STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 08/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARY HEALTH AND REHABILITATION	**6590 TRYON ROAD CARY, NC 27518**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 staff and Nurse Practitioner interviews and record review, the facility staff let go of a resident while giving care to one of three residents reviewed for accidents (Resident #3) resulting in a fall causing the re-opening of a wound and being transported to the hospital. Findings included: A review of medical records revealed Resident #3 was readmitted on 4/15/2018 with diagnoses of open wound of abdominal wall peri umbilic region (around the belly button), Diabetes, hypertensive heart and chronic kidney disease with heart failure and Stage 5 chronic kidney disease and morbid obesity. The Significant Change Minimum Data Set (MDS) dated 5/13/2018 noted Resident #3 to be moderately impaired for cognition and needed extensive to total assistance for all Activities of Daily Living (ADLs). The MDS indicated Resident #3 was totally dependent for bathing and required the assistance of two persons. Resident #3 needed extensive assistance for bed mobility with the physical assistance of two persons. The MDS noted impairment on both sides of the lower	F 689	1. Resident #3 no longer resides in the facility. Root Cause analysis completed on 8/29/18. Ad Hoc QAPI committee meeting held on 8/29/18. Director of Nursing provided staff members, C.N.A. #4 and #5 re-education on 7/20/18 in regard to our policy and procedure on lifting and moving residents requiring 2 person assistance with bed mobility and bathing, ensuring services provided with recommended support / technique. 2. Director of Nursing, ADON and Unit Manager completed a quality review of residents requiring 2 person assistance with bed mobility and bathing ensuring services provided with recommended support / technique meet standard. Regional Director of Clinical services validated findings of quality review. Followed up based on Findings. 3. Director of Nursing, ADON and Unit Manager provided Nurse assistants re education regarding our policy and procedure on lifting and moving patients requiring 2 person assistance with bed mobility and bathing, ensuring services provided with appropriate support /	9/20/18

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

Electronically Signed | 09/10/2018

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F 689	Continued From page 1 extremities. The Care Area Assessment (CAA) focused on ADL function and this went to care planning. The CAA also noted a focus of risk for falls related to antidepressant use, need for assistance with mobility and functional limitations, and this was care planned also. No recent falls noted. The care plan dated 5/29/2018 noted Resident #3 had an ADL self-care deficit related to limited mobility and morbid obesity. The goal was Resident #3 would receive appropriate staff support for personal hygiene. Interventions included: Resident #3 was dependent on two staff regarding bathing. Resident #3 was on Hospice care. A review of the wound rounds progress notes revealed an assessment on 7/17/2018 stated Resident #3 was seen for chronic post-operative wound to the left abdomen. The wound measured 2 x 0.8 x 0.1. The wound had unhealthy/inadequate granulation tissue to the wound bed and mild serous drainage. No signs or symptoms of infection. The nurse progress note for 7/20/2018 indicated the writer was notified Resident #3 had slid out of bed during a bed bath. Upon entering the room, the writer found Resident #3 on her knees on the floor beside the bed. Resident #3 was assisted back to bed and the writer noted the abdominal wound had reopened and was bleeding. The treatment nurse was notified to assess the wound. Resident #3 denied pain or discomfort at that time and attempts were made to administer pain medication that were refused by Resident #3. The Physician Assistant (PA) was notified and an order was given to transport Resident #3 to	F 689	technique. 4. Director of Nursing, ADON and Unit Manager to conduct random quality improvement monitoring using a sample size of 5 patients requiring 2 person assistance with bed mobility and bathing to ensure appropriate support / technique, 5x/week x 4 weeks, 3x / week x 4 weeks, weekly x 4 weeks, then monthly and as needed. Utilizing a random sample, the Regional Director of Clinical Services to conduct validation of Quality improvement findings monthly x2, then quarterly x1 and as needed thereafter. Findings to be reviewed at monthly QAPI committee meeting. Monitoring schedule modified based on findings.	

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the hospital.

A review of the Situation, Background, Appearance, Review (SBAR) communication form revealed on 7/20/2018 the abdominal wound for Resident #3 re-opened. No pain or neurological changes noted. Vital signs were documented. Noted the clinician was notified.

A review of the hospital record dated 7/20/2018 revealed Resident #3 had a past medical history that included a non-healing abdominal wound since a surgery in 2015. Resident #3 was assessed in the Emergency Department (ED) and the ED physician noted the case was discussed with surgery. Further review of notes from the surgery indicated the abdominal wound was repaired with a surgical mesh.

On 8/16/2018 at 11:25 AM, NA #4 was interviewed and stated he and NA #5 were giving Resident #3 a bed bath on 7/20/2018. NA #4 noted he had given her a bed bath in the past and she was always able to hold on to the side rail. NA #4 said her hands were shaky and he had not noticed that before. NA #4 stated he turned to get a towel or toward the wash basin, let go of Resident #3 and she slid off the mattress and onto the floor on her knees. NA #4 stated it happened so fast and he could not grab her or keep her from falling. NA #4 noted there was a chair at the bedside and Resident #3 held onto it and NA #5 stayed with the Resident while he went for the nurse. NA #4 stated at no time was only one NA in the room and he had never given Resident #3 a bed bath without another NA with him, she was a two person assist for a bath.

In an interview on 8/16/2018 at 12:15 PM, the

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Unit Manager for Resident #3's hall stated NA #4 came to her and she entered the room and Resident #3 was on the floor, on her knees, holding on to a chair. The Unit Manager indicated she asked Resident #3 if she was hurt and the Resident stated no, she just wanted to get up. The Unit Manager noted the treatment nurse was called and, by that time, other staff were in the room and got the lift and got her into bed. The Unit Manager stated Resident #3 said she was not in pain, but the open wound could be seen.

On 8/16/2018 at 3:00 PM Nurse #1 was interviewed and stated she was told Resident #3 had fallen, she went into the room and the Resident was on the floor, on her knees, holding onto a chair. Nurse #1 stated there was some blood on the floor. Nurse #1 indicated she took Resident #3's vital signs and staff used the mechanical lift to put Resident #3 back into the bed. Nurse #1 noted the treatment nurse assessed the open wound and said Resident #3 had to be sent to the hospital. In describing the wound, Nurse #1 stated it looked like a skin tear, like the flap of skin could be picked up and laid back over the wound. Nurse #1 stated the Resident did not complain of pain.

On 8/16/2018 at 3:15 PM NA #5 was interviewed and stated he was in the room the entire time of the bed bath for Resident #3. NA #5 stated she was on one side of the bed with the side rail up and NA #4 was on the other side of the bed with the side rail up. NA #5 indicated the two NAs had rolled Resident #3 over toward NA #4 and NA #5 had finished washing and rinsing Resident #3's back and bottom and she asked NA #4 for a towel and when he turned to get it, he let go of Resident #3 and the Resident let go of the side

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rail and she went sliding out of the bed. NA #5 said "it happened so fast, I could not hold onto her." NA #5 stated the other NA went to get the nurse and I stayed with Resident #3 and she told me she was not hurt, she wanted to get up.

In an interview on 8/16/2018 at 4:36 PM, the Nurse Practitioner (NP) stated she was in the building and was called to look at Resident #3 who she did not know. The NP stated she looked at the wound and told staff to call the physician and 911. The NP stated the wound looked red.

The treatment nurse was interviewed on 8/17/2018 at 10:45 AM, and stated she was familiar with the wound because she made weekly rounds with the wound care specialist who came to the facility. The treatment nurse stated when she got to the room, Resident #3 was in bed. The treatment nurse described it as the skin was torn away, like a skin tear. The treatment nurse stated she did not see bleeding and the Resident did not complain of pain.

The Director of Nursing stated on 8/17/2018 at 11:30 AM that her expectation was that NAs needed to make sure residents were safe while care was being given.