STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345555	A. BUILDING _____ B. WING _____	C 01/29/2015

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CRABTREE VALLEY REHAB CENTER	**3830 BLUE RIDGE ROAD RALEIGH, NC 27612**

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F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to use a mechanical lift to transfer one of two residents reviewed who required the use of a mechanical lift for transfer, which resulted in a hip fracture (Resident#1). Findings included: Resident #1 was admitted to the facility on 1/15/2013 with diagnoses of stroke with hemiplegia (inability to move) on the left side of his body. The annual Minimum Data Set (MDS) dated 10/11/2014 noted that Resident #1 was cognitively intact and was totally dependent for transfers with the physical assistance of two persons. The Care Area Assessment (CAA) noted the resident to be non-ambulatory (could not walk alone), and that the resident was dependent on staff for transfers via the mechanical lift. This area of transfer went to care plan. The care plan, dated 10/11/2014, noted a focus of risk for falls related to the resident was dependent for transfers (total assist).The goal was to remain free of injury related to a fall through the next review. The interventions included assist with	F 323	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 02/16/2015

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F 323	Continued From page 1 transfers with mechanical lift with two assists, and safety measures per policy. A review of nurse aide statements revealed that on 1/7/2015 Resident #1 was to be gotten up for lunch. Nurse Aide (NA) #1 stated that she got the mechanical lift and brought it to Resident #1 ' s room, but the battery was not working. NA#1 further indicated that another battery was put on the mechanical lift, but it did not function then either. At that time NA#3, who was the restorative aide, was in the room to assist with the transfer and called NA#2 into the room, and stated that the three NAs would do a three person transfer. NA#1 and NA#2 told NA#3 that they would get another mechanical lift, but NA#3 had already begun to lift Resident #1 off of the bed. The statement by NA#1 concluded that the three NAs got Resident #1 into the chair, and NA#1 pushed Resident #1 to the dining room. On 1/27/2015 at 11:00 AM, in a telephone interview, NA#3 stated that the battery was not working in the lift, and NA#1 tried another battery, but it did not work either. NA#3 stated that he could not see Resident #1 ' s hip because he was standing behind Resident #1 during the transfer. NA#3 stated that Resident #1 did not complain of pain. NA#3 indicated that he knew how to operate the lift, and had used a mechanical lift many times. NA#3 stated that he just decided to get Resident #1 into the chair and said " I used bad judgment. " NA#3 was terminated. NA#2 was terminated and was not available for interview during the investigation. On 1/27/2015 at 12:50 PM, in an interview, NA#1 stated that she had never done a three person lift, but NA#3 seemed to want to get Resident #1 up quickly, and had already started to lift Resident #1 out of the bed, so she quickly got one of his legs to assist. NA#1 stated that Resident #1 did not hit	F 323		

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his hip on the chair and did not complain of pain. NA#1 stated that she took Resident #1 to the dining room, and later that afternoon used the mechanical lift with assistance to put Resident #1 back to bed, provided incontinent care, and he did not complain of pain.

A review of nurse notes on 1/8/2015 during the 7AM-3 PM shift revealed that Resident #1 complained of severe left leg and hip pain, and was medicated with Tylenol (a pain medication), 650 milligrams (mg) by mouth at 8:00 AM. The note also revealed that Resident #1 refused to be moved out of bed because of the pain. The nurse called Resident #1 ' s physician, who gave an order for an in-house x-ray of the left leg and hip. The x-ray was noted to be positive for a fracture, and the physician was notified. Resident #1 was also notified, and was transferred to the hospital Emergency Room (ER). An x ray at the hospital confirmed a left hip fracture.

A review of hospital records revealed that during the orthopedic (bone) physician consult the physician explained the surgical and non-surgical treatment for Resident#1 ' s hip fracture, and Resident #1 stated that he did not want any surgery. The orthopedic physician recommended non-surgical treatment of the broken hip. Resident #1 would be discharged back to the facility with supportive care, and management by Resident #1 ' s physician. A prescription for pain medication was given.

On 1/27/2015 at 10:20 AM, in an interview in his room, Resident #1 stated that three of the NAs had moved him from the bed to the chair, and his hip was broken.

On 1/27/2015 at 10:30 AM, an observation was made of the mechanical lifts in the storage room on the 400 hall. NA#1 stated that 11:00 PM-7:00 AM shift was supposed to charge the batteries for

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the lifts, but that it is not always done, and then one must wait for the batteries to charge.
On 1/27/2015 at 10:47 AM, in an interview, the administrator stated that Resident #1 ' s accident happened on 1/7/2015, but Resident #1 did not complain of pain or tell anyone what happened until 1/8/2015, when an x-ray was performed and showed a hip fracture.
On 1/27/2015 at 2:15 PM, in an interview, NA#4 stated that the care cards are kept in a book at the nurses ' station, and these cards tell what kind of transfer the residents get. NA#4 indicated that the cards are updated every day. NA#4 stated that there is always a mechanical lift available in the facility.
On 1/27/2015 at 2:30 PM, in an interview, the Maintenance Director demonstrated how the batteries are charged and how they fit into the mechanical lift, and how the lift worked. The Maintenance Director stated that a company comes in and checks all of the lifts to see if they are working properly. The Maintenance Director indicated that if there is a problem with equipment in the facility, that concerns resident safety, the staff know that they can come to him, call him, or page him, because those issues go to the top of the list for importance. The Maintenance Director indicated the maintenance work orders that are located at every nurse ' s station, and stated that he checks for those orders several times throughout the day.
On 1/27/15 at 5:00 PM in an interview, Resident #1 stated that the NAs picked him up and dropped him into the chair on 1/7/15. Resident #1 stated that he did not hit his hip on the chair. Resident #1 stated that he did have pain at first, but it had gotten much better since he had returned from the hospital.
A review of Resident #1 ' s Medication

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Administration Record (MAR) revealed that he had been medicated for complaints of pain three times in the first 24 hours following discovery of the hip fracture, and one time the next day. A review of nurse notes revealed that on the evening of the second day, the resident had no complaints of pain.

On 1/28/15 at 8:30 AM in an interview the Unit Manager for the 300/400 hall stated that Resident #1 ' s family member told her on 1/8/15, that Resident #1 had been dropped by the NAs the day before. The Unit Manager stated that she immediately went to Resident #1 and the Resident told her what had happened. The Unit Manager stated that she called the physician immediately and got an order for an x-ray, and when the report was noted to be positive for fracture, Resident #1 was sent to the hospital emergency room.

On 1/28/15 at 9:00 AM, in an interview, NA#5 stated that she works on different halls in the facility, and has been employed in the facility for two years. NA#5 stated that she is familiar with using a mechanical lift and that the staff is inserviced on using mechanical lifts, including return demonstration which means that the NA must show that they can use the mechanical lift correctly. NA#5 indicated that she would go to another hall to borrow a lift if the battery was not working. NA#5 stated that she had never lifted a resident physically if they were supposed to be lifted with a mechanical lift.

On 1/28/15 at 9:20 AM, in an interview, Nurse#1 stated that care is given by what is on the care cards, including how the residents are to be transferred. Nurse#1 stated that if the battery was not working in a lift, then the NA would be instructed to leave the resident in bed and tell the resident that as soon as the battery is charged for

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F 323	Continued From page 5 the mechanical lift, the resident will be gotten up. On 1/29/2015 at 9:20 AM, in an interview, the Assistant Director of Nursing (ADON) stated that her expectation was that the care would be given according to the care card. The ADON indicated that the in-services had reinforced using the care cards, and an immediate audit of all care cards was done after Resident#1 was found to have a fractured hip. The ADON stated that NA#4 checks all of the care cards daily, for all residents. On 1/29/15 at 10:15 AM, an observation was made of all mechanical lifts in the facility, along with the Maintenance Director. All five mechanical lifts were working. On 1/29/15 at 11:30 AM, in an interview, NA#4 stated that her job, as Lead NA, was to check all of the care cards in the facility every day. NA#4 stated that she is aware of all resident ' s methods of transfer, and if there were changes, the change would be verified and she would make sure that the care card was updated and the nurse and the NA were informed. NA#4 stated that sometimes when Therapy changes something, they will note it on the card, and she will follow up with them to make sure what the change is. In an interview on 1/29/2015 at 11:40 AM , the administrator stated that since NA#1 was suspended during the investigation of the accident, she did not attend the in-services on 1/8/15/or 1/9/15, but was in-serviced on 1/10/2015. On 1/29/2015 at 11:40 AM, the administrator presented a four step plan, dated 1-8-15, which consisted of: · Upon notification of incident administrator interviewed Resident#1, facility suspended three employees pending outcome of investigation.	F 323		

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F 323	Continued From page 6 Facility immediately investigated incident. · Staff were educated immediately regarding lift and transfers. · Staff were in-serviced 1-8-15. Education will be added to monthly staff meeting, regarding lift and transfers. · The DON/ designee will present evidence of training of staff a minimal of three months. The QA tool consists of DON/ designee will randomly select staff to demonstrate the use of the mechanical lift for transfer for three months. These results will be taken to the QA committee to determine if further monitoring is required. Documents were reviewed for staff inservice on 1/8/2015 and 1/9/2015 in regard to residents would be transferred according to the plan of care, and in regard to moving residents. The inservice included the topics of: · Must follow care cards. · Transfers: mechanical lifts. · Batteries, charges placed, mounted · Nurses to check that batteries work. · Must not lift residents. · Will be terminated. · Will not allow residents to be put in harms way. A review of the agenda for the facility staff meeting on January 13, 2015 included lifts/ transfers with transfer residents according to care card orders. Not to assume. Take easy way- do what ' s correct and safe for resident and yourself! Signed inservice sheets were reviewed for this mandatory staff meeting. The staff meeting was for all staff employed in the facility. NA#1 was not present. Audits of care cards by NA#4, whose title was Lead NA, were done on 1/8/15, and each day following. This is a continuing process.	F 323		

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F 323	Continued From page 7 A review of the investigation by the facility included specific measures taken following Resident #1 ' s fracture. These measures, dated 1/8/15, included mechanical lift inspection, slings for lifts inspected and found to be in good working condition. Staff inservices. Care cards reviewed and updated. Staff inserviced on care cards and reporting change in condition to proper staff. Both proper use of the mechanical lift for transfer, and use of care cards to determine proper transfer needs will be addressed in monthly mandatory staff meeting for three months. The monitoring will be conducted by the DON/ADON and will be random, one on one in-service with the staff in regard to proper use of the mechanical lift for transfer, with a return demonstration by staff. This will be done for three months and presented to the Quality Assurance (QA) committee and reviewed when necessary. An investigation of the hip fracture of Resident #1 revealed that the resident was sent to the hospital, the NAs involved were suspended pending an investigation. The staff was in serviced regarding using the mechanical lift. All residents in the facility were audited for correct information on the care cards for transfers. A monitoring tool was developed for observation and return demonstration by staff for use of mechanical lifts for transfer. The results would be taken to QA for three months. The facility is in compliance as of 1/13/2015.	F 323		