STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 07/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

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F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews the facility failed to safely transfer 1 of 1 (#1) residents resulting in a fracture. Findings included: Resident #1 was admitted to the facility on 4/28/16 with diagnosis including chronic obstructive pulmonary disease, chronic pain, hypertension, hypothyroidism, and diabetes type II with chronic kidney disease.	F 323	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law. 1. F323 Free of Accident Hazards-It is the	8/14/17

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

Electronically Signed | 08/09/2017

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F 323	Continued From page 1 Review of the minimum data set assessment completed 4/18/17 revealed a score of 15 on the brief interview of mental status indicating that the resident has good memory and cognition. The resident required assistance with bed mobility and had not transferred or walked during the review period. Review of the care plan 4/24/17 revealed a goal for the resident to maintain her current level of functioning through the next review date. The care plan stated that the resident was totally dependent on staff for transfer by 2 staff with a mechanical lift. The care plan included an intervention for the physical therapy to evaluate and treat the resident as ordered. Review of physical therapy progress note 5/3/17 revealed that Resident #1 had the following impairments: balance deficits, decreased dynamic balance, decreased safety awareness, decreased functional activity tolerance, decreased static balance, and strength impairments. Physical Therapy Encounter Note 5/5/17 written by the Physical Therapy Assistant stated, "worked on standing and partial pivot with walker, sit to stand SBA (stand by assist) from elevated bed to walker, pivot was CGA (contact guard assist) to minimum assist for walker and cures when to move walker and feet, patient went to sit on bed and did not get completely on it, wen to lower bed for patient and during this time patient slide off bed and down to the floor, patient also had a silky gown on, grabbed for patient to help prevent any hard landing and to prevent head from hitting floor."	F 323	policy of this facility to 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. Corrective action for Resident affected: Resident #1 readmitted from the hospital on May 16, 2017. Rehab Program Manager informed Resident #1 that immediate education was provided to Therapist #1 and Therapist #2 on proper transfers and to use appropriate assistance devices. Therapist #1 and Therapist #2 able to return demonstrate proper transfer techniques to Rehab Program Manager on May 5, 2017. Resident #1 was reevaluated for therapy needs and is currently on therapy caseload. 2. Other Residents potentially affected by this deficient practice have been accessed as follows: All residents on therapy caseload with transfer goals on their plan of care have the potential to be affected; currently no falls with fractures have been reported since the May 5, 2017 incident. 3. The facility initiated the following corrective measures to assure that the deficient practice does not reoccur as follows: Immediately, Therapist #1 and Therapist	

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F 323	Continued From page 2 Occupational Therapy Treatment Encounter Note 5/5/17 stated, that Resident #1 sat down half way on the bed and was educated on scooting back to decrease fall risk. The resident stated she couldn ' t and started to slide down to the floor and was lowered to the floor. Review of the facility Incident/Accident report 5/5/17 stated, "Called to room by therapy with report they were transferring resident to bed when bed too high for resident and she slid onto floor. Found lying on back at bed with therapy at bedside. Complained of right leg pain and says her leg is broken." Hospital emergency department notes 5/5/17 stated, " 57 year old female with multiple comorbidities including HTN (hypertension), DM (Diabetes Mellitus, COPD (Chronic Obstructive Pulmonary Disease) and morbid obesity who presents as a transfer from Randolph for evaluation of RLE (Right lower extremity) tib/fib (tibia/fibula) fracture that occurred during rehab at her facility. Plain films demonstrated comminuted distal right tibial shaft fracture along with proximal, distal shafts of right fibula. Neurovascularly intact on exam." Review of the hospital operative report 5/8/17 revealed a pre-operative diagnosis of right tibial fracture. The resident ' s fracture was repaired with surgical management. Review of the resident assessment completed 7/3/17 revealed that the resident scored 15 on the brief interview of mental status indicating that she had no problem with memory and was cognitively intact. During interview with Resident #1 at 5:15 PM on	F 323	#2 were reeducated by Rehab Program Manager on how to complete proper transfers and how to use appropriate assistance devices. On May 8, 2017 an in-service was held by the Rehab Program Manager for full-time therapists, therapy assistants, and rehab aides to include how to complete proper transfers and to use appropriate assistance devices. July 24, 2017 Rehab Program Manager in-serviced all therapy staff including therapists, therapy assistants, and rehab aides including weekend and PRN staff to include how to complete proper transfers and to use appropriate assistance devices. Staff was not allowed to work with residents until they had received this in-service. All new therapy hires will not be permitted to work with residents until they receive this education. The Rehab Program Manager and/or Staff Development Coordinator will do 100% transfer audits on patients on current caseload with transfer goals on their plan of care. Rehab Program Manager and/or Staff Development Coordinator will complete 10% audits on patients on current caseload with transfer goals on their plan of care weekly times 12 weeks. 4. The facility initiated the following measures to monitor compliance with the plan of corrective measures as follows: The results of the transfer audits will be reported in monthly QAPI times three	

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F 323	Continued From page 3 7/23/17 she stated that she got out of the wheelchair and staff told her to pivot backwards and move until her legs hit the bed then to sit down. The resident said she did and sat on the edge of the bed. There was one staff down near the closet and one at the head of the bed. After she sat down the therapy staff member raised the bed causing her to fall and break her leg. Resident #1 stated that her feet came off the floor, she began falling and she heard her leg snap. She also reported that staff usually come to her to get her legs up. She said that she had pain in her knee, hands, arms, ankle and toes prior to the fall due to neuropathy. "It felt like wearing a sock all the time and now it felt painful and sharp from her knee to her ankle. The resident said that she had pivoted before and there was someone there holding her arm or a walker. She stated, "I told them it wore me out." She stated that she had the walker that day but someone moved it out of her reach. The resident stated that the staff did not use a safety belt. The resident reported that the OT (occupational therapy) staff told her that it was their fault. Interview with the PT (Physical Therapy) staff at 9:15 PM on 7/23/17 revealed that she was standing right next to Resident #1 next to the bed on the right hand side. The resident sat on the bed but not far enough. The resident had on a slippery gown and slid to the floor. The staff stated she was hanging onto the walker and I was standing next to her. The OT staff was trying to get the remote to lower the bed but she could not really reach the remote because it was on the opposite side at the foot of the bed if I recall. She stated that the bed was at the height needed for the resident to stand up. She was said the resident was so nervous and want to sit. She	F 323	months by the Rehab Program Manager or Rehab Aide for tracking and trending purposes with all follow up action determined by the Interdisciplinary Team.	

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was rushing, doing it so quickly sat down too soon. The bed height had not been a problem in the past. She stated they were working on moving from the bed to the wheelchair and the resident had already turned back and took a little step backwards to get back to the bed. She was practicing sitting down. Her back was to the bed and she needed to go 5-6 inches with her feet. She stated it happened so fast, not rushing would have prevented the fall. She stated that she had not seen Resident #1 since her return from the hospital.

During interview with the OT staff at 9:25 PM on 7/23/17 she stated, "Myself and PT were working with her to safely transfer to the wheelchair. " We stood her up bed raised and she did her half turn. She told her to sit when she felt the back of the bed behind her. She sat halfway. Then told her to stand up so that we could get her on the bed, that ' s when she fell. The bed was the same height as when she got out of bed. When she tried to get back on the bed we braced her feet and tried to lower the bed but couldn ' t get to the remote in time. The resident said I ' m going down, I ' m going down. The other staff was in front of the resident bracing her feet. The PT staff said that she was on the resident ' s right side (closet side) and the remote was on the resident ' s left side. The physical therapist was in front of the resident. The walker was right in front of her and the legs went up a little bit when she fell.

Interview with the rehabilitation manager at 9:06 PM revealed that she in-serviced her staff regarding using gait belts and safe transfers. She did not take any written statements from the staff. The rehabilitation manager stated the staff told

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her they were using a gait belt.

Interview with a nursing assistant at 9:30 PM on 7/23/17 revealed that Resident #1 is alert and oriented.

Interview with Resident #1 at 9:45 PM on 7/23/17 revealed that the physical therapy staff was at the head of the bed with her back turned and OT staff was standing in the corner. The resident said that she was sitting pretty good but she was not all the way on the bed.

Interview with the OT (occupational therapy) staff at 1:49 PM on 7/24/17 revealed that they did not use a gait belt because it hurt the resident more.

During interview with the PT (physical therapist) at 2:04 PM on 7/24/17 she stated that they did not use a gait belt. The one she had with her would not fit. The resident is a large woman.

Interview with a nurse on the resident ' s hall at 4:01 Pm on 7/24/17 revealed that the resident was alert and oriented and if the resident said something happened, it ' s true.