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FIVE OAKS REHABILITATION AND CARE CENTER	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

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F 000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted on site from 5/9/23 through 5/11/23. The team conducted an off site review on 5/16/23 to conduct the partial extended survey. Therefore the exit date was changed to 5/16/23. Event ID# N2E911. The following intakes were investigated NC00200195, NC00201634, NC00200141, and NC00200935. One of ten allegations resulted in deficiency. Intake NC00200195 resulted in immediate jeopardy. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tag F689 constituted Substandard Quality of Care. A partial extended survey was conducted.	F 000		
F 689 SS=J	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 reviews and family, resident, physician, physical therapist, and staff interviews, the facility failed to ensure a safe transfer for 1 of	F 689	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/24/2023

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3 residents reviewed for accidents (Resident #8). An agency nurse aide (NA #1) transferred Resident #8 without the use of a mechanical lift from the bed to the wheelchair. NA #1 lifted Resident #8 under his arms and the Resident's left lower leg made contact with the side rail during the transfer. Resident #8 reported pain which worsened as a 10 centimeter (cm) by 6 cm hematoma (a collection of blood under the surface of the skin) developed rapidly on his left lower leg between the knee and the ankle. He was prescribed two medications that can cause bleeding prior to the incident. Resident #8 was transferred to the hospital for evaluation and was diagnosed with blood loss anemia.

The findings included:

Resident #8 was admitted to the facility 2/10/2023. Diagnoses for Resident #8 included peripheral vascular disease, right above the knee amputation, contracture of left leg, history of strokes, anemia, and muscle wasting.

The admission Minimum Data Set (MDS) assessment dated 2/16/2023 assessed Resident #8 to be moderately cognitively impaired (a score of 9 out of 15 on the Brief Interview for Mental Status). The MDS documented Resident #8 required the extensive assistance of 2 people to transfer and he was not stable to perform surface to surface transfers without assistance. The MDS documented limited range of motion of one lower extremity. Resident #8's weight on admission was 127 pounds and he was 61 inches tall (5 feet 1 inch).

Physician orders for Resident #8 were reviewed. Resident #8 was prescribed Clopidogrel (an

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antiplatelet medication that acts as a blood thinner) 75 milligrams (mg) daily on 2/11/2023 and aspirin 81 mg daily on 2/11/2023.

A baseline physical therapy assessment performed by PT #2 dated 2/27/2023 assessed Resident #8's ability to transfer from bed to wheelchair with the use of a slide board and one person assistance and Resident #8 required maximum assistance to use the slide board. This intervention was discontinued on 3/25/2023 due to the risk of skin shearing and breakdown. A mechanical lift for transfers was recommended by physical therapy.

Additionally, the baseline physical therapy assessment assessed Resident #8's ability to stand and pivot to transfer and at baseline on 2/27/2023 Resident #8 was unable to perform due to weakness and muscle tightness. This intervention was discontinued on 3/10/2023.

The Kardex (information about the care needs of a resident, used by NAs to provide resident specific care) dated 3/21/2023 was reviewed and an intervention addressed transfer needs for Resident #8, which included the use of the mechanical lift for transfers.

The physical therapy discharge recommendations dated 3/25/2023 and written by PT #1 included total dependence for transfers.

Physical Therapist (PT) #1 was interviewed on 5/10/2023 at 2:36 PM. PT #1 reported she provided therapy services to Resident #8 and after working with him and the slide board, he told her that the slide board was hurting him, and it was difficult for him to use. PT #1 explained on

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3/22/2023 Resident #8 was reevaluated for transfers and he expressed he was most comfortable with a mechanical lift. PT #1 informed the nursing staff to initiate mechanical lift with the understanding the nursing staff would change the intervention on the Kardex. PT #1 concluded by reporting that Resident #8 was "dead weight" and could not help with a transfer by bearing weight on his left leg.

A nursing note written by Nurse #1 dated 3/26/2023 at 6:25 PM documented that at 3:00 PM Nurse #1 arrived at the facility to begin her shift and was getting shift change report when Resident #8's family member approached her and reported Resident #8 hit his left leg during a transfer. The note documented Resident #8 was out on the smoking patio and the family member wanted Nurse #1 to come and assess his left lower leg. Nurse #1 documented that she went to the smoking patio and assessed Resident #8's left lower leg and did not see any swelling. The note documented the family member brought Resident #8 back to his room and stated she was going to call an ambulance to transfer Resident #8 to the hospital for evaluation. Nurse #1 reassessed Resident #8's left lower leg and noted there was "some swelling". Nurse #1 documented that Resident #8 reported he had pain in his left lower leg that increased by the time medics arrived to transport Resident #8 to the hospital. Nurse #1 documented Resident #8 left the facility at 3:45 PM.

An interview was conducted by phone with Nurse #1 on 5/11/2023 at 10:04 AM. Nurse #1 reported she was receiving change of shift report on 3/26/2023 when Resident #8's family member came to her and asked her to look at Resident

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#8's leg. Nurse #1 reported she went out to the smoking patio and assessed Resident #8's leg but didn't see anything wrong with it. Nurse #1 explained she told Resident #8 and the family member she would get him some pain medication if his leg was hurting. This was the first time Nurse #1 had met Resident #8, and Nurse #1 explained she did not know his baseline (normal state). The family member brought in Resident #8 from smoking and said she was going to call EMS to take him to the hospital because of his leg. Nurse #1 reported she looked at his left leg again and she was able to see an area that was bruised and appeared swollen. Nurse #1 explained that when she looked at Resident #8's leg outside on the smoking patio, there was no area of bruising or swelling and she offered to get him pain medication. When she looked at the leg in his room, Nurse #1 said that the area on the leg appeared to be swelling up as they were watching and EMS was on their way, so there was nothing else for her to do for Resident #8. Nurse #1 said that by the time EMS arrived, Resident #8 was yelling in pain from his left leg.

NA #1 was interviewed by phone on 5/10/2023 at 5:39 PM. NA #1 reported that she was assigned to Resident #8 on 3/26/2023. NA #1 explained that Resident #8 wanted to go outside to smoke, and his family was there to take him outside. NA #1 said that she transferred Resident #8 to the wheelchair by lifting him under his arms. NA #1 reported she had not used the mechanical lift because she had observed another NA transfer Resident #8 the day before by lifting him under his arms. NA #1 reported she lifted Resident #8 to the wheelchair, and he never mentioned he had hit his leg. NA #1 reported she thought everything was fine.

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Resident #8 was interviewed by phone on 5/11/2023 at 4:39 PM. Resident #8 reported that his family member had arrived to visit and was going to take him outside to smoke. Resident #8 said that NA #1 lifted him under his arms to transfer to the wheelchair, and when she moved him off the bed, his left lower leg hit the top side rail. Resident #8 explained that the side rail was in the lowered position so that the NA could get the wheelchair closer to the bed. Resident #8 said he had told NA #1 "my leg hit the side rail" and she had replied "Ok", but nothing more was said about it. Resident #8 reported when his leg was hit, it was "tender, but it wasn't a sharp pain." He then explained that after he went outside to smoke, his leg started to get very painful, and he could feel it swelling. Resident #8 said by the time he finished his cigarette, his leg was getting very swollen and very painful, and his family member said she would call EMS to take him to the hospital. Resident #8 reported he was unable to remember exactly when Nurse #1 looked at his leg, but he knew she looked at it when he was smoking and then later when he returned to his room.

The family member for Resident #8 was interviewed by phone on 5/10/2023 at 9:33 AM. The family member reported she had arrived on 3/26/2023 to visit Resident #8 and was in the room when he was transferred to the wheelchair from the bed by NA #1. The family member reported NA #1 did not use a mechanical lift, but instead lifted Resident #8 under his arms from the bed to his wheelchair. The family member explained that during the transfer, she had observed Resident #8's left lower leg hit the side rail of the bed. The family member reported that

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Resident #8 had not cried out when his leg hit the side rail, and NA #1 did not seem to be aware that his leg hit the side rail. When she took Resident #8 outside to smoke, he told her that his left leg was hurting, and the family member went inside the facility to get Nurse #1 to assess the leg. The family member said that the nurse came out to the smoking patio and said that she did not see anything wrong with the left lower leg, but the family member could see an area that was swelling and appeared bruised. Resident #8 continued to report lower leg pain. The family member reported Resident #10 was outside smoking at the same time and observed Resident #8's leg and the interaction with Nurse #1. When Resident #8 finished smoking, he said the left lower leg was very painful and the family member decided to call for an ambulance to transfer him to the hospital for evaluation.

An Emergency Department evaluation dated 3/26/2023 at 4:19 PM was reviewed. The note documented that Resident #8 was transferred from the facility for a "rapidly expanding hematoma" after hitting his leg during a transfer from the bed to the wheelchair and hit his leg on a metal object during the transfer. The note documented that the hematoma spontaneously ruptured and started leaking blood upon arrival to the emergency room and the resident reported relief from pain. The hematoma measured 10 cm by 6 cm and was located on his left lateral (outer) lower leg between the knee and the ankle. A non-adherent absorbent dressing was applied over the hematoma and the lower left leg was wrapped with an elastic bandage. The hospital history and physical examination noted Resident #8 had a contracture (a condition that causes hardening of muscle, tendon, and other tissue

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leading to deformity and rigidity of a joint) of the left leg.

Emergency Department labs drawn on 3/26/2023 at 4:31 PM revealed Resident #8's hemoglobin (red blood cells in the blood that carry oxygen to organs) was 9.9 (normal 12.1 to 17.4) and hematocrit (the percentage of volume of red blood cells in the blood) measured 31% (normal 36-52%) which was at baseline for resident. According to the emergency department note, the plan was to repeat hemoglobin and hematocrit to evaluate if there was a significant drop. Resident #8's repeat hemoglobin and hematocrit drawn on 3/26/2023 at 8:39 PM showed significant drop from 9.9 to 8 and 31% to 25%. The labs were ordered to be obtained every 4 hours for 8 hours to monitor the hemoglobin and hematocrit, and the next lab results on 3/28/2023 at 1:25 AM resulted in a hemoglobin of 7.2 and hematocrit of 22%. Resident #8 was admitted to the hospital for hematoma to left lower extremity and a diagnosis of blood loss anemia.

The facility physician (MD) was interviewed on 5/11/2023 at 10:24 AM. The MD reported he had provided care to Resident #8 since his admission and Resident #8 had a low pain tolerance due to his medical conditions. The MD explained that he was not certain what happened to the left leg of Resident #8 because if he had hit it on the bed, Resident #8 would have let the staff know by calling out in pain, or telling someone he was hurt. The MD concluded by explaining that he was unable to determine if the injury was a traumatic injury or if the hematoma had spontaneously occurred.

An interview was conducted with the

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Administrator, the Chief Nursing Officer, and the Director of Nursing (DON) on 5/11/2023 at 9:15 AM. The Administrator reported she began her position on 4/11/2023 and this incident occurred prior to her arrival at the facility. The Administrator reported that upon her arrival, the plan of correction was in place and the staff were monitoring and performing audits as the plan of correction directed. The Chief Nursing Officer reported that she was contacted on 3/26/2023 by the DON after the incident with Resident #8 and she arrived at the facility to initiate an investigation. During the investigation, the Chief Nursing Officer reported she was able to determine the root cause of the incident had to do with NA #1 not following the activity orders on the Kardex. The Chief Nursing Officer reported the DON obtained statements from all the involved staff members, interviewed the residents who observed Resident #8 after the incident and started working on the plan of correction. The DON reported she was called on 3/26/2023 after the incident and she called the Chief Nursing Officer to notify her of the incident. The DON reported she talked to staff and residents to determine a timeline and get statements from the staff and residents. The DON reported that once that investigation was completed, they determined that the incident did not need to be reported, nor an incident reported needed to be completed, however, there were gaps in training, and they needed to monitor to prevent further incidents of transferring a resident incorrectly.

The Administrator was notified of Immediate Jeopardy on 5/12/2023 at 1:25 PM.

The facility provided the following corrective action plan with a compliance date of 4/3/2023:

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How corrective action will be accomplished for those residents found to have been affected by the deficient practice:

On 3/26/2023, the (family member) of resident #8 who had a history of Peripheral Vascular disease, right above the knee amputation, aneurysm of the iliac artery, and moderate impaired cognition reported to Nurse #2 that Resident #8's left leg had been hit during transfer and wanted someone to come look at it while they were out at the smoking area. Nurse #1 evaluation documented no swelling was present. After returning from the smoking area, the family member stated she was calling Emergency Medical Services (EMS). Nurse #1 re-examined the leg at this time and noted some swelling but did not document any discoloration. Resident #8 was sent to the hospital at that time related to pain and swelling in the left lower extremity. According to hospital records, Resident#8 was evaluated at the hospital on 3/26/2023 and found to have a 10 centimeter (cm) by 6 cm hematoma of the left lateral aspect of the left lower leg distal to the knee. Resident #8 had complaints of severe pain until the hematoma spontaneously ruptured when he arrived in the emergency department. The resident did not return to the facility.

Nursing Assistant (NA) #1 who had transferred Resident#8 on 3/26/2023, denied hitting Resident #8's leg during any transfers. NA #1 transferred him twice, from the wheelchair to the bed and then from the bed to the wheelchair. NA #1 was interviewed on 3/27/2023 and was asked if the resident ever complained of pain during the transfers, she stated no. NA #1 confirmed she did not utilize the Kardex prior to transferring the

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resident using a stand pivot technique. She stated she was aware that the resident was a mechanical lift transfer but did not use it because she had asked the resident prior to each transfer how he wanted to be transferred and he expressed that he was ok with the stand pivot method. NA #1 did re-enact how she transferred the resident stating that she put his arms around her neck and placed her arms under his arms and locked her hands around his back. She demonstrated moving the resident as he pivoted on his left leg from the bed to the wheelchair. NA #1 was asked if she had been educated on how to care for residents utilizing the Kardex prior to providing care, she replied yes.

After a thorough review it was found that NA #1 did not review the Kardex prior to caring for Resident#8 but knew that the resident was transferred via a mechanical lift. Immediately following, a Kardex training and monitoring tool was put in place to assure all nursing assistant staff were aware of the importance of reviewing the Kardex prior to caring for residents.

After interviewing NA #1 on 3/27/2023, the decision was made at that time to no longer have her work at Five Oaks due to her deliberate disregard of reviewing and implementing care according to Resident#8's Kardex as it relates to his/her transfers.
Based on record review, interviews, and re-enactment, we were unable to establish a point of contact during transfer and therefore were unable to confirm that the resident hit his leg during transfer as alleged by the family member.

Address how the facility will identify other residents having the potential to be affected by

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the same deficient practice:

All resident Activities of Daily Living (ADL) care are guided by the Kardex and therefore all residents are at risk for the deficient practice.

The Kardex competency tools would be reviewed by the DON and or Unit Coordinators prior to the morning meeting with any identified Kardex education discussed at the meeting Monday through Friday to include weekends. There were no identified competency issues regarding the Kardex reported.

NA#1 received Kardex education 2/24/2023, and the competency tool was completed 3/5/2023.

3/30/2023 Education to the nursing assistants for the Kardex was verbally reviewed and verified by the DON, Unit Coordinators, and other nursing designee using the same education provided on 2/24/2023:

- o rounding with off-going nursing assistants
- o review of the Kardex
- o report from shift nurse
- o reporting to shift nurse if resident refuses care as indicated on the Kardex

Nursing assistants who were not educated by 3/30/2023 were not allowed to care for residents until the education had been received. This included newly hired nursing assistants and agency nursing assistants. The unit nurse coordinator that does staffing is responsible for tracking new staff and agency staff. New staff or agency staff that work Monday through Friday are educated by the Unit Coordinators and the new or agency staff that work weekends are educated by

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the weekend RN Supervisor.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.

An ADHOC Quality Assurance Process Improvement (QAPI) meeting was held on 3/30/2023 by the Medical Director, the DON, the unit coordinators, the social worker, maintenance director, housekeeping, medical records (CNA) and administrator to review the plan of correction for Resident #8 discharged 3.26.2023. Results of The Safety: Room Round Observation Tools and Kardex competency tools completed prior to this date were discussed. There were no findings related to unsafe issues involving transfers and no findings indicating that the nursing assistants did not know that the Kardex is used to care for the resident. The new Kardex education monitoring tool developed by the Director of Nursing, Chief Nursing officer and Unit Coordinators and was introduced and explained to the QAPI committee at that time. The new Kardex observation tool requires unit coordinators and RN weekend supervisor and other nursing staff (Nurse Consultant, RN Staff) as designated by the DON to select a minimum of three residents' Kardex weekly to review and then observe the assigned nursing assistant providing care. Increased observations would be based on finding and or at the request of the QAPI committee. The unannounced observations are for the designated staff to validate that nursing assistants are providing care according to the resident's Kardex. Observations include transfers, bathing, repositioning, ambulating, eating, etc. all care reflected on a resident's Kardex. The new Kardex education monitoring

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING _____ B. WING _____	C 05/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS REHABILITATION AND CARE CENTER	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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tool results will be reviewed daily in the morning meeting Monday through Friday. This tool is ongoing.

Incident logs are reviewed daily Monday through Friday in morning meetings by the unit coordinators and or the DON. The information from the incident logs are tracked and trended and presented by the Director of Nursing in the monthly QAPI meetings and at times (if needed) in ADHOC QAPI meetings. There have not been any findings related to unsafe issues involving transfers or issues indicating Kardex's were not being reviewed prior to care or issues or that indicated nursing assistants did not know where or how to get report on their assigned residents. This process is ongoing.

The Kardex observation tool began 4/3/2023 and will remain in place. The audits were reviewed in the morning meeting by the unit coordinators and or the Director of Nursing. The results of the tool as of 4/20/2023 revealed no findings indicating Kardex's were not being reviewed prior to care or issues that indicated nursing assistants did not know where or how to get report on their assigned resident in morning meeting daily. A QAPI meeting was held on 4/20/2023 and a summary of 15 nursing assistants who were observed using the new Kardex education observation tool revealed there were no findings indicating Kardex's were not being reviewed prior to care or any issues with transfers.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

The Safety Room Round observation tool

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information is tracked and trended monthly by the administrator and or the Director of Nursing and monitored in the QAPI committee ongoingly as determined by the QAPI Committee.

Incident log information will continue to be tracked and trended monthly and reported by the Director of Nursing ongoingly in QAPI unless determined otherwise by the QAPI Committee.

The Kardex education has been added to the new hire orientation. The Kardex competency tool remains ongoing for newly hired, prn and agency nursing assistant staff. The information is tracked and trended by the Director of Nursing and or Nurse designee in her absence and monitored monthly and ongoingly as determined by the QAPI Committee.

Information from the new Kardex education and monitoring tool will be tracked and trended by the Director of nursing for 3 months and presented ongoingly as determined by the QAPI committee.

The date of compliance is 4/3/2023.

The corrective action plan was reviewed on-site and validated on 5/11/2023:
" interviewing nursing staff, NAs and confirming they had monitoring of provision of care to residents.
" Education for the nursing staff and NA staff was reviewed.
" The audits of the incident reports and Kardex reviews were reviewed, and they were completed three times per week. The Administrator reported there was no end date planned for this intervention and it would continue indefinitely.
" The ad-hoc QAPI meeting minutes were

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F 689	Continued From page 15 reviewed and the incident with Resident #8 was discussed, the plan for corrective action was discussed and ongoing audits were being conducted. " A transfer of a resident was observed, and no issues were identified. " NA staff were able to identify the transfer needs of residents in the Kardex and perform the correct resident transfer. The compliance date of 4/3/2023 was validated.	F 689		