STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425035	A. BUILDING _____ B. WING _____	03/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
J F HAWKINS NURSING HOME	1330 KINARD STREET NEWBERRY, SC 29108

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 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to thoroughly investigate accidents/fall injuries for two of four sampled residents reviewed for accidents/fall. Resident #1 was left unattended on a comprising position. Resident #2 acquired hematoma with laceration requiring suture while being provided activity of the daily living (ADL) care. Findings: The facility admitted Resident #1 on 2/20/2020 with [DIAGNOSES REDACTED]. The incident report reviewed 3/19/2020 stated that Resident #1 experienced a fall from bed resulting in a left femur fracture after being turned to the left side in (his/her) bed and left unsupervised. The facility admitted Resident #2 on 7/4/2013 with [DIAGNOSES REDACTED]. The incident report reviewed on 3/19/2020 at 11: 00 AM stated that on 1/1/2020 at approximately 10:30 AM, Resident #2 sustained a fall from bed during peri-care resulting in a laceration to left temporal regions requiring sutures. According to the facility incident report, the certified nursing assistant (CNA) #2 noted Resident #2's right leg to be jerking sporadically and (his/her) body turning farther on to her/his left side. The CNA was unable to stop the resident before falling from the left side of the bed. The review of the facility five-day follow-up report on 3/20/2020 at 10:35 AM indicated that the form was not completed as required. It said see attachments in multiple places. The witness statements begin with leading questions. Such as, was the call light in reach? Yes, was the bed rail up? Yes. The staff involved in the incidents were not suspended pending an investigation, nor were they reeducated. Fall prevention interventions were not included in the report. In an interview with the DON on 3/20/2020 at approximately 11:05 AM, s/he confirmed that the nursing staff were not suspended pending during investigation, and reeducation was conducted after the fall/incident.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **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** Based on record review and interview, the facility failed to develop and implement a resident-centered care plan to address residents with impaired mobility and self-care deficits for two of four sampled residents reviewed for accidents. Findings: The facility admitted Resident #1 on 2/20/2020 with [DIAGNOSES REDACTED]. The facility incident report stated that Resident #1 experienced a fall from bed resulting in a left femur fracture while being turn to (his/her) left side. The Minimum Data Set (MDS) assessment dated [DATE] and reviewed 3/20/2020 at approximately 9:00 AM, revealed that Resident #1 scored a 12 (moderately impaired) in the brief interview for mental status (BIMS). The MDS required 2 or more staff to assist with bed mobility, toilet use, personal hygiene, and transfer. Care plan review on 3/19/2020 at 9:58 AM revealed that resident #1 needed assistance with activities of daily living (ADLs) and is at risk for falls related to debility, [MEDICAL CONDITION], cerebral hemorrhage, right below-the-knee amputation, acute [MEDICAL CONDITION], and [MEDICAL CONDITION]. Interventions included a mechanical lift with two or more staff assistance for transfer, Bed in the lowest position when providing care. and easy to remove clothing for toileting. In an interview with the MDS coordinator and the DON on 3/20/2020 at approximately 11:00 AM, the MDS coordinator acknowledged that the information gathered during the MDS assessment was provided by the nursing staff. Based on that information, Resident #1 needed extensive assistance with two-plus persons physical assist for bed mobility and toilet use. The DON agreed the resident needed extensive assistance with two or more staff assist for bed mobility and toilet use, but (s/he) believed that that only applies if the resident was up and out of bed. The facility admitted Resident #2 on 7/4/2013 with [DIAGNOSES REDACTED]. The facility incident report reviewed on 3/19/2020 at 11: 00 AM stated that on 1/1/2020 at approximately 10:30 AM, Resident #2 sustained a fall from bed during peri-care resulting in a laceration to left temporal regions requiring sutures. According to the facility report, the certified nursing assistant (CNA) #2 noted Resident #2's right leg to be jerking sporadically and (his/her) body turning farther on to her left side. The CNA was unable to stop the resident before s/he falling fell out of the bed. Care plan reviewed on 3/20/2020 at 11:16 AM revealed that Resident #2 is at risk of falls related to cognition, medications, musculoskeletal impairment, and history of falls. Fall prevention interventions included: call light within reach, extensive assistant with two staff for the activity of daily living (ADLs) to include bed mobility, fluids (unless contraindicated) within reach, and frequently used items within reach. It also stated s/he has self-care deficit related to cognitive deficits, resistance to ADLs, weakness, Diabetic [MEDICAL CONDITION], severe DJD. The interventions included two staff to provide bath with morning and bedtime care. In an interview with the DON on 3/20/2020 at approximately 11:45 AM, (s/h) agreed that the resident needed extensive assistance with two or more staff assist for bed mobility and toilet use, but (s/he) believe that it only applies if the resident was up and out of bed.
F 0689 **Level of harm** - Actual harm **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** Based on observation, record review and interview, the facility failed to provide adequate supervision to prevent residents from falling. The facility was unable to develop precise fall-prevention interventions for residents at risk of falls, impaired mobility, and inability for self-care. Resident #1 fell from the bed and suffered a [MEDICAL CONDITION] after being turned to (his/her) left side and left unsupervised for a short period. Resident #2 fell from the bed and suffered a laceration to the forehead. This included two of four sampled residents reviewed for accidents. Findings: The facility admitted Resident #1 on 2/20/2020 with [DIAGNOSES REDACTED]. The facility incident report stated that Resident #1 experienced a fall from bed resulting in a left femur fracture. The Minimum Data Set (MDS) assessment dated [DATE] and reviewed 3/20/2020 at approximately 9:00 AM, revealed that Resident #1 scored a 12 (moderately impaired) in the brief interview for mental status (BIMS). The MDS required 2 or more staff to assist with bed mobility, toilet use, personal hygiene, and transfer. Care plan review on 3/19/2020 at 9:58 AM revealed that resident #1 needed assistance with activities of daily living (ADLs) and is at risk for falls related to debility, [MEDICAL CONDITION], cerebral hemorrhage, right below-the-knee amputation, acute [MEDICAL CONDITION], and [MEDICAL CONDITION]. Interventions included a mechanical lift with two or more staff assistance for transfer, Bed in the lowest position when providing care. and easy to remove clothing for toileting. Nurse's notes, reviewed on 3/19/2020 at 10:44 AM, noted that on 3/3/2020 at 4:48 PM, the licensed practical nurse (LPN) #1, called the duty Physician Assistant (PA) with a verbal report of the fall. New orders were received and processed to send resident to the hospital for evaluation of left lower extremity (LLE) related to complaints of left knee pain. In a phone interview with Certified Nursing Assistance (CNA) #1, on 3/19/20, at 1:15 PM, (s/he) stated that (s/he) went to the resident's room to answer the call light. Resident #1 requested to be turned on (his/her) left side. S/he wanted to be turned to ease bowel elimination (a brief on). The CNA turned resident to the left side with the resident's

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

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

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) assistant. The resident pulled on the side rails, which were up during this time, to help with turning. Once the CNA turned the resident, (s/he) stepped out of the room to give the resident some privacy. A few minutes later, the CNA checked on the resident and asked (his/her) if she was done. The resident stated (s/he) was still trying to go. Shortly after that, the CNA heard a loud sound and the call light. S/he went into the resident's room and found Resident #1 on the floor and on her right side. When asked how the resident fell considering Resident #1's condition of missing a limb, impaired mobility, and both side-rails up. The CNA stated that (s/he) did not know. The CNA believed Resident #1 pushed the call light at the same time (s/he) fell . In an interview with the MDS coordinator and the DON on 3/20/2020 at approximately 11:00 AM, the MDS coordinator acknowledged that the information gathered during the MDS assessment was provided by nursing staff and that Resident #1 needed extensive assistance with two-plus persons for bed mobility and toilet use. The DON agreed that the resident required extensive assistance with two or more staff to assist with bed mobility and toilet use, but (s/he) believed that only applied if the resident was up and out of bed. The facility admitted Resident #2 on 7/4/2013 with [DIAGNOSES REDACTED]. The facility incident report investigation reviewed on 3/19/2020 at 11: 00 AM stated that on 1/1/2020 at approximately 10:30 AM, Resident #2 sustained a fall from bed during peri-care resulting in a laceration to left temporal regions requiring sutures. According to the facility report, the certified nursing assistant (CNA) #2 noted Resident #2's right leg to be jerking sporadically and (his/her) body turning farther on to her left side. The CNA was unable to stop the resident before falling from the left side of the bed. Care plan reviewed on 3/20/2020 at 11:16 AM revealed that Resident #2 is at risk of falls related to cognition, medications, musculoskeletal impairment, and history of falls. Fall prevention interventions included: call light within reach, two or more staff assistance with activity of daily living (ADLs), bed mobility, fluids (unless contraindicated) within reach, and frequently used items within reach. Self-care deficit and interventions related to cognitive deficits included: resistance to ADLs, weakness, Diabetic [MEDICAL CONDITION], severe DJD. The interventions required at least two staff whild providing baths and bedtime care. The progress notes, reviewed on 3/20/2020 at 11:37 AM, noted that on 1/1/2020 at 10:30 AM, Resident #2 was sent to the emergency room because staff were not able to stop bleeding without holding pressure on the laceration. The resident had lacerations to the right temporal area. The resident returned from the ER with 6 sutures to the right temporal area. In an interview with CNA #2 on 3/20/2020 at 11:45 AM, S/he stated that while performing resident care to Resident #2, the resident fell off the bed and (s/he) was not able to prevent the resident from falling. According to the CNA, (s/he) raised the resident's bed to the level (s/he) felt comfortable while providing care to the resident. S/he had all the supplies necessary within reach. The CNA was by (him/her) self, and the bed did not have side rails. After providing care to front of Resident #2's body, the CNA turned the resident to (his/her) left side and as (s/he) noticed the resident's right leg jerked. Then the resident's right leg went over the left leg, and then fell to the floor. S/he tried to grab the resident but was unable prevent the fall. S/he stated everything happened very fast. The CNA called for help and the nurse came to assist. In a phone interview with LPN #2, (s/he) stated that (s/he) heard CNA #2 calling for assistance and went to the room. When LPN#2 entered the room (s/he) saw Resident #2 face down on the floor. Resident #2 and saw the Resident bleeding from a laceration on her forehand. LPN #2 provided care and called the doctor. The resident was sent to the ER. The CNA told the LPN that (s/he) could not stop the resident from falling. In an interview with the DON on 3/20/2020 at approximately 11:05 AM, the surveyor shared concerns regarding Resident #2, who was care-planned for self-care deficit and required assistance by 2 or more staff for bathing, morning and bedtime care. During the interview the DON acknowledged Resident #2 only had one CNA performing care when the fall took place.