STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345574	A. BUILDING ______ B. WING ______	C 04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLAROSE NURSING AND REHAB	200 BELLAROSE LAKE WAY GARNER, NC 27529

(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 000	INITIAL COMMENTS A complaint survey was conducted on 4/5/22. One of one complaint allegation was substantiated. (NC00187382) Past-noncompliance was identified at: CFR 483.25 at tag F 689 at a scope and severity of "G" Non-noncompliance began on 3/15/22. The facility came back in compliance effective 3/21/22.	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 observation, record review, and staff interview, for one (Resident # 1) of three sampled residents, the facility failed to assure a Nurse Aide safely assisted a resident with personal care. Nurse Aide # 1 attempted to dress Resident # 1 on a shower bed with the safety rail down. While the Nurse Aide assisted Resident # 1, the resident rolled off the shower bed and sustained a hip fracture which required surgical repairment. The findings included: Resident # 1 was admitted to the facility on	F 689	Past noncompliance: no plan of correction required.	4/11/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 04/11/2022

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.

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F 689	Continued From page 1 11/15/17 and had a diagnosis of Alzheimer's disease. Resident # 1's last quarterly assessment, dated 1/17/22, coded Resident # 1 as being severely cognitively impaired. The resident was also assessed to need extensive assistance with her bed mobility, dressing, and hygiene. She was totally dependent on staff for bathing and transferring. According to the assessment, she had not sustained any falls since the prior quarterly assessment. On 3/15/22 at 12:52 PM Nurse # 1 entered the following information into Resident # 1's facility record. The nurse was called to Resident # 1's room by a Nurse Aide (NA). Upon entering she observed Resident # 1 on the floor on her back side with blood on the left side of her head. The NA stated that upon rolling Resident # 1 on the shower stretcher to dry and dress her she rolled off the shower stretcher onto the floor. The NA had tried to stop the momentum of the fall but was unable to prevent the fall. Resident # 1 was immediately sent to the emergency room. Resident # 1's hospital records, for the dates of 3/15/22 to 3/19/22, were reviewed and revealed Resident # 1 sustained a left hip fracture from the fall. The bone was comminuted (broken in at least two places), and mildly displaced (out of alignment.) Resident #1 underwent surgery for the hip fracture on 3/16/22. According to the hospital records, Resident # 1 had an injury above her left eye which was documented to be "superficial." Resident # 1 was readmitted back to the facility on 3/19/22 for care.	F 689		

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F 689	Continued From page 2 Resident # 1 was observed on 4/5/22 at 11:20 AM with Nurse # 2. Resident # 1 did not verbally respond, but it was observed she had a slight tremor in her arm. Nurse # 2 commented her eyes seemed to be "squinched" and the tremor was possibly because of pain. Nurse # 2 stated Resident # 1 had pain medication and she would administer. NA # 1 had been the Nurse Aide who had cared for Resident # 1 on the day of her fall. NA # 1 was interviewed on 4/5/22 at 12:45 PM and again at 2:35 PM and reported the following details. On the day of the incident, she had obtained the assistance of another Nurse Aide to transfer Resident # 1 to the shower bed using a mechanical lift. Once Resident # 1 was on the shower bed, she (NA # 1) was able to shower her independently. Following the shower, she rolled the shower bed into Resident # 1's room so that the shower bed was beside Resident #1's bed in a parallel position. She decided to dress Resident # 1 on the shower bed, get the mechanical lift sling beneath her, and then get another staff member's assistance to use the mechanical lift to transfer her back to bed. She left a gap between the resident's bed and the shower bed so that she could go around the shower bed to assist Resident # 1. Therefore, the shower bed was not up against the resident's bed. She placed Resident # 1's shirt completely on and her pants partially on. By that point, she (NA # 1) was on Resident # 1's left side. She had also gotten the mechanical lift sling under Resident # 1's right side and needed to pull it through to the left side. She rolled Resident # 1 toward the right side away from her in order to pull the sling completely from underneath Resident # 1; using the sling to	F 689		

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F 689	Continued From page 3	F 689		

help her move the resident as she was moving her and pulling it on through. Resident # 1 moved her left leg at that time and started to roll off the right side of the shower bed. The safety rail was not up on the right side of the shower bed. The NA reported she had left it down because she was going around the shower bed while assisting to dress her. She could not stop Resident # 1 from rolling off the bed. During the 2:35 PM interview, NA # 1 was accompanied to view the shower bed she had been using. The shower bed was observed to have a narrower bed surface than a standard bed. The bed surface was stationary at a level which would be at the waist level of working staff members.

On 4/5/22 measurements of the facility's beds and the shower bed were confirmed with the Quality Assurance Nurse. (QA) The shower bed was 26.5 inches in width. The resident's standard bed was 35 inches in width.

The QA nurse was interviewed on 4/5/22 at 2:10 PM and 2:50 PM and reported the following. They had investigated the fall and worked to determine the root cause of the incident. According to the QA nurse the NA should not have been trying to dress and maneuver Resident # 1 on the shower bed with a mechanical lift sling. The QA nurse stated the surface area was narrower than a standard bed, the surface could still have been slippery, and there needed to have been a draw sheet beneath the resident rather than pulling on the mechanical lift sling to maneuver the resident. The QA nurse reported that NA #1 had been Resident # 1's long term NA, often cared and dressed for Resident # 1 alone and there had never been any incidents because Resident # 1 was always in the bed. The QA nurse felt NA # 1's

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F 689	Continued From page 4	F 689		

decision to attempt to dress her on a shower bed before getting help to transfer her back to bed and dress her had contributed to the fall. Following their investigation, they had implemented a plan of correction which involved In-service training for all their nurse aides regarding safety in showering and dressing residents who required the use of the shower bed. The nurse aides had been taught to always transfer residents back in bed from the shower bed prior to dressing a resident, to always use a draw sheet to position a resident, and to keep the safety rail up on the shower bed when not in attendance. They had also initiated audits where they observed nurse aides who required the use of the shower bed. The QA nurse presented documentation of their plan of correction. The plan of correction was directed to assure all residents who required showering on a shower bed received care safely.

The plan of correction included the following:

Identified Area: Shower Bed Dressing:
Root cause analysis/What led to the deficient practice. Resident fell off shower bed. NA dressed resident on shower bed. NA did not realize shower bed was still slippery. NA used mechanical lift pad to turn resident from side to side. NA did not know she needed to put resident back in bed before dressing. NA did not realize fall would occur from dressing on shower bed. The resident had a witnessed fall while being dressed on the shower bed.

All residents, who required the use of the shower bed, were identified to be at risk for the deficient practice and the plan of correction addresses their risk.

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F 689	Continued From page 5	F 689		

The procedure for implementing the acceptable plan of correction for the deficient practice: All NAs were in-serviced on transferring residents that use the shower bed back to bed before dressing. All new staff will be in-serviced during orientation. Resident was sent out to be examined by ER immediately after fall. The staff development. Inservice training was conducted by the staff development coordinator. The training was begun on 3/15/22 with target completion date of 3/18/22.

The QA team met on 3/15/22 and decided to include this issue within their quality assurance program and initiate monitoring procedures to ensure that the plan of correction is effective and that the deficient area remained in compliance: Monitoring began on 3/16/22 by the Quality Assurance Nurse. Monitoring included: Staff will be observed for proper techniques dressing residents who use the shower bed after shower, 2 residents 2 X a week X 4 weeks and then 2 residents 1 X a week X 4 weeks and then 2 residents 1 X a week for a total of 12 weeks. The results from these audits will be brought to the QA meeting monthly for review and continued monitoring if needed.

Title of the person responsible for implementing the plan of correction: QA Nurse/SDC (Staff Development Nurse)

Facility's planned date when corrective action will be completed by 3/18/22

The facility's corrective action plan was validated on 4/5/22 by the following.

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F 689	Continued From page 6 Nurse Aides (including Nurse Aide # 1) from different shifts were interviewed and reported they had received Inservice training about falls. Nurse Aides reported they would use 2 people to transfer a resident back to bed after using a shower bed, keep the rail up if not by that side of the shower bed, and always dress the resident in the bed and not on the shower bed. Inservice training logs were reviewed and revealed nurse aides had signed they attended the facility's education following the incident or were called via phone and received training. Quality assurance monitoring logs were reviewed and revealed audits were begun on 3/16/22 and continued per the facility's plan of correction timeline. Residents were interviewed during the survey and reported they felt Nurse Aides cared for them in a safe manner. On 4/5/22 it was validated with the facility's QA nurse that Inservice training for nurse aides had been completed on 3/21/22 rather than 3/18/22. The facility is found to be back in compliance effective 3/21/21; which corresponds to the date the QA nurse stated in-service training was complete and audits were documented to be under-way.	F 689		