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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345202	A. BUILDING ______ B. WING ______	C 04/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITAL NURSING AND REHABILITATION CENTER	**3000 HOLSTON LANE RALEIGH, NC 27610**

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 4/23/19 to 4/24/19 (Event ID #2JNN11). Past-noncompliance was identified at: CFR 483.25 at tag F-689 at a scope and severity level G.	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 medical record review, staff and family interview the facility failed to ensure the safety of a resident by positioning a resident too close to the edge of the bed when staff were attempting to change the sheets on the resident's bed for 1 of 1 (Resident #1) residents reviewed for accidents. Resident #1 fell from bed while a staff member attempted to change the sheets on the bed which resulted in the resident experiencing a broken femur. Findings included: Resident #1 was admitted to the facility on 8/25/14. Medical record review revealed diagnosis of major depressive disorder and chronic kidney disease stage 3.	F 689	Past noncompliance: no plan of correction required.	5/8/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/08/2019

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 Review of Resident #1's care plan dated 2/8/19 revealed that the resident had an increased risk for fall related to a history of fall, impaired balance, generalized weakness, decreased mobility and an actual fall. The resident had a goal to minimize falls through current interventions for the next 90 days. Interventions included transfer with 3 person/maximum /total assistance with Hoyer lift, anticipate needs, keep furniture in locked position, a safe environment (working and reachable call light, bed in a low position when in bed, personal items within reach). Review of the minimum data set (MDS) dated 2/26/19 revealed that the resident scored 9 on the brief interview of mental status indicating cognitive impairment. She was coded as needing extensive 1 person assistance with bed mobility and transfer. She was coded as having no limits in range of motion. Medical record review revealed a health status note dated 3/25/19, at 3:30 PM written by Nurse #1 which stated, "Resident hit her left knee and lower leg on her bed while getting ADL (activities of daily living) care, x-ray of the left knee and lower leg requested by hospice." A health status note dated 3/25/19 at 11:03 PM stated, x-ray of left knee/leg completed, results not in yet. Steri-strips applied to right knee per hospice for skin tear. No complaints of pain, no signs/symptoms of distress. Will continue to monitor. Review of a statement written by the hospice Nursing Assistant (NA) dated 3/25/19 revealed the following. "On 3/25/19 I was performing my	F 689		

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F 689	Continued From page 2 CNA (certified nursing assistant) care on (Resident #1). I was cleaning her bottom and turned her over onto her right side, when I observed (Resident #1) legs going off of the bed. I quickly grabbed hold of her shirt to prevent her body from falling out of bed. I managed to keep the resident upper body up but her knees slid to floor. At that point the resident was on the floor sitting up on her knees. I still had her top half. I managed to pull her back onto the bed using the shirt." Interview with hospice NA on 4/24/19 at 6:29 PM revealed on 3/25/19 around 2:30 PM she was in Resident #1's room to give her care. The hospice NA reported that after she washed the resident up and dressed her and then she started to change the sheets on the resident's bed with the resident in the bed. She stated she had the clean sheet underneath the resident and the dirty sheet rolled up under the resident on the side she finished. She went to the other side of the bed to pull out the dirty sheets to remove them from the bed and get the clean sheet (pull the clean sheet over). The NA explained that as she was pulling the sheet she observed the resident's legs go over the side of the bed. She stated she grabbed Resident #1 to break her fall from the bed and lowered her to the floor. The resident was on the floor in a kneeling position on her knees. The NA reported that she still had a hold the residents' top part. She stated that she got her by both arms and pulled her under her arms back up into the bed. The resident was telling her to get her up. The NA stated after she got Resident #1 back into bed she informed Nurse #1 and Nurse #1 helped her pull the sheet out and pull the resident up in the bed. The hospice NA stated the resident complained of pain after she positioned	F 689		

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F 689	Continued From page 3	F 689		

her legs in bed.

Review of the incident report prepared by Nurse #1 dated 3/25/19, 3:00 PM with a revision date of 4/8/19 at 9:05 PM included a staff statement from Nurse #1 dated 3/26/19 "This nurse notified that the resident had hit her knee on the side of the bed while giving ADL care. Resident was assessed and order given for x-ray of the left knee left tibia, left fibula. The incident description on the report stated, "This nurse notified by hospice CNA (certified nursing assistant) that the resident was in the process of sliding out of her bed when she caught her and pulled her back onto the bed." The immediate action taken section of the report stated, "Resident was assessed no signs of swelling, no bleeding but resident had complaints of pain in her left knee, x-ray of the left knee, left tibia and left fibula ordered.

Interview with Nurse #1 at 6:20 PM on 4/24/19 revealed on 3/25/19 the hospice nursing assistant came to the door of the resident's room and asked him to come to Resident #1's room. The NA told him that Resident #1 was coming off the bed, she pulled her back up and the resident hit her hip on the bed itself. Nurse #1 stated the resident was on the bed when he went into the room. He got orders to get an x-ray of the resident's hip. Nurse #1 stated he did not know that Resident #1 actually hit the floor. Per nurse #1 the incident occurred close to 3:00 PM. He stated he called for the x-ray and then went off shift.

Review of the medical record revealed a mobile x-ray report dated 3/26/19 12:39 AM which stated, acute mildly displaced complete

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F 689	Continued From page 4	F 689		

supracondylar fracture of the distal femur, moderate degree of osteopenia, moderate osteoarthritis.

A Health status note dated 3/26/19 12:15 PM written by the DON stated, Informed by hall nurse that resident x-ray results noted with femur fracture. MD made aware of results and received order to send to emergency room. Hospice nurse also made aware of x-ray results. Health status note 3/26/19 3:56 PM stated, Resident out of facility, at hospital for evaluation of fracture in left femur.

A Hospice note dated 4/17/19 written by the Hospice nurse stated, "Hospice Note for 3/25/19, regarding patient fall: PRN nurse visit. HCA (Nursing Assistant) called to report that patient has had a fall, and was complaining of pain to left knee. While performing personal care HCA rolled patient over, however Patient went over too far and her knees hit the floor. HCA reported she was able to protect upper body by grabbing patient blouse. Upon assessment skin tear was noted to right knee. Site cleaned and steri-strips applied by skilled nurse. Swelling noted to left knee and a report of pain. Primary physician was notified by facility nurse who ordered x-ray. Safety education provided to HCA. Understanding verbalized. Skilled nurse ensured that pain medication was administered."

Interview with hospice nurse at 6:40 PM on 4/24/19 revealed that she was not present at the time of the incident on 3/25/19. She reported that the hospice NA called her and said that she was providing personal care to Resident #1 with the resident in bed and the resident started rolling and rolled off the bed. The resident's knees hit

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F 689	Continued From page 5	F 689		

the floor. She stated her understanding was the NA rolled the resident to one side of the bed then rolled her to the other side of the bed (as she was taking off the dirty sheet and putting on the clean sheet). She further stated that the resident was in a great deal of pain when she was at the facility. The nurse was giving her pain medication and the nurse called the MD for an order for an x-ray. The hospice nurse stated she told the hospice NA that she could finish getting her dressed after the pain medication kicked in.

Review of hospital records dated 3/26/19 revealed the following under chief complaint, "Pt. (Patient) was apparently dropped last night by nursing staff while attempting to move her. X-ray performed at midnight last night, showed supracondylar fracture of the femur. The exam section of the hospital record stated, severe pain with any range of motion of the left lower extremity.

Interview with a family member on 4/23/19 at 3:15 PM revealed that the nursing assistant from hospice dropped Resident #1 out of bed. The facility took x-rays right after the fall happened. The resident had fractured femur. The family member reported that she fell on March 25 and was sent to the hospital on March 26.

Interview with the Director of Nurses (DON) at 7:03 PM on 4/24/19 revealed that they called the physician (MD) and made her aware of the x-ray results for Resident #1. The MD said they could send her out to the emergency room. Interview with the DON at 7:33 PM on 4/24/19 revealed that when she spoke with the MD; the MD asked if Resident #1 was stable and if she was in pain. She (DON) told the nurse to check on the

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F 689	Continued From page 6 resident; she told the MD the resident was stable and that she was scheduling transportation. The DON reported the MD did not state to send the resident out immediately. Review of a written statement by the MD stated, "(Resident Name) has been a hospice resident for the past 2 years. Also has been bed bound and family requested no hospitalizations or extensive treatment/surgery. When x-ray was available and family informed they stated they wanted her sent out for evaluation. Resident was not considered surgery candidate related to bed bound status. The resident was placed in immobilizer and discharged to different facility per family request." Review of the facility's Investigation guide portion of the plan of correction revealed a Conclusions-Root Cause(s) section which stated, what do you believe to be the root causes(s) of this incident? The facility response stated, "Resident had a fall that resulted in her knees sliding to the floor and her sitting on her knees. Resident's legs began to slide off edge of bed. Resident was receiving care from aide. Resident was positioned too close to edge of bed." The following is the facility's corrective action plan: Facility Review to Ensure Quality (Plan of Correction) dated 3/31/19. Facility compliance date of corrective action 4/8/19. Corrective Action for resident involved: On the evening shift of 3/25/19 the physician and responsible party were notified of the incident and	F 689		

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F 689	Continued From page 7 an x-ray was ordered of the left leg and knee with the results of the x-ray received on 3/26/19. The physician was notified of the results and the resident was sent to the emergency room for further evaluation. The responsible party was notified. Incident report corrected for the fall that was indicated as an "other" incident. Identification of potentially affected resident and corrective actions taken: All current residents who have had an incident in the last 14 days were reviewed on 3/31/19 by the nurse consultant to ensure that incident reports had been appropriately categorized and that the post fall process had been followed. 100% of incidents in the last 14 days were identified with the post fall process in place and with appropriate categorization of the incident report. Systemic changes: Education On 3/31/19 the DON/ADON (Assistant /Director of Nursing) began education of all full time, part time, as needed licensed nurses and certified nurse's aides on the following topics: definition of a fall, post fall process completion and follow through, and bed positioning safety. The DON will ensure that any of the above identified staff who does not complete the in-service training by 4/7/19 will not be allowed to work until the training is completed. This in-service was incorporated into the new employee facility orientation for the above identified staff. Quality Assurance Plan:	F 689		

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F 689	Continued From page 8	F 689		

The DON/ADON will monitor this issue using the post fall process quality assurance tool and bed positioning tool for monitoring. The monitoring will include review of three falls for compliance with the post fall process. In addition positioning of 4 residents by CNA's while in bed receiving care, will be observed to include each shift and weekends. This will be completed weekly times 2 weeks then monthly times 3 months or until resolved. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action was initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA meeting. The weekly QA meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, ADON, Therapy, HIM and Dietary Manager.

Review of the facility Plan of Correction on 4/24/19 revealed, Falls and Post Fall Process Nursing Education Packet dated 3/31/19, which included a sign in sheet with signature of licensed practical nurses (LPN's). The packet addressed:

" Common causes of falls
" How to prevent falls
" Basic responsibility
" General documentation guidelines to consider
" Falls management

Review of the facility post fall process sheet revealed review of falls for 4 residents over two weeks.
The facility quality assurance tool for bed position safety plan revealed the facility utilized this tool for 8 residents over 2 weeks on the 7-3 shift. The

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F 689	Continued From page 9 review sheet included the following areas: " Resident initials " Shift/Date " Care being provided such as: dressing, bathing, incontinence care " Was the resident appropriately positioned for the provision of safe care " Was the bed in the appropriate position to provide safe care " Did staff have all needed supplies ready/available at bedside to provide care " Follow up actions The facility's date of compliance was validated as 4/8/19.	F 689		