STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345383	A. BUILDING _____ B. WING _____	C 03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTTISH PINES REHABILITATION AND NURSING CENTER	620 JOHNS ROAD LAURINBURG, NC 28352

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID #4WHY11.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to use the assigned mechanical lift to transfer a resident from the bed to a wheelchair, resulting in a left femur fracture which required surgery for 1 of 1 sampled residents (Resident #98). Findings included: Review of Resident #98's annual Minimum Data Set (MDS) dated 01/19/18 revealed a readmission date of 11/02/16 and diagnoses of Parkinson's disease, non-Alzheimer's dementia and diabetes. Resident #98 was severely cognitively impaired. Resident #98 required the extensive assistance of two persons for transfers and had no impairment in the functional range of motion in the upper and lower extremities. Resident #98 did not reject care. Review of Resident #98's Care Plan revised 01/19/18 revealed the resident was at risk for falls due to increased weakness and that extensive assistance for activities of daily living (ADLs) was	F 689	Past noncompliance: no plan of correction required.	3/27/18

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

Electronically Signed | 03/27/2018

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required. Goals included a reduction in the risk for falls and the improvement to limited assistance for ADLs. Interventions included the use of a mechanical lift. Included in the Care Plan was the Kardex which direct care staff utilized to provide care to residents. The Kardex revealed Resident #98 was a transfer by mechanical lift only.

Review of the General Nursing Notes dated 02/11/18 at 6:12 PM written by Nurse #2, revealed that approximately one hour prior to shift change Resident #98 was lowered to the ground by Nursing Assistant (NA) #4 who was transferring the resident to a wheelchair from the bed. Resident #98 was picked up off the floor by Nurse #2 and NA #4 and placed into the wheelchair. Nurse #2 assessed Resident #98 at that time and no complaints were noted. As the day progressed Resident #98 complained of left leg pain and an order for an x-ray was obtained and the x-ray was completed.

Review of the Radiology impression dated 02/11/18 revealed Resident #98 had a fracture to her left leg.

Review of a Late Entry General Nursing Note dated 02/12/18 revealed Physician #1 had been notified of Resident #98's fracture at approximately 8:20 PM on 02/11/12. A new order was received to send Resident #98 to the Emergency Room (ER).

Review of the Hospital Discharge Summary dated 02/14/18 revealed Resident #98 underwent a surgical repair of the left leg fracture.

Review of the undated and unsigned Summary of

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Investigation revealed the facility determined the incident was related to the employee's failure to follow Resident #98's plan of care as indicated on the Kardex.

Review of the facility Investigation initiated 02/12/18 revealed NA #4 failed to transfer Resident #98 per the plan of care utilizing the mechanical lift. NA #4 attempted to transfer Resident #98 without assistance which resulted in a guided fall to the floor. Later in the day Resident #98 complained of pain and was transferred to the hospital. X-rays revealed an acute impacted fracture of the distal femur.

Review of the typed witness statement in the Occurrence Report dated 02/11/18 revealed Nurse #2 indicated Resident #98 was being dressed and transferred into a wheelchair and was lowered to the ground.

In a telephone interview on 03/15/18 at 2:29 PM Nurse #2 indicated NA #4 came to her and informed her that Resident #98 had been lowered to the ground after becoming weak during a transfer. Nurse #2 stated that she and Charge Nurse #1 physically lifted Resident #98 off the floor into the wheelchair. She stated she assessed Resident #98 who had no complaints of pain at that time. She indicated that later that day Resident #98 began to complain of pain and an x-ray was ordered. Nurse #2 stated that NA #4 had not asked her how to transfer Resident #98. She indicated that if an aide did not know how a resident was transferred, the aide should ask the nurse or look it up. She stated if there was any doubt then a mechanical lift should be used.

Review of NA #4's undated handwritten witness

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statement revealed she had asked Nurse #2 how residents were transferred and had not been told that Resident #98 required a mechanical lift. During the physical transfer of Resident #98 to the wheelchair, Resident #98's knees became weak and NA #4 placed Resident #98 on the floor. NA #4 notified Nurse #2 who came to the room and attempted to physically lift Resident #98 off the floor. The attempt was unsuccessful and the assistance of Charge Nurse #1 was requested. Nurse #2 and Charge Nurse #1 physically lifted Resident #98 into the wheelchair from the floor. Resident #98 had no complaints for the remainder of the shift.

In a telephone interview on 03/15/18 at 10:02 AM NA #4 stated she had been employed by the facility for three weeks at the time of the incident and was not that familiar with Resident #98. NA #4 stated she asked Nurse #2 how residents got up and was not told that Resident #98 needed a mechanical lift for transfers. She indicated she knew she should look at Resident #98's care plan but since she was not familiar with the resident she asked the nurse. NA #4 stated she sat Resident #98 on the side of the bed, wrapped her arms around her, and lifted the resident off the bed. She indicated Resident #98's knees became weak and she lowered the resident to the floor. NA #4 stated she went to get Nurse #2 and they attempted to lift Resident #98 off the floor. When they were unable to lift Resident #98, Charge Nurse #1's assistance was requested. Charge Nurse #1 and Nurse #2 physically lifted Resident #98 off the floor and into the wheelchair. NA #4 indicated Resident #98 did not complain of pain to her.

Review of a Witness Interview Form dated

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03/15/18 and signed by the Director of Nursing Services (DNS) revealed a hand written interview with Charge Nurse #1. In the interview, Charge Nurse #1 revealed Nurse #2 requested assistance with transferring Resident #98. When Charge Nurse #1 arrived at the room, Resident #98 was sitting on the floor and had no complaints. Resident #98 was physically lifted into the wheelchair and then began to complain of left leg pain.

In a telephone interview on 03/15/18 at 1:27 PM Charge Nurse #1 stated NA #4 indicated Resident #98 had been eased to the floor. Charge Nurse #1 and Nurse #2 physically lifted Resident #98 to the wheelchair and did not use a mechanical lift for the transfer. Charge Nurse #1 stated Resident #98 did not complain of pain at that time but started to complain of pain about an hour or two after the incident. Charge Nurse #1 stated resident transfer information was listed on the Kardex and that aides should check there to see what type of transfers residents needed.

In an interview on 03/15/18 at 3:30 PM the Director of Nursing Services (DNS) stated she expected the aides to check the Kardex in the computer kiosk for resident transfer requirements. She indicated that if an aide did not know how a resident was transferred they could always call her, the Administrator, or a therapist for the information. The DNS indicated if there was any doubt then a mechanical lift should be used.

Review of the facility Plan of Action dated 02/12/18 revealed:

1. Corrective action for the resident affected.

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An in-house x-ray was ordered and an order to send the resident to the ER for an evaluation was received. An interview with the aide was conducted to determine the root cause analysis of the incident. It was determined the aide did not utilize the computer kiosk to determine the correct transfer method for Resident #98. Disciplinary action took place.

2. Corrective action for residents with the potential to be affected. All mechanical lifts were inspected by the Maintenance Director. Resident Kardexes and care plans were reviewed to make sure they matched and were the safest transfer method. The safest transfer methods for new admissions were to be determined by a therapist and placed in Kardex. The resident census was updated and lift transfers highlighted and placed in NA notebook and in the narcotic book on each resident hall.

3. What measures/systems will be put into place to ensure the deficient practice does not occur again? All NA's were in-serviced on facility policy to properly transfer residents, how to determine proper transfer method on the Kardex and how to safely remove residents from the floor post fall. During new hire orientation NAs will be trained on the proper use of mechanical lifts and where to find the transfer information in the Kardex. "Safe Resident Handling" Power Point presentation will be reviewed with all new hires. Mechanical lifts will continue to be inspected weekly and repaired as needed. "Safe Resident Handling" and the facility "Buddy Program" will be reviewed annually. Transfer audits will be conducted randomly for four weeks. Any non-compliance will be addressed as it occurs and discussed in morning clinical meetings.

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Transfer audits will be reviewed and discussed by the safety committee monthly. The Orientation Checklist was updated to include a return demonstration of locating the Kardex on the facility kiosk.

4. How will performance be monitored and how often? The results of the compliance with the plan will be discussed and the minutes recorded for four months during the facility's monthly QAPI meeting with adjustments to the plan made as needed. The results of the audits and compliance with the plan will be discussed and minutes recorded quarterly for three quarters during the quarterly QAPI committee meeting. Should revisions be necessary appropriate staff would be re-in-serviced by the Administrator, DNS, or appropriate designee.

The Action Plan showed in-servicing of NAs had been completed by 02/13/18. Mechanical Lift Transfer lists were seen in the NA notebook and in the narcotic books on each hall. The mechanical lifts had been inspected by the Maintenance Director. Audits were ongoing.

In an interview on 03/15/18 at 11:35 AM NA #5 stated if she needed to find out how a resident needed to be transferred she would look in the computer kiosk. NA #5 proceeded to bring the lift information up on the kiosk screen. She indicated the information was also kept in the NA book at the nursing station.

In an interview on 03/15/18 at 1:45 PM NA #1 indicated if she did not know how to transfer a resident she would look in the computer for the information.