

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/25/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345534</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>SANFORD HEALTH &amp; REHABILITATION CO</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2702 FARRELL ROAD</b> <b>SANFORD, NC 27330</b>		
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F 000	INITIAL COMMENTS  The 2567 was amended on 4/5/18. A revisit and complaint survey was conducted from 3/12/18 through 03/15/18. Immediate Jeopardy was identified at:  CFR 483.25 at tag F 689 at a scope and severity (J) CFR 483.12 at tag F 600 at a scope and severity (J)  The tags F 689 and F 600 constituted Substandard Quality of Care.  Immediate Jeopardy began on 03/07/18. Immediate jeopardy was removed on 3/12/18.	F 000			
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1)  §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.  §483.12(a) The facility must-  §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and interviews with facility staff, the facility neglected to use 2 staff	F 600	Resident #1 reported leg pain to Nurse #1 on 3/7/18 at approximately 3:35 pm.	3/22/18	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/03/2018

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 600	<p>Continued From page 1</p> <p>members to provide incontinence to Resident #1, failed to report a fall sustained by Resident #1 to the nurse or any other staff. The staff member moved the resident, alone, before being assessed for serious injury, from the floor to the bed using a mechanical lift (resident required the assistance of two persons) putting the resident at risk for more injuries. This resulted in delay in treatment of a fractured left femur and pain for three days. This was evident for 1 of 3 residents reviewed for neglect.</p> <p>Immediate jeopardy began on 3/07/18 when nurse aide (NA) #1 failed to report a fall sustained by Resident #1 to the nurse or any other staff member, moved the resident by herself from the floor to the bed using a mechanical lift, putting the resident at risk for more injuries. This resulted in delay of treatment of a fractured femur and pain to her leg from 3/07/18 to 3/10/18. Immediate jeopardy was removed on 3/12/18. The facility remains out of compliance at a lower scope and severity of "D" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to complete staff education and ensure monitoring systems put into place are effective.</p> <p>Findings included:</p> <p>Resident #1 was admitted to the facility on 6/2/14 with the current diagnosis of diabetes, peripheral neuropathy, muscle weakness, and hemiplegia.</p> <p>Resident's #1 Quarterly Minimum Data Set (MDS) dated 1/3/18 revealed Resident's #1 cognition was moderately impaired. The resident had no behaviors or moods. Resident #1 was totally dependent on staff for bed mobility and transfers and required the assistance of 2 people.</p>	F 600	<p>Nurse #1 contacted physician with new orders for increased Neurontin on 3/7/18 at 6pm. The RP was notified on 3/7/18 of complaint of pain and new order. The Resident reported relief with new orders on 3/7/18. The Resident reported on 3/8/18 that Neurontin continued to be effective for leg pain. Resident reported increased leg pain to Nurse #2 on 3/10/18 at approximately 3:00 pm. Assessment by Nurse #2 indicated increased pain upon palpation. The Physician was notified by Nurse #2 with orders for an x-ray. The X-ray was obtained on 3/10/18 at 4:30 pm and indicated a left femur fracture. The Physician was notified of results by Nurse #2 on 3/10/18 at approximately 5:00pm with new orders to send resident to Central Carolina Hospital for direct admission. The RP was notified by Nurse #2 on 3/10/18 at approximately 5:00pm.</p> <p>The Resident denied any accidents/injuries when assessed by Nurse #2 on 3/10/18; however, resident's roommate reported that during care, a CNA rolled Resident #1 off bed and onto floor. Resident #1 was coded as moderately cognitively impaired, was usually understood, and always understood others per the MDS assessment of 1/3/18. The roommate was assessed as cognitively intact, was always understood, and always understood others per the MDS assessment of 12/28/17. The roommate was interviewed on 3/11/18 by the Director of Nursing, and reported she had not</p>		

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F 600	<p>Continued From page 2</p> <p>The resident also was totally dependent on staff with locomotion, dressing, toilet use and personal hygiene and supervisor with eating. Resident #1 was not steady with surface to surface transfers and had impairment on 1 side of her upper extremity and on one side of her lower extremity. The resident was always incontinent of bowel and bladder.</p> <p>Review of Resident #1's current care guide (which are located in the resident's closet) dated 2/22/18 revealed that the resident required 2 people for assistance with turning, repositioning, and incontinence care.</p> <p>Review of the Medication Administration Record (MAR) dated 3/2018 revealed the resident received the increase dose of 400 milligrams (mg) Gabapentin on 3/7/18 at 9:00 PM; 3/8/18 at 9:00 AM, 1:00 PM and 9:00 PM; 3/9/18 at 9:00 AM, 1:00 PM and 9:00 PM and on 3/10/18 at 9:00 AM and 1:00 PM.</p> <p>The pain assessment on the MAR revealed the resident's pain level was a 3 on 3/8/18 at 9:00 AM.</p> <p>A nursing note dated 3/7/18 written by Nurse #1 stated that Resident #1 complained of increased pain to legs this shift and the physician was contacted and received a new order to increase the Gabapentin (a medication given for neuropathic pain) dosage and to administer three times a day.</p> <p>A nursing note dated 3/10/18 written by nurse #6 revealed Resident #1 complained of pain to the left femur and hollered out in pain when palpated. The physician was notified and a left femur</p>	F 600	<p>confided in any staff that Resident #1 was rolled onto the floor on 3/7/18.</p> <p>The event occurred as a staff member did not follow facility procedures for following the care guide for turning and repositioning, did not follow facility procedures for use of a mechanical lift, and did not follow facility procedures for reporting accidents/incidents. CNA #1 reported during an interview on 3/11/18 and 3/12/18 that she was aware of her requirements to report accidents and injuries, follow the care guide, and did not ask for assistance although assistance was available. Resident #1's care guide indicated that the resident required 2-person assistance with turning, repositioning, and incontinent care. CNA #1 reported during the interview that she was in a hurry to complete her last rounds and did not ask for help as she felt she could care for the resident alone. CNA #1 stated in the interview that she was aware of her responsibility to report but neglected to do so without reason. CNA #1 was aware that failure to report an incident is considered neglect as per education and in-servicing providing throughout her employment.</p> <p>CNA #1 informed the DON on 3/11/18 at approximately 11:30am that while providing care on the morning of 3/7/18 that she accidentally rolled Resident #1 out of the bed and onto floor. CNA reported that she was aware that care path indicated resident requires 2-person assistance, but she was in a hurry and</p>		

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F 600	<p>Continued From page 3</p> <p>X-RAY was ordered. The X-RAY result showed a displaced spiral fracture of the proximal femur. The physician was notified and the resident was sent to the hospital. Resident #1 left the facility via Emergency Medical Services at 6:00 PM.</p> <p>An incident report (no incident time or date) but had a date of 3/10/18 under notification. The incident report stated that Resident #1 had a fall/injury and the resident had a fracture. After complaint of increased left leg pain and a nursing assessment, an X-RAY was ordered and revealed a left femur fracture. The Resident denied accident/injuries. The resident's roommate (Resident #2) reported that NA #1 rolled the resident off of the bed and onto the floor while performing care on the morning of 3/7/18. The left femur X-RAY revealed a displaced spiral fracture of the proximal femur. The physician was informed and the resident was sent to the hospital on 3/10/18. The incident report also revealed that the incident was reported to the state on 3/11/18 at 8:35 PM.</p> <p>Review of Resident #1's Hospital records dated 3/10/18 revealed that the resident was admitted with reports of left, thigh pain and was noted to have an acute left, proximal, spiral, displaced fracture of the femur. There were no reports from the nursing facility of trauma. The resident's hemoglobin was 4.3 and she was admitted to the intensive care unit for profound anemia and required multiple blood transfusions. Orthopedics were consulted, and on assessment, showed that the resident was unable to move her left lower extremity.</p> <p>NA #1 (who worked with Resident #1 during the night shift of 3/6/18 and the early morning on</p>	F 600	<p>failed to illicit assistance. CNA #1 reported that after Resident #1 was on the floor, working alone, she utilized a mechanical lift to transfer resident from floor to bed. CNA #1 stated that she was aware of reporting requirements, but failed to report the incident to anyone. CNA#1 was removed from the schedule on 3/11/18. The Police were contacted by the Director of Nursing, on 3/11/18 at 7:29pm. A 24-hour report for neglect was submitted by the Director of Nursing on 3/11/18 at 8:35pm.</p> <p>The resident left the facility with EMS on 3/10/18 at approximately 5pm in transfer to the hospital.</p> <p>A 100% skin assessment of all residents was completed by the Director of Nursing, and staff nurses on 3/11/18 including assessment of ROM, bruising, swelling, and signs/symptoms of pain. During the assessments, the Director of Nursing questioned the alert and oriented residents if they have had any pain, accidents, falls or issues with feeling they have been neglected. No concerns were identified.</p> <p>An in-service was initiated on 3/11/18 by the Staff Development Coordinator to include all staff regarding reporting of incidents/accidents and abuse/neglect immediately to the Charge Nurse. The in-service included that lack of providing care to a resident per the care plan is considered neglect and included the definition of neglect. This in-service</p>		

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F 600	<p>Continued From page 4</p> <p>3/7/18) was interviewed on 3/13/18 at 12:59 PM. NA #1 stated Resident #1 was in the bed most of the time. Resident #1 was alert and oriented. NA #1 stated on 03/07/18, Resident #1 was incontinent and she went to change her. During the provision of care, Resident #1 rolled off the left side of the bed onto the floor. NA #1 stated she was changing Resident #1 by herself and she tried to stop her from rolling off the bed by grabbing her arm. She stated that after the resident fell off the bed, she left the resident's room to get the mechanical lift. NA #1 stated that she moved the furniture in the resident's room and placed Resident #1 back in the bed with the lift on her own. She stated that the resident reported pain and she let the nurse know the resident was in pain. NA #1 stated she did not report to the nurse that Resident #1 fell from her bed onto the floor and she knew it was wrong, but she didn't want to lose her job. NA #1 stated that she did not report the incident to anyone. NA #1 stated they were supposed to have 2 people to help with the lift and providing care to Resident #1 but sometimes you could not get 2 people to help and the nurses would not help sometimes so they had to use only 1 person.</p> <p>Nursing Assistant #2 (who worked with Resident #1 during the 7:00 AM to 3:00 PM shift on 3/7/18, 3/8/18, 3/9/18, and 3/10/18) was interviewed on 3/13/18 at 12:16 PM. NA #2 stated Resident #1 was alert and oriented. The resident would be changed in the bed but would get up occasionally. The resident transferred via the mechanical lift and the assistance of 2 people. She stated Resident #1 required 2 people to be turned in bed but sometimes she just did it herself. She stated she was recently giving Resident #1 a bed bath and the Resident complained of pain in her leg</p>	F 600	<p>included instruction on not moving a resident after a fall due to danger of causing further injury until assessed by a nurse. All employees receive education on hire and annually that indicates that it is safe to report accidents/injuries without fear of disciplinary action. No staff will work beyond 3/11/18 until they have received the in-service. Newly hired staff will receive the in-service during orientation.</p> <p>Utilizing a Progress Note Review QI Audit Tool, the Unit Managers x 2 and/or Weekend Supervisor will review progress notes daily x 2 weeks, then twice weekly x 2 weeks, then weekly x 4 weeks, then monthly x 1 month to identify any resident complaints of pain to assure a full assessment had been documented. Utilizing a Resident Interview for Neglect QI Audit Tool, the Social Worker will interview 5 alert and oriented residents weekly x 8 weeks, then 5 residents monthly x 1 month to ensure no neglect of care had occurred. Utilizing a Pain Audit tool, the Unit Managers x 2 and/or Weekend Supervisor will review progress notes daily x 2 weeks, then twice weekly x 2 weeks, then weekly x 4 weeks, then monthly x 1 month to identify any nonverbal residents with complaints of pain to assure a full assessment has been documented.</p> <p>The Director of Nursing will review the QI Audit Tools weekly x 8, then monthly x 1 for trends and concerns.</p>		

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F 600	<p>Continued From page 5</p> <p>(stated this was on Tuesday, 3/6/18 or Wednesday 3/7/18). NA #2 stated that the Resident's roommate (Resident #2) stated that something happened to Resident #1 and Resident #1 told Resident #2 to "mind her business." Resident #1 stated that nothing happened but that her leg hurt. She stated that she told nurse #1 and she didn't get the resident up. Resident #2 never said exactly what happened and could be confused at times. Resident #1 then became very drowsy and did not want to get up. Resident #1 also stated that she had pain whenever she asked her. NA #2 stated she got Resident #1 up one time that week (either on Wednesday, 3/7/18 or Thursday 3/8/18) because the resident stated she wanted to see if it would help with the pain. She gave the resident her lunch tray and it was usual that Resident #1 fell asleep when she gave her meal. However, on Saturday 3/10/18, she gave Resident #1 her lunch and Resident #1 was confused and started saying "where am I." NA #2 stated that she and Nursing Assistant #3 were changing Resident #1 and when they turned the Resident, she started hollering, crying and grabbed NA #2 like she was in horrible pain. Nurse #1 came in to see the resident and barely touched her leg and the resident yelled out. NA #2 stated that the Resident's roommate (Resident #2) then stated that earlier in the week, NA #1 was changing the resident by herself and rolled her off the bed.</p> <p>Nurse #1 (who worked with Resident #1 on 3/7/18 and 3/8/18 during the 7:00 AM to 7:00 PM shift was interviewed on 3/13/18 at 2:15 PM. She stated Resident #1 was alert and oriented and could make her needs known. Nurse #1 specified that Resident #1 required maximum assistance</p>	F 600	<p>The Administrator will report the results of the monitoring to the Quality Assurance Committee monthly x 3 months for trends, concerns, and recommendations for any modification of the process.</p> <p>The Administrator will be responsible for implementing the plan of correction.</p>		

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F 600	<p>Continued From page 6</p> <p>and the assistance of 2 people to get up. Resident #1 needed 2 people for transfers and for bed mobility. Nurse #1 stated during the morning of 03/07/18, the NA informed her that Resident #1 was having some pain. Nurse #1 stated that Resident #1 was complaining of pain in her leg but could not pinpoint the location of the pain. The Resident stated that the pain was burning and she gave the resident some medication for pain. She stated the Resident was also rubbing her leg but it was not red or swollen. She stated that she looked at the Resident's leg and that she was able to move the Resident's leg, adjust it and it was ok but it just hurt per the Resident. Nurse #1 stated she contacted the doctor and was given orders for Neurontin to be increased to three times a day and she gave the resident the medication. She thought the Resident was having possible nerve pain, which was why she got the Neurontin medication increased. Nurse #1 stated that she did not get any reports from the staff that night about Resident #1 falling.</p> <p>Attempts were made to contact Nurse #5, who worked with Resident #1 on 3/7/18 from 7:00 PM to 7:00 AM, but Nurse #5 could not be contacted for an interview.</p> <p>NA #4 (who worked with Resident #1 on 3/7/18 from 3:00 PM to 11:00 PM) was interviewed on 3/13/18 at 3:57 PM. NA #4 stated she got in report that the Resident's leg had been sore. NA #4 stated that Resident #1 informed her that her leg was hurting and that Resident #1 did not usually complain of pain. NA #4 stated that she told the nurse that Resident #1 was in pain. Resident #1 would not tell her why her leg was hurting. NA #4 stated that the Resident would let</p>	F 600			

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F 600	<p>Continued From page 7</p> <p>them change her, but was having pain in her leg when they rolled her over so she adjusted how she rolled her and the resident seemed fine.</p> <p>NA #5 (who worked with Resident #1 during the 3rd shift on 3/7/18 and 3/9/18) was interviewed on 3/13/18 at 2:43 PM. She stated the resident was incontinent and she usually changed the resident by herself but technically they were supposed to have 2 people. NA #5 stated that she changed Resident #1 by herself because she was used to the resident. NA #5 stated that Resident #1 was usually alert and oriented and would tell staff if something was wrong. She stated that recently she turned Resident #1 on the right side, crossed her legs over with a little push and the resident said it hurt so she turned the Resident on the other side. She thought the Resident was uncomfortable and she turned her the other way and the resident seemed ok the other side.</p> <p>NA #8 was (who assisted NA #2 with the care of Resident #1 on 3/10/18 during 3:00 PM to 11:00 PM shift) was interviewed on 3/13/18 at 3:54 PM. She stated that Resident #1 needed 2 people to get her up and needed the lift. The Resident was usually alert and oriented. NA #8 stated that NA #2 asked her to come in the room to help with the care of Resident #1 on 3/10/18 and she asked the resident if she was having pain. The resident was rubbing her leg. She stated she also asked the Resident if she had a fall and the resident did not respond. NA #8 went to turn Resident #1 and the resident started hollering. The Resident's Roommate (Resident #2) then told them that the resident had fallen. The nurse came in and assessed Resident #1 and the resident was having pain when the nurse touched the area on her leg. NA #8 stated she stayed with the resident</p>	F 600			



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F 600	<p>Continued From page 8</p> <p>until she was transferred to the hospital. The resident's roommate (Resident #2) was interviewed on 3/13/18 at 12:50 PM. Resident #2 stated that on 03/07/18 she was in her room when she heard Resident #1 fall out of bed. Resident #2 specified that NA #1 was providing care to Resident #1 by herself when the resident fell out of bed. She stated the fall occurred between the evening and early morning. Resident #2 stated the staff member did not get the nurse after the fall occurred. Resident #2 stated she observed the NA push the lift pad under the resident after she fell and use the lift to lift by herself and put the resident back in the bed. She stated Resident #1 would holler every time she was moved. Resident #2 stated that it was about 3 or 4 days later when Resident #1 went to the hospital. Resident #2 further stated that the nurse was right across the hall when Resident #1 fell, but the NA never got the nurse after the resident fell.</p> <p>Attempts were made to contact Nurse #6 (who worked on 3/10/18 from 7:00 AM to 7:00 PM with Resident #1) for an interview but she could not be contacted.</p> <p>The Administrator was interviewed on 3/13/18 at 4:25 PM. She stated that on 12/15/17, when the Resident #1's first fall from bed occurred with the same NA (NA #1) independently assisting her with care they determined all residents who needed 2 person assistance with care. Education included for the staff to follow the care guides in the resident's closet and use 2 person assistance. An incident report was put in on 3/10/18 about Resident #1's fall on 3/7/18, so she did not find out about the fall which occurred on 03/07/18 until 3/10/18. The administrator stated that Resident #1 denied that the incident had</p>	F 600			

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F 600	<p>Continued From page 9</p> <p>occurred. Resident #1's roommate spoke up and stated "aren't you going to tell them about you rolling them out of bed". When they found out about the resident's fracture and since they had a report from the roommate, they started contacting staff when the resident started complaining of pain, which was on 3/7/18. They started interviewing all staff about the resident being dropped out of the bed. On 3/11/18, NA #1 was questioned and this was the first time they were able to get in contact with her. NA #1 admitted that she rolled Resident #1 out of the bed and that she did not report the fall to anyone. NA #1 admitted to her that on 3/07/18 the resident was laying on her left and she was the only staff member providing care to Resident #1 and the resident rolled off the bed. NA #1 stated she used the mechanical lift to get Resident #1 back into the bed with no assistance. The administrator stated she contacted the sheriff's office and contacted the state with all the paper work and turned over the investigation to the sheriff's office.</p> <p>Resident #1's Physician was interviewed on 3/14/18 at 11:18 AM. The Physician stated a nurse called the office and said Resident #1 was having increased pain in her left leg and the nurse thought it was neuropathic pain and wanted an increase in her Neurontin pain medication (he could not recall the exact date). He stated that 99% of the time when he saw the resident, the resident was just lying in bed with the covers over her and that she usually never had complaints of pain. He stated that Saturday morning (3/10/18), the nurse called and said the Resident was having pain in the left thigh and he thought the nurse assessed the patient at that time. They got an X-RAY and it showed a display spiral fracture to the leg. The resident was admitted to the</p>	F 600			

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F 600	<p>Continued From page 10</p> <p>hospital. When Resident #1 got to the hospital, the resident was hypothermic and her Hemoglobin was 4.3. The Resident was close to hemorrhagic shock and the Resident still has not had surgery yet at the hospital. The Physician further stated that Resident #1 was on anticoagulation therapy and was probably bleeding into her leg. He thought the resident probably had a history of osteoporosis and stated the Resident had not had a fracture or break before that he could think of. He stated that he asked the resident that happened and she told him that she fell out of bed the other night and stated that she didn't tell the nurse.</p> <p>NA #1 was interviewed again on 3/14/18 at 2:51 PM. NA #1 stated that the fall Resident #1 experienced on 03/07/18 occurred at around 5:30 AM to 6:00 AM. NA #1 stated the resident on her left side and she told the resident to roll. The Resident was rolled away from her and off of the bed.</p> <p>Nurse #1 was interviewed again on 3/14/18 at 3:03 PM. She stated that if a resident fell she would assess the resident, call the doctor, report the fall to the family and supervisors and fill out an incident report.</p> <p>NA # 4 stated on 3/14/18 at 3:11 PM that she would report it to the nurse if a resident was abused or had a fall.</p> <p>The Administrator was interviewed on 3/15/18 at 3:40 PM and stated that she would expect for any witness or involved party to report any incident of abuse or neglect.</p> <p>The Administrator was notified of Immediate Jeopardy on 3/14/18 at 2:22 PM. On 03/15/18 at 1:41 PM, the facility provided the following credible allegation of Immediate Jeopardy removal.</p>	F 600			

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F 600	Continued From page 11  1. Resident #1 reported leg pain to Nurse #1 on 3/7/18 at approximately 3:35 pm. Nurse #1 contacted physician with new orders for increased Neurontin on 3/7/18 at 6pm. The RP was notified on 3/7/18 of complaint of pain and new order. The Resident reported relief with new orders on 3/7/18. The Resident reported on 3/8/18 that Neurontin continued to be effective for leg pain. Resident reported increased leg pain to Nurse #2 on 3/10/18 at approximately 3:00 pm. Assessment by Nurse #2 indicated increased pain upon palpation. The Physician was notified by Nurse #2 with orders for an x-ray. The X-ray was obtained on 3/10/18 at 4:30 pm and indicated a left femur fracture. The Physician was notified of results by Nurse #2 on 3/10/18 at approximately 5:00pm with new orders to send resident to the hospital for direct admission. The RP was notified by Nurse #2 on 3/10/18 at approximately 5:00pm.  The Resident denied any accidents/injuries when assessed by Nurse #2 on 3/10/18; however, resident's roommate reported that during care, a CNA (nurse aide) rolled Resident #1 off bed and onto floor. Resident #1 was coded as moderately cognitively impaired, was usually understood, and always understood others per the MDS assessment of 1/3/18. The roommate was assessed as cognitively intact, was always understood, and always understood others per the MDS assessment of 12/28/17. The roommate was interviewed on 3/11/18 by the Director of Nursing, and reported she had not confided in any staff that Resident #1 was rolled onto the floor on 3/7/18.  The event occurred as a staff member did not follow facility procedures for following the care	F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 600	Continued From page 12 guide for turning and repositioning, did not follow facility procedures for use of a mechanical lift, and did not follow facility procedures for reporting accidents/incidents. CNA #1 reported during an interview on 3/11/18 that she was aware of her requirements to report accidents and injuries, follow the care guide, and did not ask for assistance although assistance was available. Resident #1's care guide indicated that the resident required 2-person assistance with turning, repositioning, and incontinent care. CNA #1 reported during the interview that she was in a hurry to complete her last rounds and did not ask for help as she felt she could care for the resident alone. CNA #1 stated in the interview that she was aware of her responsibility to report but neglected to do so without reason. CNA #1 was aware that failure to report an incident is considered neglect as per education and in-servicing providing throughout her employment. CNA #1 informed the DON on 3/11/18 at approximately 11:30am that while providing care on the morning of 3/7/18 that she accidentally rolled Resident #1 out of the bed and onto floor. CNA reported that she was aware that care path indicated resident requires 2-person assistance, but she was in a hurry and failed to illicit assistance. CNA #1 reported that after Resident #1 was on the floor, working alone, she utilized a mechanical lift to transfer resident from floor to bed. CNA #1 stated that she was aware of reporting requirements, but failed to report the incident to anyone. CNA#1 was removed from the schedule on 3/11/18. The Police were contacted by the Director of Nursing, on 3/11/18 at 7:29pm. A 24-hour report for neglect was submitted by the Director of Nursing on 3/11/18 at 8:35pm. The resident left the facility with EMS on 3/10/18	F 600			

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F 600	<p>Continued From page 13</p> <p>at approximately 5pm in transfer to the hospital.</p> <p>2. A 100% skin assessment of all residents was completed by the Director of Nursing, and staff nurses on 3/11/18 including assessment of ROM, bruising, swelling, and signs/symptoms of pain. During the assessments, the Director of Nursing questioned the alert and oriented residents if they have had any pain, accidents, falls or issues with feeling they have been neglected. No concerns were identified.</p> <p>An in-service was initiated on 3/11/18 by the Staff Development Coordinator to include all staff regarding reporting of incidents/accidents and abuse/neglect immediately to the Charge Nurse. The in-service included that lack of providing care to a resident per the care plan is considered neglect and included the definition of neglect. This in-service included instruction on not moving a resident after a fall due to danger of causing further injury until assessed by a nurse. All employees receive education on hire and annually that indicates that it is safe to report accidents/injuries without fear of disciplinary action. No staff will work beyond 3/11/18 until they have received the in-service. Newly hired staff will receive the in-service during orientation.</p> <p>3. Utilizing a Progress Note Review QI Audit Tool, the Unit Managers x 2 will review progress notes daily to identify any resident complaints of pain to assure a full assessment had been documented. The Weekend Supervisor will review progress notes each weekend daily to identify any resident complaints of pain to assure a full assessment had been documented. Utilizing a Resident Interview for Neglect QI Audit Tool, the Social Worker will interview 5 alert and oriented residents weekly to ensure no neglect of care had occurred. Utilizing a Pain Audit tool, the</p>	F 600			

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F 600	<p>Continued From page 14</p> <p>Unit Managers x 2 will review progress notes daily to identify any nonverbal resident's with complaints of pain to assure a full assessment has been documented. Audits will occur Monday through Friday x 2 weeks, Weekends x 2, then twice weekly x2 weeks, then weekly x 4 weeks, then monthly x 1 month.</p> <p>The Director of Nursing will review the QI Audit Tools weekly x 8, then monthly x 1 for trends and concerns.</p> <p>4. The Administrator will report the results of the monitoring to the Quality Assurance Committee monthly x 3 months for trends, concerns, and recommendations for any modification of the process.</p> <p>The Administrator will be responsible for implementing this credible allegation of removal.</p> <p>The credible allegation was verified on 3/15/18 at 3:30 PM as evidence by interviews of licensed and non-licensed staff on in- service training on when and how to report incidents, accidents, neglect and abuse. Nursing staff were interviewed on how to document pain assessments and when to assess a resident after an incidents/accident. The abuse protocol was initiated and other residents were interviewed on neglect/abuse. The facility's abuse policy and procedure for abuse/neglect was also reviewed along with other abuse cases that had been reported. Record review revealed the QA neglect audit tool was completed on 100 % of residents in the facility on 3/11/18. In-service on abuse was started on 3/11/18. All residents' interviews about abuse were conducted on 3/11/18. QA tool for pain was started on 3/11/18.</p>	F 600			

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F 689 F 689 SS=J	Continued From page 15 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 interviews with the staff, family, and the physician the facility failed to provide the assistance of two staff members during the provision of incontinence care to prevent a resident from falling from bed and sustaining an injury for 1 of 3 residents sampled reviewed for accidents (Resident #1). Resident #1 fell from her bed when only one nurse aide was providing her with incontinence care and she sustained a fractured left femur. The staff member moved the resident, alone, before being assessed for serious injury, from the floor to the bed using a mechanical lift (resident required the assistance of two persons) putting the resident at risk for more injuries. This resulted in delay in treatment of a fractured left femur and pain for three days.  Immediate jeopardy began on 3/07/18 when nurse aide (NA) #1 failed to report a fall sustained by Resident #1 to the nurse or any other staff member, moved the resident by herself from the floor to the bed using a mechanical lift, before being assessed for injury putting the resident at risk for more injuries. This resulted in delay of treatment of a fractured femur and pain to her leg	F 689 F 689	Resident #1 reported leg pain to Nurse #1 on 3/7/18 at approximately 3:35 pm. Nurse #1 contacted physician with new orders for increased Neurontin on 3/7/18 at 6pm. The RP was notified on 3/7/18 of c/o of pain and new order. The Resident reported relief with new orders on 3/7/18. The Resident reported on 3/8/18 that Neurontin continued to be effective for leg pain. Resident reported increased leg pain to Nurse #2 on 3/10/18 at approximately 3:00 pm. Assessment by Nurse #2 indicated increased pain upon palpation. The Physician was notified by Nurse #2 with orders for an x-ray. The X-ray was obtained on 3/10/18 at 4:30 pm and indicated a left femur fracture. The Physician was notified of results by Nurse #2 on 3/10/18 at approximately 5:00pm with new orders to send resident to Central Carolina Hospital for direct admission. The RP was notified by Nurse #2 on 3/10/18 at approximately 5:00pm.  The Resident denied any	3/22/18	



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F 689	<p>Continued From page 16</p> <p>from 3/07/18 to 3/10/18. Immediate jeopardy was removed on 3/12/18. The facility remains out of compliance at a lower scope and severity of "D" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to complete staff education and ensure monitoring systems put into place are effective.</p> <p>Findings included: Resident #1 was admitted to the facility on 6/2/14 with the current diagnosis of diabetes, peripheral neuropathy, muscle weakness, and hemiplegia.</p> <p>An incident report dated 12/15/17 stated Resident #1 was receiving incontinent care by nursing assistant (NA) #1. The Resident was on her left side while the NA was cleaning the resident. The Resident reached out as to grab onto the non-existing bedrail and rolled off the bed onto the floor. Resident #1 was assessed and put back to bed. Vital signs were taken. The immediate action taken stated that Resident #1 needed the assistance of 2 people to change her and for perineal care. No injury was noted.</p> <p>Review of Resident's #1 Quarterly Minimum Data Set (MDS) dated 1/3/18 revealed her cognition was moderately impaired. The Resident had no behaviors or moods. Resident #1 required total dependence for bed mobility and transfers and required the assistance of 2 people. The Resident also required total dependence with locomotion, dressing, toilet use and personal hygiene and supervisor with eating. Resident #1 was not steady with surface to surface transfers and had impairment on 1 side of her upper extremity and on one side of her lower extremity. The resident was always incontinent of bowel and bladder.</p>	F 689	<p>accidents/injuries when assessed by Nurse #2 on 3/10/18; however, resident's roommate reported that during care, a CNA rolled Resident #1 off bed and onto floor. Resident #1 was coded as moderately cognitively impaired, was usually understood, and always understood others per the MDS assessment of 1/3/18. The roommate was assessed as cognitively intact, was always understood, and always understood others per the MDS assessment of 12/28/17. The roommate was interviewed on 3/11/18 by the Director of Nursing and reported she had not confided in any staff that Resident #1 was rolled onto the floor on 3/7/18.</p> <p>The event occurred as a staff member did not follow facility procedures for following the care guide for turning and repositioning, did not follow facility procedures for use of a mechanical lift, and did not follow facility procedures for reporting accidents/incidents. CNA #1 reported during an interview on 3/11/18 and 3/12/18 that she was aware of her requirements to report accidents and injuries, follow the care guide, and did not ask for assistance, although assistance was available. Resident #1's care guide indicated that the resident required two-person assistance with turning, repositioning, and incontinent care. CNA #1 reported during the interview that she was in a hurry to complete her last rounds and did not ask for help as she felt she could care for the resident alone.</p>		

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F 689	<p>Continued From page 17</p> <p>Resident #1's current care plan, which was most recently updated/reviewed by staff on 3/14/18, addressed issues including her need for assistance with activities of daily living and for being at risk falls which were initiated on 8/5/17. Interventions for falls included that the resident would be transferred with the assistance of 2 people via a mechanical lift and repositioned in the bed as she often leans to the right side.</p> <p>Review of Resident #1's current care guide (which are located in the resident's closet) dated 2/22/18 revealed that the resident required 2 people for assistance with turning, repositioning, and incontinence care.</p> <p>A nursing note dated 3/7/18, written by Nurse #1, stated that Resident #1 complained of increased pain to legs this shift and the physician was contacted and received a new order to increase the Gabapentin (a medication given for neuropathic pain) dosage and to administer three times a day.</p> <p>A nursing note dated 3/10/18, written by Nurse #6, revealed Resident #1 complained of pain to the left femur and hollered out in pain when palpated. The physician was notified and a left femur X-RAY was ordered. The X-RAY result showed a displaced spiral fracture of the proximal femur. The physician was notified and the resident was sent to the hospital. Resident #1 left via Emergency Medical Services at 6:00 PM.</p> <p>An incident report (no incident time or date) but had a date of 3/10/18 under notification. The incident report stated that Resident #1 had a fall/injury and the resident had a fracture. After complaint of increased left leg pain and a nursing</p>	F 689	<p>CNA #1 informed the DON on 3/11/18 at approximately 11:30am that while providing care on the morning of 3/7/18 that she accidentally rolled Resident #1 out of the bed and onto floor. CNA reported that she was aware that care path indicated resident requires 2-person assistance, but she was in a hurry and failed to illicit assistance. CNA #1 reported that after Resident #1 was on the floor, working alone, she utilized a mechanical lift to transfer resident from floor to bed. CNA #1 stated that she was aware of reporting requirements, but failed to report the incident to anyone. CNA#1 was removed from the schedule on 3/11/18. The Police were contacted by the Director of Nursing on 3/11/18 at 7:29pm. A 24-hour report for abuse was submitted by the Director of Nursing on 3/11/18 at 8:35pm.</p> <p>The resident left the facility with EMS on 3/10/18 at approximately 5pm in transfer to the hospital.</p> <p>A 100% skin assessment of all residents was completed by the Director of Nursing and staff nurses on 3/11/18 including assessment of ROM, bruising, swelling, and signs/symptoms of pain. During the assessments, the Director of Nursing questioned the alert and oriented residents if they have had any pain, accidents, or falls. No concerns were identified.</p> <p>An in-service was initiated on 3/11/18 by the Staff Development Coordinator to</p>		

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F 689	<p>Continued From page 18</p> <p>assessment, an X-RAY was ordered and revealed a left femur fracture. The Resident denied accident/injuries. The resident's roommate (Resident #2) reported that NA #1 rolled the resident off of the bed and onto the floor while performing care on the morning of 3/7/18. The left femur X-RAY revealed a displaced spiral fracture of the proximal femur. The physician was informed and the resident was sent to the hospital on 3/10/18.</p> <p>Review of Resident #1's Hospital records dated 3/10/18 revealed that the resident was admitted with reports of left, thigh pain and was noted to have an acute left, proximal, spiral, displaced fracture of the femur. The resident reported that she fell out of the bed on 3/7/18 and that she crawled back in the bed. There were no reports from the nursing facility of trauma. The resident's hemoglobin was 4.3 and she was admitted to the intensive care unit for profound anemia and required multiple blood transfusions. Orthopedics were consulted and on assessment showed that the resident was unable to move her left lower extremity.</p> <p>NA #1 (who worked with Resident #1 during the night shift of 3/6/18 and the early morning on 3/7/18) was interviewed on 3/13/18 at 12:59 PM. NA #1 stated Resident #1 was in the bed most of the time. Resident #1 was alert and oriented. NA #1 stated on 03/07/18, Resident #1 was incontinent and she went to change her. During the provision of care, Resident #1 rolled off the left side of the bed onto the floor. NA #1 stated she was changing Resident #1 by herself and she tried to stop her from rolling off the bed by grabbing her arm. She stated that after the resident fell off the bed, she left the resident's</p>	F 689	<p>include all licensed nurses regarding assessment upon notification of pain including AROM and PROM and documentation of findings in the resident's progress notes. No licensed staff will work beyond 3/11/18 until they have received the in-service. Newly hired licensed nursing staff will receive the in-service during orientation.</p> <p>An in-service was initiated on 3/11/18 by the Staff Development Coordinator to include all clinical staff including nurses and certified nursing assistants regarding use of care guide, 2-person assist requirements, and use of mechanical lift requiring 2-persons. Although staffing was not an issues; staff were made aware that they can illicit help from any clinical staff member. No staff will work beyond 3/11/18 until they have received the in-service. Newly hired nursing staff will receive the in-service during orientation.</p> <p>An in-service was initiated on 3/11/18 by the Staff Development Coordinator to include all staff regarding reporting of incidents/accidents and abuse/neglect immediately to the Charge Nurse. This in-service included that is safe to report accidents/injuries and included the definition of neglect. This in-service included instruction on not moving a resident after a fall due to danger of causing further injury until assessed by a nurse. No staff will work beyond 3/11/18 until they have received the in-service. Newly hired nursing staff will receive the in-service during orientation.</p>		

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F 689	<p>Continued From page 19</p> <p>room to get the mechanical lift. NA #1 stated that she moved the furniture in the resident's room and placed Resident #1 back in the bed with the lift on her own. She stated that the resident reported pain and she let the nurse know the resident was in pain. NA #1 stated she did not report to the nurse that Resident #1 fell from her bed onto the floor and she knew it was wrong, but she didn't want to lose her job. NA #1 stated that she did not report the incident to anyone. NA #1 stated they were supposed to have 2 people to help with the lift and providing care to Resident #1 but sometimes you could not get 2 people to help and the nurses would not help sometimes so they had to use only 1 person.</p> <p>Nursing Assistant (NA) #2 (who worked with Resident #1 during the 7:00 AM to 3:00 PM shift on 3/7/18, 3/8/18, 3/9/18, and 3/10/18) was interviewed on 3/13/18 at 12:16 PM. NA #2 stated Resident #1 was alert and oriented. The resident would be changed in the bed but would get up occasionally. The resident transferred via the mechanical lift and the assistance of 2 people. She stated Resident #1 required 2 people to be turned in bed but sometimes she just did it herself. She stated she was recently giving Resident #1 a bed bath and the Resident complained of pain in her leg. NA #2 stated that the Resident's roommate (Resident #2) stated that something happened to Resident #1 and Resident #1 told Resident #2 to "mind her business." Resident #1 stated that nothing happened but that her leg hurt. NA #2 stated that on 3/10/18, she and Nursing Assistant #3 were changing Resident #1 and when they turned the Resident, she started hollering, crying and grabbed NA #2 like she was in horrible pain. Nurse #1 came in to see the resident and barely</p>	F 689	<p>Utilizing a QI audit tool, the unit managers x2 will observe 3 incidents of staff operating mechanical lifts Monday through Friday x 2 weeks, then twice weekly x 2 weeks, then weekly x 4 weeks, then monthly x 1 month to ensure that the resident is being transferred via mechanical lift according to the care guide and the resident's care plan. The Weekend Supervisor will observe 3 incidents of staff operating mechanical lifts on weekends x 2 weekends, then every other weekend x 2, then monthly x 1 month to ensure that the resident is being transferred via mechanical lift according to the care guide and the resident's care plan.</p> <p>Utilizing a QI audit tool, the unit managers x 2 will observe 3 incidents of staff turn and reposition residents Monday through Friday x 2 weeks, then twice weekly x 2 weeks, then weekly x 4 weeks, then monthly x 1 month to determine if the resident is being turned and repositioned in bed according to the resident care guide and care plan. The Weekend Supervisor will observe turning/repositioning on weekends x 2 weekends, then every other weekend x 2, the monthly x 1 month to determine if the resident is being turned and repositioned in bed according to the resident care guide and care plan.</p> <p>Utilizing a Progress Note Review QI Audit Tool, the Unit Managers x 2 will review progress notes daily to identify any</p>		

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F 689	<p>Continued From page 20</p> <p>touched her leg and the resident yelled out. NA #2 stated that the Resident's roommate (Resident #2) then stated that earlier in the week, NA #1 was changing the resident by herself and rolled her off the bed.</p> <p>Nurse #1 (who worked with Resident #1 on 3/7/18 and 3/8/18 during the 7:00 AM to 7:00 PM shift was interviewed on 3/13/18 at 2:15 PM. She stated Resident #1 was alert and oriented and could make her needs known. Nurse #1 specified that Resident #1 required maximum assistance and the assistance of 2 people to get up. Resident #1 needed 2 people for transfers and for bed mobility. Nurse #1 stated during the morning of 03/07/18, the NA informed her that Resident #1 was having some pain. Nurse #1 stated that Resident #1 was complaining of pain in her leg but could not pinpoint the location of the pain. The Resident stated that the pain was burning and she gave the resident some medication for pain. She stated the Resident was also rubbing her leg but it was not red or swollen. She stated that she looked at the Resident's leg and that she was able to move the Resident's leg, adjust it and it was ok but it just hurt per the Resident. Nurse #1 stated she contacted the doctor and was given orders for Neurontin to be increased to three times a day and she gave the resident the medication. She thought the Resident was having possible nerve pain, which was why she got the Neurontin medication increased. Nurse #1 stated that she did not get any reports from the staff that night about Resident #1 falling.</p> <p>Attempts were made to contact Nurse #5, who worked with Resident #1 on 3/7/18 from 7:00 PM to 7:00 AM, but Nurse #5 could not be contacted</p>	F 689	<p>resident complaints of pain to assure a full assessment had been documented. The Weekend Supervisor will review progress notes each weekend daily to identify any resident complaints of pain to assure a full assessment had been documented. Pain assessments are completed by the charge nurse each shift for all residents, including those residents who are nonverbal. Utilizing a Pain Audit tool, the Unit Managers x 2 will review progress notes daily to identify any nonverbal residents with complaints of pain to assure a full assessment has been documented. The Weekend Supervisor will review progress notes each weekend daily to identify any nonverbal residents with complaints of pain to assure a full assessment has been documented. Audits will occur Monday through Friday x 2 weeks, Weekends x 2, then twice weekly x 2 weeks, then weekly x 4 weeks, then monthly x 1 month.</p> <p>The Director of Nursing will review the QI Audit Tools weekly x 8, then monthly x 1 for trends and concerns</p> <p>The Director of Nursing will report the results of the monitoring to the Quality Assurance Committee monthly x 3 months for trends, concerns, and recommendations for any modification of the process.</p> <p>The Administrator will be responsible for implementing the plan of correction.</p>		

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F 689	<p>Continued From page 21 for an interview.</p> <p>NA #4 (who worked with Resident #1 on 3/7/18 from 3:00 PM to 11:00 PM) was interviewed on 3/13/18 at 3:57 PM. NA #4 stated she got in report that the Resident's leg had been sore. NA #4 stated that Resident #1 informed her that her leg was hurting and that Resident #1 did not usually complain of pain. NA #4 stated that she told the nurse that Resident #1 was in pain. Resident #1 would not tell her why her leg was hurting. NA #4 stated that the Resident would let them change her, but was having pain in her leg when they rolled her over so she adjusted how she rolled her and the resident seemed fine.</p> <p>NA #5 (who worked with Resident #1 during the 3rd shift on 3/7/18 and 3/9/18) was interviewed on 3/13/18 at 2:43 PM. She stated the resident was incontinent and she usually changed the resident by herself but technically they were supposed to have 2 people. NA #5 stated that she changed Resident #1 by herself because she was used to the resident. NA #5 stated that Resident #1 was usually alert and oriented and would tell staff if something was wrong. She stated that recently she turned Resident #1 on the right side, crossed her legs over with a little push and the resident said it hurt so she turned the Resident on the other side. She thought the Resident was uncomfortable and she turned her the other way and the resident seemed ok the other side.</p> <p>NA #8 was (who assisted NA #2 with the care of Resident #1 on 3/10/18 during 3:00 PM to 11:00 PM shift) was interviewed on 3/13/18 at 3:54 PM. She stated that Resident #1 needed 2 people to get her up and needed the lift. The resident was usually alert and oriented. NA #8 stated that NA</p>	F 689			

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F 689	<p>Continued From page 22</p> <p>#2 asked her to come in the room to help with the care of Resident #1 on 3/18/18 and she asked the resident if she was having pain. The resident was rubbing her leg. She stated she also asked the Resident if she had a fall and the resident did not respond. NA #8 went to turn Resident #1 and the resident started hollering. The Resident's Roommate (Resident #2) then told them that the resident had fallen. The nurse came in and assessed Resident #1 and the resident was having pain when the nurse touched the area on her leg. NA #8 stated she stayed with the resident until she was transferred to the hospital.</p> <p>The resident's roommate (Resident #2) was interviewed on 3/13/18 at 12:50 PM. Resident #2 stated that on 03/07/18 she was in her room when she heard Resident #1 fall out of bed. Resident #2 specified that NA #1 was providing care to Resident #1 by herself when the resident fell out of bed. She stated the fall occurred between the evening and early morning. Resident #2 stated the staff member did not get the nurse after the fall occurred. Resident #2 stated she observed the NA push the lift pad under the resident after she fell and use the lift to lift by herself and put the resident back in the bed. She stated Resident #1 would holler every time she was moved. Resident #2 stated that it was about 3 or 4 days later when Resident #1 went to the hospital. Resident #2 further stated that the nurse was right across the hall when Resident #1 fell, but the NA never got the nurse after the resident fell.</p> <p>Attempts were made to contact Nurse #6 (who worked on 3/10/18 from 7:00 AM to 7:00 PM with Resident #1) for an interview but she could not be contacted.</p>	F 689			

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F 689	Continued From page 23  The Administrator was interviewed on 3/13/18 at 4:25 PM. She stated that on 12/15/17, when the Resident #1's first fall from bed occurred with the same NA (NA #1) independently assisting her with care they determined all residents who needed 2 person assistance with care. Education included for the staff to follow the care guides in the resident's closet and use 2 person assistance. An incident report was put in on 3/10/18 about Resident #1's fall on 3/7/18, so she did not find out about the fall which occurred on 03/07/18 until 3/10/18. The administrator stated that Resident #1 denied that the incident had occurred. Resident #1's roommate spoke up and stated "aren't you going to tell them about you rolling them out of bed". When they found out about the resident's fracture and since they had a report from the roommate, they started contacting staff when the resident started complaining of pain, which was on 3/7/18. They started interviewing all staff about the resident being dropped out of the bed. On 3/11/18, NA #1 was questioned and this was the first time they were able to get in contact with her. NA #1 admitted that she rolled Resident #1 out of the bed and that she did not report the fall to anyone. NA #1 admitted to her that on 3/07/18 the resident was laying on her left and she was the only staff member providing care to Resident #1 and the resident rolled off the bed. NA #1 stated she used the mechanical lift to get Resident #1 back into the bed with no assistance. The administrator stated she contacted the sheriff's office and contacted the state with all the paper work and turned over the investigation to the sheriff's office.  Resident #1's Physician was interviewed on 3/14/18 at 11:18 AM. The Physician stated a	F 689			



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F 689	<p>Continued From page 24</p> <p>nurse called the office and said Resident #1 was having increased pain in her left leg and the nurse thought it was neuropathic pain and wanted an increase in her Neurontin pain medication (he could not recall the exact date). He stated that 99% of the time when he saw the resident, the resident was just lying in bed with the covers over her and that she usually never had complaints of pain. He stated that Saturday morning (3/10/18), the nurse called and said the Resident was having pain in the left thigh and he thought the nurse assessed the patient at that time. They got an X-RAY and it showed a display spiral fracture to the leg. The resident was admitted to the hospital. When Resident #1 got to the hospital, the resident was hypothermic and her Hemoglobin was 4.3. The Resident was close to hemorrhagic shock and the Resident still has not had surgery yet at the hospital. The Physician further stated that Resident #1 was on anticoagulation therapy and was probably bleeding into her leg. He thought the resident probably had a history of osteoporosis and stated the Resident had not had a fracture or break before that he could think of. He stated that he asked the resident that happened and she told him that she fell out of bed the other night and stated that she didn't tell the nurse.</p> <p>NA #1 was interviewed again on 3/14/18 at 2:51 PM. NA #1 stated that the fall Resident #1 experienced on 03/07/18 occurred at around 5:30 AM to 6:00 AM. NA #1 stated the resident on her left side and she told the resident to roll. The Resident was rolled away from her and off of the bed.</p> <p>The Administrator was interviewed on 3/15/18 at 3:40 PM and stated that she would expect for any</p>	F 689			

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F 689	<p>Continued From page 25 incident to be reported to her immediately.</p> <p>The Administrator was notified of Immediate Jeopardy on 3/14/18 at 2:22 PM. On 03/15/18 at 1:41 PM, the facility provided the following credible allegation of Immediate Jeopardy removal.</p> <p>1. Resident #1 reported leg pain to Nurse #1 on 3/7/18 at approximately 3:35 pm. Nurse #1 contacted physician with new orders for increased Neurontin on 3/7/18 at 6pm. The RP was notified on 3/7/18 of c/o of pain and new order. The Resident reported relief with new orders on 3/7/18. The Resident reported on 3/8/18 that Neurontin continued to be effective for leg pain. Resident reported increased leg pain to Nurse #2 on 3/10/18 at approximately 3:00 pm. Assessment by Nurse #2 indicated increased pain upon palpation. The Physician was notified by Nurse #2 with orders for an x-ray. The X-ray was obtained on 3/10/18 at 4:30 pm and indicated a left femur fracture. The Physician was notified of results by Nurse #2 on 3/10/18 at approximately 5:00pm with new orders to send resident to the hospital for direct admission. The RP was notified by Nurse #2 on 3/10/18 at approximately 5:00pm.</p> <p>The Resident denied any accidents/injuries when assessed by Nurse #2 on 3/10/18; however, resident's roommate reported that during care, a CNA (nurse aide) rolled Resident #1 off bed and onto floor. Resident #1 was coded as moderately cognitively impaired, was usually understood, and always understood others per the MDS assessment of 1/3/18. The roommate was assessed as cognitively intact, was always</p>	F 689			

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F 689	<p>Continued From page 26</p> <p>understood, and always understood others per the MDS assessment of 12/28/17. The roommate was interviewed on 3/11/18 by the Director of Nursing and reported she had not confided in any staff that Resident #1 was rolled onto the floor on 3/7/18.</p> <p>The event occurred as a staff member did not follow facility procedures for following the care guide for turning and repositioning, did not follow facility procedures for use of a mechanical lift, and did not follow facility procedures for reporting accidents/incidents. CNA #1 reported during an interview on 3/11/18 that she was aware of her requirements to report accidents and injuries, follow the care guide, and did not ask for assistance, although assistance was available. Resident #1's care guide indicated that the resident required two-person assistance with turning, repositioning, and incontinent care. CNA #1 reported during the interview that she was in a hurry to complete her last rounds and did not ask for help as she felt she could care for the resident alone.</p> <p>CNA #1 informed the DON on 3/11/18 at approximately 11:30am that while providing care on the morning of 3/7/18 that she accidentally rolled Resident #1 out of the bed and onto floor. CNA reported that she was aware that care path indicated resident requires 2-person assistance, but she was in a hurry and failed to illicit assistance. CNA #1 reported that after Resident #1 was on the floor, working alone, she utilized a mechanical lift to transfer resident from floor to bed. CNA #1 stated that she was aware of reporting requirements, but failed to report the incident to anyone. CNA#1 was removed from the schedule on 3/11/18. The Police were contacted</p>	F 689			

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F 689	<p>Continued From page 27</p> <p>by the Director of Nursing on 3/11/18 at 7:29pm. A 24-hour report for abuse was submitted by the Director of Nursing on 3/11/18 at 8:35pm. The resident left the facility with EMS on 3/10/18 at approximately 5pm in transfer to the hospital.</p> <p>2. A 100% skin assessment of all residents was completed by the Director of Nursing, and staff nurses on 3/11/18 including assessment of ROM, bruising, swelling, and signs/symptoms of pain. During the assessments, the Director of Nursing questioned the alert and oriented residents if they have had any pain, accidents, or falls. No concerns were identified</p> <p>An in-service was initiated on 3/11/18 by the Staff Development Coordinator to include all licensed nurses regarding assessment upon notification of pain including AROM and PROM and documentation of findings in the resident's progress notes. No licensed staff will work beyond 3/11/18 until they have received the in-service. Newly hired licensed nursing staff will receive the in-service during orientation.</p> <p>An in-service was initiated on 3/11/18 by the Staff Development Coordinator to include all clinical staff including nurses and certified nursing assistants regarding use of care guide, 2-person assist requirements, and use of mechanical lift requiring 2-persons. Although staffing was not an issues; staff were made aware that they can illicit help from any clinical staff member. No staff will work beyond 3/11/18 until they have received the in-service. Newly hired nursing staff will receive the in-service during orientation.</p> <p>An in-service was initiated on 3/11/18 by the Staff Development Coordinator to include all staff</p>	F 689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345534</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>03/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>SANFORD HEALTH &amp; REHABILITATION CO</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2702 FARRELL ROAD</b> <b>SANFORD, NC 27330</b>		
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F 689	<p>Continued From page 28</p> <p>regarding reporting of incidents/accidents and abuse/neglect immediately to the Charge Nurse. This in-service included that is safe to report accidents/injuries and included the definition of neglect. This in-service included instruction on not moving a resident after a fall due to danger of causing further injury until assessed by a nurse. No staff will work beyond 3/11/18 until they have received the in-service. Newly hired nursing staff will receive the in-service during orientation.</p> <p>3. Utilizing a QI audit tool, the unit managers x2 will observe 3 incidents of staff operating mechanical lifts Monday through Friday x 2 weeks, then twice weekly x 2 weeks, then weekly x 4 weeks, then monthly x 1 month to ensure that the resident is being transferred via mechanical lift according to the care guide and the resident's care plan. The Weekend Supervisor will observe 3 incidents of staff operating mechanical lifts on weekends x 2 weekends, then every other weekend x 2, then monthly x 1 month to ensure that the resident is being transferred via mechanical lift according to the care guide and the resident's care plan .</p> <p>Utilizing a QI audit tool, the unit managers x 2 will observe 3 incidents of staff turn and reposition residents Monday through Friday x 2 weeks, then twice weekly x 2 weeks, then weekly x 4 weeks, then monthly x 1 month to determine if the resident is being turned and repositioned in bed according to the resident care guide and care plan. The Weekend Supervisor will observe turning/repositioning on weekends x 2 weekends, then every other weekend x 2, the monthly x 1 month to determine if the resident is being turned and repositioned in bed according to the resident</p>	F 689			

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F 689	<p>Continued From page 29 care guide and care plan.</p> <p>Utilizing a Progress Note Review QI Audit Tool, the Unit Managers x 2 will review progress notes daily to identify any resident complaints of pain to assure a full assessment had been documented. The Weekend Supervisor will review progress notes each weekend daily to identify any resident complaints of pain to assure a full assessment had been documented. Pain assessments are completed by the charge nurse each shift for all residents, including those residents who are nonverbal. Utilizing a Pain Audit tool, the Unit Managers x 2 will review progress notes daily to identify any nonverbal residents with complaints of pain to assure a full assessment has been documented. The Weekend Supervisor will review progress notes each weekend daily to identify any nonverbal residents with complaints of pain to assure a full assessment has been documented. Audits will occur Monday through Friday x 2 weeks, Weekends x 2, then twice weekly x 2 weeks, then weekly x 4 weeks, then monthly x 1 month.</p> <p>The Director of Nursing will review the QI Audit Tools weekly x 8, then monthly x 1 for trends and concerns</p> <p>4. The Director of Nursing will report the results of the monitoring to the Quality Assurance Committee monthly x 3 months for trends, concerns, and recommendations for any modification of the process.</p> <p>The Administrator will be responsible for implementing the credible allegation of removal.</p>	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 30 The credible allegation was verified on 3/15/18 at 3:30 PM as evidence by nurse's interviews regarding in-servicing on pain assessment, documentation and notification. Licensed and non-licensed staff were interviewed on in-servicing about when to use 2 person assistance when providing resident care, proper use of the mechanical lift, and reporting of accidents and incidents. Review of on- going in service records revealed that staff present would receive training who did not receive in servicing prior to working the floor. An observation was made on 3/15/18 at 1:56 PM of the mechanical lift being used properly by staff.	F 689			