STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 06/10/2019

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PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted on 6/10/19. Past-noncompliance was identified at CFR 483.25 at tag F689 at a scope and severity 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 record review, observation, resident and staff interviews, and physician interview the facility failed to transfer a resident from the chair to the bed using 2 staff members and a mechanical lift as specified in her plan of care for 1 of 4 residents reviewed for accidents (Resident #2). During this transfer Resident #2's leg got caught in the aide's clothing and the resident was diagnosed at the hospital with a fractured left femur. The findings included: Resident #2 was admitted to the facility on 11/25/09 with diagnoses that included a left below the knee amputation (BKA), a right above the knee amputation (AKA), legal blindness, rheumatoid arthritis and diffuse osteopenia (a condition of decreased bone density).	F 689	Past noncompliance: no plan of correction required.	7/1/19

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

Electronically Signed | 07/01/2019

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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A review of the active Nurse Tech Information Kardex showed the resident needed a mechanical lift and the help of 2 people for transfers.

The resident's most recent Minimum Data Set (MDS) coded as a quarterly assessment and dated 4/16/19 revealed the resident was cognitively intact. Resident #2 received extensive assistance of one person for bed mobility and extensive assistance of 2 people for transfers. Impairment was present to bilateral lower extremities.

The resident's active care plan dated 4/16/19 revealed a care plan present for the risk of falls related to blindness and bilateral lower extremity amputation status. Interventions included to use mechanical lift for all transfers.

A nursing progress note dated 5/16/19 at 2:07pm stated, "the nurse aide came to nurse and stated that while she was putting the resident into bed (transferring resident from the wheelchair to the bed) her leg went into the aide's scrub pocket and she heard a crunching noise and a pop. Resident currently in the bed stating her left leg above knee was a 10 out of 10 pain level. MD (physician) was notified and ordered the resident to be sent to the ED (Emergency Department)". Emergency contact was notified as the resident was her own responsible party.

The facility's initial investigation report dated 5/16/19 noted the aide was transferring the resident from the wheelchair (WC) to the bed. When the resident was placed in the bed she related pain and was sent to the ED for x-rays.

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The staff member was suspended pending the outcome of the investigation.

The Emergency Department (ED) progress note dated 5/16/19 noted the resident "injured her left leg while being transferred from the wheelchair, apparently it got stuck and a crunch was heard". The resident complained of severe pain in the distal femur and knee area. Pain medications were given in route to the ED. She was alert and oriented. Significant tenderness was present to the left leg over the distal femur (she has amputation below the knee). X-rays were completed and revealed a distal femur fracture. Orthopedics was consulted and ordered immobilization and follow-up with their clinic.

Review of the 5-day investigation report dated 5/21/19 read: On 5/16/19 at roughly 2:00pm, the resident related pain at a 10 out of 10 following a transfer from chair to bed. The aide reported to the nurse immediately and the resident was sent to the ED for evaluation and treatment. The Unit Manager and Administrator were notified, and the aide was immediately suspended pending investigation that was initiated at that moment. The resident returned to the facility on the evening of 5/16/19. Rheumatoid arthritis, arthropathy, osteopenia and other comorbidities diminished the bone density of the resident. It was reported the resident's left stump got caught in the aide's scrub top and this was likely the cause of the fracture. All staff were in serviced on abuse and neglect and safe transfers pursuant to the Kardex and care plan. All Kardex's and care plans were reviewed for transfer accuracy.

On 6/10/19 at 9:00am the resident was observed lying in her bed listening to the TV. She was able

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to recall the events of 5/16/19 and stated, "my leg got broke". She explained, on the day of the incident, the aide was putting her back to bed from the wheel chair. Instead of using a mechanical lift the aide picked the resident up by herself and the resident felt extreme pain to her left stump area when she placed in the bed. Resident #2 stated the other staff used a lift for her transfers out of the bed, but she didn't say anything to the aide because "she was so nice to me". She stated that she had pain to the left upper leg when she moved or during transfers, however pain medication helped to relieve it.

A phone interview was completed with NA #3 on 6/10/19 at 12:30pm. She indicated she was the aide that transferred Resident #2 at the time of the incident on 5/16/19. NA #3 explained that she was transferring the resident from the wheel chair to the bed in the afternoon of 5/16/19. She stated that the resident grabbed her around the neck and she used her arms to lift the resident under the buttocks. The resident's left stump became stuck in her scrub top pocket and when she was laid down in the bed a noise was heard and Resident #2 began to complain of severe pain. She went on to say that once the resident was in the bed safely she went to retrieve the nurse. NA #3 stated she had never used the mechanical lift when transferring the resident, used the assistance of another aide or had the transfer technique questioned by the resident. She was able to recall that the resident's Kardex indicated full body lift for transfers but had never obtained clarification from a nurse or manager.

On 6/10/19 at 12:42pm a telephone interview was conducted with Nurse #1. She indicated she was the nurse on duty at the time of the incident on

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5/16/19. Nurse #1 recalled the aide came out of Resident #2's room distraught and asked her to come to see the resident. The resident was laying in the bed and complained of severe pain to left stump area. She stated the aide had picked up the resident to transfer her back to the bed from the WC instead of using a mechanical lift and the resident's left stump got caught in the pocket of her scrub top. Nurse #1 stated she contacted the physician and emergency contact and the resident was sent to the ED for evaluation and treatment of the severe left leg pain. She was able to recall the resident's Kardex indicated she was a full body lift of 2 people for all transfers. Nurse #1 added the same day of the incident, she received an in-service on abuse and neglect as well as proper transfer techniques and was required to participate in demonstration of transfers.

An interview occurred with Nurse Aide (NA) #1 on 6/10/19 at 9:15am who stated she was a regular caregiver to Resident #2. NA #1 explained Resident #2 needed a mechanical lift with 2 staff members for all transfers out of the bed. She further stated that she had recently received an in-service on abuse and neglect as well as proper resident transfers and had to demonstrate transfers with mechanical lifts and sit to stand.

On 6/10/19 at 9:30am an observation was made of NA #1 and NA #2 providing a transfer to Resident #2. She was observed being transferred out of bed to a gerichair with the use of a mechanical lift. Staff were observed speaking to the resident during the transfer with proper technique noted. No complaints of pain were expressed at the time of the transfer.

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The administrator was interviewed on 6/10/19 at 12:45pm. He explained the nurse reported the incident to management as soon as the resident was cared for. At that time corrective action was taken by the facility, the NA was suspended, and the investigation was started. The administrator added it was his expectation for the staff to follow the transfer guidance on the Kardex and care plan.

On 6/10/19 at 4:30pm an interview was held with NA #4. She stated she was familiar with Resident #2 who needed a mechanical lift with 2 staff members for all transfers. She indicated that each resident's transfer needs were on the Kardex inside their closets and if she had any questions or concerns regarding their transfer she would seek clarification from the nurse or unit manager. NA #4 stated when using a mechanical lift, 2 staff members were required. She recalled receiving a recent in-service on abuse and neglect as well as proper transfer techniques and had to provide demonstration of the transfers.

NA #5 was interviewed on 6/10/19 at 4:50pm. She indicated that she was an agency aide that had been helping in the facility off and on for the past 2 months. NA #5 stated each resident's Kardex, located in their closets, indicated their transfer status. She was able to recall recent in-services on abuse and neglect as well as transfer techniques with returned demonstration required.

On 6/10/19 at 4:55pm NA #6 was interviewed. She stated each resident has a Kardex located in their closet indicating their transfer assistance. If she didn't feel comfortable or had a question about what was listed, she would seek out

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guidance from the nurse or unit manager. She indicated she had received a recent in-service on abuse and neglect as well as proper transfer techniques with return demonstration required.

The Staff Development Coordinator (SDC) was interviewed via phone on 6/10/19 at 5:00pm. She stated on the afternoon of 5/16/19 she began in-services immediately with the staff in the facility regarding abuse and neglect, proper transfers using the mechanical lift and clarified full body lift as indicated on the Kardex meant a mechanical lift. She explained the in-service was provided via phone to staff, but all nursing staff were required to provide transfer demonstrations by 5/19/19. She stated all in services and transfer demonstrations were completed by 100% of the nursing staff by 5/19/19.

On 6/10/19 at 5:10pm, an interview occurred with the physician who stated if the mechanical lift had been used as directed on Resident #2's care plan and Kardex the fracture might not have occurred. He felt the accident was avoidable.

Interview with the Administrator and DON on 06/10/2019 at 12:45 PM revealed the facility developed a corrective action plan to prevent reoccurrence and provided a copy of the facility's plan.

The following is the facility's corrective action plan:

Facility compliance date of corrective action 5/19/19.

Corrective Action for the resident involved:
The physician was notified of the incident on

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5/16/19 and ordered the resident to be transported to the ED for evaluation and treatment of left leg pain. The resident's emergency contact was notified of the incident and ED transport order. Resident #2 returned to the facility in the evening of 5/16/19 with an order of Norco 5-325 milligrams 1 tab by mouth every six hours as needed for pain and her left leg immobilized. An orthopedic follow up was scheduled for 5/24/19.

Identification of potentially affected residents and corrective actions taken:
All current residents had their Kardex's and care plans audited by the Director of Nursing and Unit Managers for the correct mode of transfer assistance on 5/16/19. Beginning 5/16/19 random observations were made weekly of staff providing transfers to residents requiring assistance. The random transfer observations were made by the unit managers for 8 to 10 residents on each of the 2 wings for the 7am to 3pm and 3pm to 11pm shifts. Audits were completed weekly for 2 weeks and then will be monthly for 3 months.

Systemic Changes:

Education
On 5/16/19 the Staff Development Coordinator began education of all the full time, part time and as needed licensed nurses and nurse aides on the following topics: abuse and neglect protocol, safe transfers, clarification of meaning of full body lift per the Kardex and use of gait belts. All staff were provided verbal in-service to include phone calls to the staff that were not working. From 5/16/19 to 5/19/19 all nursing staff were required to come to the facility and participate with

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demonstration of proper transfers. The Director of Nursing will ensure that any of the above identified staff who did not complete the in-service training by 5/19/19 would not be allowed to work until the training was completed.

Per the SDC, the in-service materials to include demonstration of transfers would be incorporated into the new employee facility orientation as well as the annual evaluation for the above identified staff.

Quality Assurance Plan:
The Director of Nursing and Unit Managers will monitor the issue using the transfer audit tool for monitoring. The monitoring will include random transfer observations of 8 to 10 residents on each wing. This will be completed weekly times 2 weeks then monthly times 3 months. Reports will be presented to the weekly Quality Assurance (QA) meeting by the Director of Nursing or Unit Managers to ensure corrective action initiated as appropriate and compliance has been followed. The weekly QA meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Unit Managers, Therapy and Dietary Manager.

Review of the facility Plan of Correction on 6/10/19 revealed an Inservice record for Safe Transfers dated 5/16/19 to 5/19/19, which included a sign in sheet with signatures of nursing and nurse aide staff.

Review of the Transfer Audit form revealed the facility utilized this audit form for 8 to 10 residents on each of the 2 wings during the 7:00am to 3:00pm and 3:00pm and 11:00pm shifts. The review sheets were dated 5/16/19 and 5/23/19

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F 689	Continued From page 9 and included the following: - The resident's name - Transfer assistance need - Shift/Date - Was the transfer carried out per the Kardex/care plan - Follow up actions Additionally, staff interviews, and observations were conducted during the survey which showed staff were knowledge on how to safely transfer residents and were transferring residents as specified on the resident's care plans. The facility's date of compliance was validated as 5/19/19.	F 689		