STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425307	A. BUILDING _____ B. WING _____	09/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVER FALLS REHABILITATION AND HEALTHCARE CENTER	**2906 GREER HWY MARIETTA, SC 29661**

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews and facility policy review, the facility failed to notify the physician and family of a fall for 1 (Resident 2) of 3 residents reviewed for accidents. Findings are: The facility's policy titled, Fall Procedure, revised on 08/2019, indicated the following, Procedure 3. If a fall occurs the following actions will be taken: i. Notify MD and responsible representative. Resident 2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident 2's admission Minimum Data Set (MDS) assessment dated [DATE] revealed severe cognitive impairment and extensive assistance from staff for activities of daily living (ADL). The Care Area Assessment indicated Resident 2 was at risk for falls related to muscle weakness, need for assistance with ADLs, difficulty walking and history of falls. Resident 2's care plan, initiated on 08/19/20, included a risk for fall related injuries. Review of Resident 2's Emergency Department (ED) record dated 09/03/20 revealed Resident 2 sustained a right impacted femoral neck [MEDICAL CONDITION]. The physician recommended nonoperative care related to the fracture. A fall incident report dated 09/04/20 by Nurse 1, revealed that on 09/01/20, Certified Nursing Assistant (CNA) 1 was in the room with Resident 2 when she went down on one knee with assistance and sat on the floor. Resident 2 was assessed, vital signs were stable, was able to move lower extremities without complaints of pain or discomfort. No documentation for notifications of the physician or resident representative was found in Resident 2's electronic medical record (EMR). On 09/17/20 at 2:35 PM, an interview was conducted with CNA 1 who stated he entered Resident 2's room to see her holding onto her bedside commode with both hands, facing the commode. The CNA stated Resident 2 looked wobbly and looked like her leg would give out. As he assisted her, the resident went down to the floor with her right knee hitting the floor first and then sitting on the floor with both knees up and her feet flat on the floor. The CNA stated he left to get the nurse and the nurse looked at Resident 2. After the nurse left, Resident 2 pointed to the commode and he helped her stand up and she used the commode. The CNA stated Resident 2 leaned on the commode to get cleaned up after and then he assisted her to walk to her bed. She did not act like either of her legs were weak. The CNA reported Resident 2 was positioned in bed and went to sleep. On 09/17/20 at 3:55 PM, an interview was conducted with Nurse 1, who stated she was notified by CNA 1 on the evening of 09/01/20, that he had lowered Resident 2 to the floor. The nurse stated Resident 2 did not fall, did not have any pain, and was assessed by the nurse to the best of her ability. The nurse stated she did not write the incident report until 09/04/20. The nurse stated she did not notify anyone of the fall and was unable to explain her failure to do so. On 09/17/20 at 3:46 PM, an interview was conducted with the Nurse Practitioner (NP) who stated she had not known Resident 2 had a fall 2 days prior when she examined her on the morning of 09/03/20. The NP stated she thought it was obvious Resident 2 had a fracture because she exhibited pain and limited range of motion to the right side. The NP stated she ordered x-rays to be done that day. The NP stated she asked the Director of Nursing (DON) if Resident 2 had a fall, but the DON stated she did not know of one. On 09/18/20 at 10:26 AM, an interview was conducted with the DON who stated Resident 2 had a witnessed fall on 09/01/20 and Nurse 1 had not notified her or the physician of the fall. The DON stated she had not known of the possibility of the fall until after the NP examined Resident 2. The DON stated Nurse 1 wrote the incident report for the fall on 09/04/20 and the care plan was updated on that date. The DON stated staff were educated on the fall policy on 09/07/2020, but Nurse 1 did not attend the education and resigned shortly after. The DON stated she expected to be notified along with the physician and resident representative anytime a resident had a fall.
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews and facility policy review, the facility failed to report a fall and follow the facility's policy for monitoring a resident after a fall for one (Resident 2) of three residents reviewed for accidents. This deficient practice delayed timely intervention for a resident who sustained a [MEDICAL CONDITION]. Findings are: The facility's policy titled, Fall Procedure, revised on 08/2019, indicated the following, Procedure 3. If a fall occurs the following actions will be taken: b. Monitor the resident each shift for 72 hours. d. Pain will be evaluated every shift for 72 hours for all residents that experience a fall. E. Document evaluation, pertinent facts. i. Notify MD and Responsible representative. Resident 2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident 2's admission Minimum Data Set (MDS) assessment dated [DATE] revealed severe cognitive impairment and extensive assistance from staff for activities of daily living (ADL). The Care Area Assessment indicated Resident 2 was at risk for falls related to muscle weakness, need for assistance with ADLs, difficulty walking and history of falls. Resident 2's care plan, initiated on 08/19/20, included a risk for fall related injuries. Resident 2 was discharged on [DATE] and was no longer residing at the facility. Review of Resident 2's Emergency Department (ED) record dated 09/03/20 revealed Resident 2 sustained a right impacted femoral neck [MEDICAL CONDITION]. The physician recommended nonoperative care related to the fracture. A fall incident report dated 09/04/20 by Nurse 1, revealed on 09/01/20, Certified Nursing Assistant (CNA) 1 was in the room with Resident 2 when she went down on one knee with assistance and sat on the floor. Resident 2 was assessed, vital signs were stable, and was able to move lower extremities without complaints of pain or discomfort. No other documentation of the fall was included in the resident's electronic medical record (EMR). On 09/17/20 at 2:35 PM, an interview was conducted with CNA 1 who stated he entered Resident 2's room to see her holding onto her bedside commode with both hands facing the commode. The CNA stated Resident 2 looked wobbly and looked like her leg would give out. As he assisted her, she went down to the floor with her right knee hitting the floor first and then sitting on the floor with both knees up and her feet flat on the floor. The CNA stated he left to get the nurse and the nurse looked at Resident 2. When the nurse left, Resident 2 pointed to the commode and he helped her stand up and she used the commode. The CNA stated Resident 2 leaned on the commode to get cleaned up after and then he assisted her to walk to her bed. She did not act like either of her legs were weak. The CNA reported Resident 2 was positioned in bed and went to sleep. On 09/17/20 at 3:55 PM, an interview was conducted with Nurse 1, who stated she was notified by CNA 1 on the evening of 09/01/20, that he had lowered Resident 2 to the floor. The nurse stated Resident 2 did not fall, did not have any pain, and was assessed by the nurse to the best of her ability. The nurse stated she did not write the incident report until 09/04/20. The nurse stated she did not notify anyone of the fall and was unable to explain her failure to do so. On 09/17/20 at 4:26 PM, an interview was conducted with CNA 2 who stated she cared for Resident 2 on 09/02/20. CNA 2 stated Resident 2 was tired that day and did not get up, but the CNA did not think that was unusual because there had been days in the past that she had not wanted to get up. The CNA stated she assisted Resident

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425307	A. BUILDING _____ B. WING _____	**09/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVER FALLS REHABILITATION AND HEALTHCARE CENTER	**2906 GREER HWY MARIETTA, SC 29661**

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 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) 2 into a wheelchair and took her to the bathroom, where Resident 2 transferred herself to the toilet and then back to bed. During the transfer, Resident 2 stated she thought her foot must be hurting, and CNA 2 reminded Resident 2 that her foot had been injured in a fall prior to her admission. On 09/17/20 at 9:21 PM, an interview was conducted with Nurse 2 who cared for Resident 2 on the night of 09/02/20. The nurse stated Resident 2 was sleepy on the night of 09/02/20 when she and another nurse went into the room to try and get a urine sample via catheterization. The nurse stated she thought Resident 2 was not her normal self. She thought Resident 2 must have had COVID-19 as she had recently had a test conducted for [MEDICAL CONDITION]. The nurse stated Resident 2 had both hands on her hips when they positioned her for the catheterization. The nurse indicated Resident 2 did not complain of pain during the positioning for the catheterization but did make facial grimacing when they were conducting the catheterization. The nurse stated Resident 2 went back to sleep after the procedure. The nurse put Resident 2 in the book to be seen by the nurse practitioner (NP) the next day since she was sleepy and not herself. The nurse made no notations in the residents record of the catheterization, hip guarding, or facial grimacing witnessed of the resident The nurse stated she did not know Resident 2 had experienced a fall at that time and did not see any bruising or swelling of the hips. On 09/17/20 at 3:46 PM, an interview was conducted with the Nurse Practitioner (NP) who stated she did not know Resident 2 had experienced a fall 2 days prior when she examined her on the morning of 09/03/20. The NP stated she thought it was obvious Resident 2 had a fracture because she exhibited pain and limited range of motion to the right side. The NP stated she ordered x-rays to be done that day. The NP stated she asked the Director of Nursing (DON) if Resident 2 had a fall, but the DON stated she did not know of one. On 09/18/20 at 10:26 AM, an interview was conducted with the DON who stated the physician saw Resident 2 on 08/31/20 for reports of nausea and vomiting. A COVID-19 test was ordered and conducted that day. The physician again saw Resident 2 on 09/02/20 for lethargy and ordered blood and urine tests. The DON stated the NP saw Resident 2 on 09/03/20 and ordered hip and knee x-rays. The DON stated she expected staff to notify her, the physician, and the resident's representative (RR) anytime a resident had a fall. The DON stated Resident 2 was not monitored after the fall as the facility had not known of the witnessed fall. The DON stated Nurse 1 came to the facility on [DATE] and filled out the incident report on that day, and the care plan was updated on that date. Staff education on falls was conducted on 09/07/20, but Nurse 1 did not attend and resigned shortly after that date.