to him. (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 11/03/2022 at 11:43 AM an interview was conducted with EI #2, Regional Nurse. EI #2 was asked, what was her involvement with the investigation into the incident involving RI #1. EI #2 replied, she was notified by EI #4, the Director of Nursing (DON) on 9/26/2022, and EI #3 and EI #4 started the investigation. EI #2 stated EI #3 and EI #4 called her with the action plan developed by the facility and she reviewed it. EI #2 was unsure when EI #3 and EI #4 called her with the plan they developed. EI #2 stated she had not documented the conversations she had with EI #3 and EI #4 regarding RI #1's accident. EI #2 was asked what feedback she gave to EI #3 and EI #4 on the facility's investigation and subsequent action plan. EI #2 said she told EI #3 and EI #4 they needed to do an investigation for any gaps in the investigation, and she also told them to call the family, and they notified her of what EI #16 said that the cause of death was (a seizure). EI #2 said based on what she knew at the time, there was no other feedback to give and she agreed with what they did. EI #2 was asked what her involvement was in the action plan. EI #2 replied, she reviewed it. EI #2 was asked what concerns she had with the facility's investigation and plan. EI #2 replied, she did not have any. EI #2 said she later found out that RI #1 had a Brief Interview for Mental Status (BIMS) score of 9 (moderate cognitive impairment) and was at the top of the stairs with no staff assistance. This deficient practice was cited as a result of the investigation of complaint/report number AL00042123. ********** On 11/04/2022 at 6:55 PM, the facility submitted the following acceptable Removal Plan addressing F837: .F837: Governing Body Effective 11/03/2022 @ 4:38pm, the Governing Body of NHC [NAME] consists of Regional Administrator (RA) and Regional Nurse (RN) hereafter referred to as Governing Body. Inservice completed 11/3/22 @ 4:38 pm by NHC AVP of Patient Services regarding responsibilities in oversight and guidance of the facility to ensure corrective actions are in place. AVP reviewed the requirements of F837 as well as the NHC QAPI Policy with both RA and RN. The requirements of F837 and the NHC QAPI Policy address the process of guidance and oversight to be provided by the Governing Body. The process for how the Governing Body will function was discussed and is as follows: The Governing Body will provide oversight and guidance to the center and the QAPI Committee by receiving copies of the QAPI meeting minutes monthly from the center's QAPI committee as well as through the review of other ongoing reports such as audits, budgets, staffing, investigations, complaints, etc. Feedback will be provided related to any identified causal factors for adverse events so the QAPI Committee can develop and implement effective plans to ensure any related problems are corrected . The Governing Body, Regional Administrator and Regional Nurse reviewed QAPI minutes on 11/03/2022 at 4:30 pm from the QAPI Committee meeting held on 10/20/22. Feedback on gaps was provided to Administrator regarding full completion of reports, fully implementing Root Cause Analysis and adequately documenting the actions of the committee as these areas were lacking in completion. (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Training was provided to the QAPI Committee (Administrator, DON, Medical Director, HIM, LE, DFNS, Environmental Services, Maintenance Director, DOR, BOM, Infection preventionist, Social services) by Regional QA Nurse related to the QAPI meeting process on 11/3/22 to ensure QAPI committee thoroughly reviews all factors r/t patient safety. To ensure QAPI committee determines and considers all causal factors for adverse events so QAPI can develop and implement effective plans to ensure any related problems are corrected. This training was conducted by use of NHC Quality Assurance Performance Improvement PowerPoint and NHC QAPI policy which includes steps and forms for use on root cause analysis (see attached) Exhibit # 3 QAPI training included: QAPI Training for above members covered CMS's five elements of QAPI: Design and Scope, Governance and Leadership, Feedback, Data Systems, & Monitoring, Performance Improvement Projects, and Systematic Analysis & Systemic Action. Quality Assurance Performance Improvement is the basis for all care delivered in this center. It is ongoing and comprehensive that includes all departments and services offered by the center to include clinical care, quality of life, and patient choice. The QAPI Committee is responsible for goal setting, monitoring of key indicators, determining PIPs to be instituted, and overall assuring the quality of all services rendered. The following key indicators of quality will be monitored on a monthly basis, In-house developed pressure ulcer rate, Rehospitalization rate, Unplanned weight loss, NPS scores, Falls rate, Antipsychotic usage rate, Census, Gift (complaint) trending, and the following will be reported as they occur Untoward Events and Survey Findings. All monitors reported will be prepared using NHC established protocols for determining center rates. All reports will contain comparison rates from the NHC Region, NHC Corporate, State averages, and national averages (if available). All reports submitted to the Committee will become attachments to the minutes for the month they were discussed along with any feedback provided by the Committee regarding reports submitted. Performance Improvement Projects will be determined by the QAPI Committee based on monitor results and/or survey findings. The number of PIPs per year should be based on monitoring results and will be prioritized based on the potential impact on patient care and the seriousness of the issue. PIPs will use rapid cycle methodology and reporting formats to accomplish goals. PIPs will include a representative from every department/job role which is impacted by the subject under improvement, including patients if appropriate. Systematic Analysis and Systemic Action will include utilizing root cause analysis that will be used to determine the underlying causes of issues. The 5 Why Method of root cause analysis will be used to determine root causes of problems. This root cause analysis will be reported to the Committee for feedback and become attachments to the minutes to ensure that submitted plans address the root cause. Minutes from meetings will be maintained by HIM and will contain at a minimum the following: Sign in sheet for those attending meeting, list of those members absent from the meeting, begin and end time of the meeting, all monitors reported and a brief synopsis of the discussion of each as well as any action to be taken from feedback from committee and the status of each PIP in progress. Copies of QAPI Committee Minutes with all attachments are to be forwarded to Governing Body by the 5th of month following the meeting for review of the center minutes, feedback will be provided as appropriate. Contents will be completed and immediacy will be removed on 11/3/22. After reviewing the facility's information provided in their Removal Plan and verifying the immediate actions had been implemented, the scope/severity level of F837 was lowered to an F level on 11/03/2022, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance.

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44165 Based on interviews, review of the facility's Quality Assurance and Performance Improvement (QAPI) Manual, Subject: GOVERNANCE AND LEADERSHIP and Subject: SAMPLE PLAN, and review of the facility's 10/20/2022 QUALITY IMPROVEMENT COMMITTEE MINUTES, the facility failed to ensure the QAPI committee thoroughly reviewed all causal factors related to Resident Identifier (RI) #1's fall from a wheelchair outdoors at the facility in order to develop an effective action plan to prevent any further resident safety concerns. On 9/26/2022 at approximately 1:00 PM, Employee Identifier (EI) #6, the Dietitian (RD), and EI #15, a Certified Nursing Assistant (CNA), took residents outdoors in wheelchairs while EI #9, a Registered Nurse (RN), held the door open. RI #1 self-propelled out the exit door with them. The RD told RI #1, a cognitively impaired resident with communication deficits and the need for assistance, to wait. The intent was to take the residents down a sloped sidewalk to a patio area. RI #1 wheeled him/her self out the door as the RN held the door open. RI #1 wheeled around the RD, who had another resident in a wheelchair, and down a sloped sidewalk unassisted. RI #1's wheelchair rolled down the slope, the left wheel of the wheelchair rolled off the sidewalk and overturned off the edge of the sidewalk, propelling RI #1 onto the ground face first on his/her left side on the ground. EI #6, the RD who initiated taking residents outside, did not know the level of supervision/assistance required for the residents before taking them outside an exit with a sloped sidewalk. EI #9, the RN who held open the door, said she was new, and she thought the RD was supervising the resident since she was wheeling another resident outside and asked the RN to hold the door open for them as she was returning from her lunch break. RI #1 was pronounced dead on the scene on 09/26/2022 at 1:02 PM, after being assessed by EI #16, the Medical Director, who was present at the facility when the incident occurred. This deficient practice placed all 114 residents residing in the facility in immediate jeopardy, as it was likely to result in serious injury, serious harm, serious impairment, or death. On 11/3/2022 at 3:17 PM, the facility's Administrator (Employee Identifier (EI) #3); the Regional Administrator of the South Central Region for NHC Healthcare and member of the facility's Governing Body (EI #1); the facility's Director of Nursing (EI #4); and a Regional Nurse for NHC Healthcare (EI #2) were given a copy of the Immediate Jeopardy (IJ) template and were notified of the immediate jeopardy findings in the area Quality Assurance and Performance Improvement, F867. Findings include: During the survey it was found that RI #1, a cognitively impaired resident with communication deficits and the need for staff assistance, sustained an accident on 09/26/2022 while going outside with facility staff unassisted. RI #1 was pronounced dead on the scene on 09/26/2022 at 1:02 PM, after being assessed by EI #16, the Medical Director, who was present at the facility when the incident occurred. Cross Reference F656, F689, and F837. Review of the facility's QAPI Manual, Subject: GOVERNANCE AND LEADERSHIP, with a revised date of 09/13/2022, revealed the following: (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The administration of the center will develop a culture that seeks input from center partners, residents, and families. .The QAPI Committee is responsible for goal setting, monitoring of key indicators, determining PIPs (Performance Improvement Projects) to be instituted, and overall assuring the quality of all services provided. . QAPI Committee Minutes: Minutes will be maintained . and will contain at a minimum the following: . All monitors reported and a brief synopsis of what the discussion of each was as well as any action to be taken . Further review of the facility's QAPI Manual, Subject: SAMPLE PLAN, with a revised date of 09/13/2022, revealed the following: . II. Scope: . f. The main focus of QAPI will be safety and high quality in all clinical interventions . g. The QAPI program will utilize regional, corporate, state, and national benchmarks as well as published best practices and clinical guidelines to determine appropriate care and to define and measure goals. . f. Systematic Analysis and Systematic Action i. Root Cause Analysis will be used to determine the underlying causes of issues. ii. The 5 (five) Why Method of root cause analysis will be used to determine root cause of problems . Review of the facility's QUALITY IMPROVEMENT COMMITTEE MINUTES, dated 10/20/2022, revealed the QAPI committee discussed a total of six untoward events during the meeting, including one fall with significant injury. These minutes also included multiple PIPs addressing various issues, but there was no information related to a root cause analysis or action plan addressing RI #1's 09/26/2022 incident. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 11/01/2022 at 12:00 PM an interview was conducted with EI #7, the Director of Health Information (HI). EI #7 was asked what was discussed regarding RI #1's 09/26/2022 incident during the 10/20/2022 QAPI meeting. EI #7 said they discussed an untoward fall with significant injuries and one investigation by an outside agency. EI #7 was asked, what was specifically discussed about the fall with significant injury during the QAPI meeting. EI #7 said they discussed what happened, what education had been provided and said it was an ongoing action plan. EI #7 was asked, what should have been included in the QAPI meeting minutes. EI #7 replied, there should a have been a brief report written about the discussion of monitors, a brief synopsis, and each action that should have been taken, if there was an action plan that was reported. EI #7 was asked when the facility implemented an action plan addressing the incident on 09/26/2022. EI #7 replied, it started that day on 09/26/2022; however, she indicated the Director of Nursing (DON), EI #4, was still working on the action plan. EI #7 said EI #4 developed the action plan. When asked what part the QAPI committee had in the development of the action plan, EI #7 replied, the plan was already written on 09/26/2022. EI #7 said that EI #4 reported she had a plan and had in-serviced the staff and was going to continue to monitor the plan to make sure that the staff were implementing the plan. On 11/02/2022 at 9:25 AM an interview was conducted with EI #4, the DON. EI #4 was asked, where in the action plan and staff training for the 09/26/2022 incident, did it address the specific type of assistance and supervision that was required when taking residents outside. EI #4 replied, it did not. EI #4 was asked why the action plan did not address that. EI #4 said she implemented her plan immediately, but it was still ongoing. When asked why all causal factors, such as providing supervision and assistance for resident safety, were not addressed in the QAPI meeting on 10/20/2022. EI #4 replied, because it was ongoing. When asked how the facility had identified what actions needed to be taken to address RI #1's 09/26/2022 incident, EI #4 again stated it was ongoing. When asked about the facility's process for root cause analysis, EI #4 explained it should involve asking who, when, why, what, and where, as all were factors that come into play when investigating an incident to prevent it from happening again. On 11/02/2022 at 12:08 PM an interview was conducted with EI #3, the Administrator. EI #3 was asked if the 10/20/2022 QAPI meeting minutes included a synopsis of the 09/26/2022 incident involving RI #1 and the actions needing to be taken to address the incident. EI #3 replied, they were not documented, only as an untoward event. On 11/02/2022 at 4:26 PM, EI #3 was asked what might have gone differently if staff had followed the care plan to assist RI #1 with locomotion. EI #3 said, RI #1's wheelchair might not have tipped over. When asked why the facility's root cause analysis of this incident had not identified that the resident's plan of care was not followed, EI #3 said it was a gap in their investigation process. This deficient practice was cited as a result of the investigation of complaint/report number AL00042123. ********** On 11/04/2022 at 6:55 PM, the facility submitted the following acceptable Removal Plan addressing F867: .F867-QAPI (continued on next page)

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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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Effective 11/03/2022 @ 4:38pm, the Governing Body of NHC [NAME] consists of Regional Administrator and Regional Nurse hereafter referred to as Governing Body. Inservice completed 11/3/22 @ 4:38 pm by NHC AVP of Patient Services regarding responsibilities in oversight and guidance of the facility to ensure corrective actions are in place. AVP reviewed the requirements of F837 as well as the NHC QAPI Policy with both RA and RN. The requirements of F837 and the NHC QAPI Policy address the process of guidance and oversight to be provided by the Governing Body. The process for how the Governing Body will function was discussed and is as follows: The Governing Body will provide oversight and guidance to the center and the QAPI Committee by receiving copies of the QAPI meeting minutes monthly from the center's QAPI committee as well as through the review of other ongoing reports such as audits, budgets, staffing, investigations, complaints, etc. Feedback will be provided related to any identified causal factors for adverse events so the QAPI Committee can develop and implement effective plans to ensure any related problems are corrected . The Governing Body, Regional Administrator and Regional Nurse reviewed QAPI minutes on 11/03/2022 at 4:30 pm from the QAPI Committee meeting held on 10/20/22. Feedback on gaps was provided to Administrator regarding full completion of reports, fully implementing Root Cause Analysis and adequately documenting the actions of the committee as these areas were lacking in completion. Training was provided to the QAPI Committee by Regional QA Nurse related to the QAPI meeting process on 11/3/22 to ensure QAPI committee thoroughly reviews all factors r/t patient safety. To ensure QAPI committee determines and considers all causal factors for adverse events so QAPI can develop and implement effective plans to ensure any related problems are corrected . QAPI training included: QAPI Training for above members covered CMS's five elements of QAPI: Design and Scope, Governance and Leadership, Feedback, Data Systems, & Monitoring, Performance Improvement Projects, and Systematic Analysis & Systemic Action. The QAPI --Committee is responsible for goal setting, monitoring of key indicators, determining PIPs to be instituted, and overall assuring the quality of all services rendered. The following key indicators of quality will be monitored on a monthly basis, In-house developed pressure ulcer rate, Rehospitalization rate, Unplanned weight loss, NPS scores, Falls rate, Antipsychotic usage rate, Census, Gift (complaint) trending, and the following will be reported as they occur Untoward Events and Survey Findings. Performance Improvement Projects will be determined by the QAPI Committee based on monitor results and/or survey findings. PIPs will use rapid cycle methodology and reporting formats to accomplish goals. Systematic Analysis and Systemic Action will include utilizing root cause analysis that will be used to determine the underlying causes of issues. The 5 Why Method of root cause analysis will be used to determine root causes of problems. This root cause analysis will be reported to the Committee for feedback and become attachments to the minutes to ensure that submitted plans address the root cause. Contents will be completed and immediacy will be removed on 11/3/22 After reviewing the facility's information provided in their Removal Plan and verifying the immediate actions had been implemented, the scope/severity level of F867 was lowered to an F level on 11/03/2022, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance.