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F 000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted on site from 5/8/23 through 5/9/23. The team returned to the facility on 5/16/23 to validate the credible allegation of compliance and to conduct the partial extended survey. Therefore the exit date was changed to 5/16/23. Event ID #X3K111. The following intake was investigated NC00201410 and resulted in immediate jeopardy. One of one allegation resulted in a deficiency. Past non compliance 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 review, observation and interview with the attending physician, resident and staff, the facility failed to provide a safe	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 05/23/2023

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transfer for a resident who was at high risk for fractures, was non-ambulatory and required extensive assistance with a mechanical lift for transfers. On 4/18/23 agency Nursing Assistants (NAs) #1 and #2 transferred Resident #1 from her wheelchair to bed utilizing a stand pivot method resulting in the resident's right lower leg getting caught under the bed during the transfer. The resident reported pain in her leg and NA #1 and NA #2 did not report the injury to a nurse. Resident #1 sustained a fracture of the right tibial plateau (a break of the large lower leg bone below the knee that breaks into knee joint itself), required a knee immobilizer, orthopedic care, and experienced pain rated a 10 out of 10 (with 0 indicative of no pain and 10 being the worst pain imaginable). NA #1 and NA #2 had no knowledge of where the resident's Kardex (a care guide for NAs) was located and were unaware Resident #1 required a mechanical lift. This deficient practice was for 1 of 3 sampled residents reviewed for accidents (Resident #1).

Findings included:

Resident #1 was originally admitted to the facility on 9/23/21 with multiple diagnoses including hemiparesis (partial weakness/paralysis on one side of the body) and hemiplegia (complete loss of strength/paralysis on one side of the body) following cerebral infarction affecting the right dominant side.

The quarterly Minimum Data Set (MDS) assessment dated 1/27/23 indicated Resident #1 had moderate cognitive impairment. The assessment further indicated the resident needed extensive assistance with two plus persons physical assist with transfers and ambulation did

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not occur over the entire 7-day period.

Resident #1's Kardex (resident care guide) completed on admission (undated) revealed that the resident was non-ambulatory, and the transfer method was "mechanical lift".

The Kardex was observed on 5/8/23 at 2:30 PM in a binder located at the nurse's station.

The Nurse Unit Manager was interviewed on 5/8/23 at 10:56 AM. She reported that Resident #1 had been using a mechanical lift for transfer for a long time, sometime in 2022.

Review of the incident report dated 4/18/23 at 7:01 PM completed by Nurse #1 revealed Resident #1 was lying in bed with her right leg propped up on a pillow. Nurse #1 removed the pillow and the resident winced in pain and stated, "can you please put that pillow back?" Nurse #1 noticed the right leg was swollen and the resident stated that it hurt from her knee to her ankle. Resident #1 stated the pain was 10 on the scale of 1 to 10. The report indicated Resident #1 was alert and oriented to person, place, and time.

A nursing progress note dated 4/18/23 at 10:02 PM revealed Nurse #1 went into Resident #1's room to obtain a urine specimen. The resident's right leg was propped up on a pillow. When the nurse removed the pillow under the resident's right leg, the resident winced for pain and stated, "can you please put that pillow back?" When asked, the resident stated her right leg hurt from her knee down to her ankle. She reported that when the 2 Nurse's Aides (NA #1 and NA #2) were transferring her from the wheelchair to bed, her foot got caught under the bed and she felt

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something pop, and it had been hurting bad. The resident was sent to the emergency room (ER) for evaluation.

Nurse #1 was interviewed on 5/9/23 at 9:45 AM. She reported she had known Resident #1 since 2022. The resident was alert and oriented to person, place and time, and was reliable. The resident was non-ambulatory and had been using mechanical lift for transfer. The Nurse stated on 4/18/23 after 3:00 PM, she went to Resident #1's room and noticed a pillow under the resident's leg. She indicated when she removed the pillow under the resident's right leg, the resident winced in pain and requested to put the pillow back under her right leg. The nurse observed the resident's right leg to be swollen and the resident rated her pain as 10 on the scale of 1 to 10 when she removed the pillow. The nurse indicated nobody had informed her of the incident nor the resident's complaints of pain.

The ER report dated 4/18/23 revealed that Resident #1 arrived in ER for an injury that happened approximately 2:00 PM at the nursing facility. The Emergency Medical Services (EMS) stated that resident's right lower leg got caught under the bed when the resident was being transferred back to bed from the wheelchair. The resident reported pain and swelling to lower leg and ankle. The resident was alert and oriented to person, place, date, and time. Evaluation in ER revealed a right tibial plateau fracture. She was placed in a knee immobilizer, non-weight bearing and Percocet (narcotic pain medication) for pain control and to follow up with the orthopedic in 1 week.

The result of the Computerized Tomography (CT)

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of the lower right extremity dated 4/18/23 revealed "acute, mildly depressed fracture of the anterior aspect of the lateral tibial plateau. Diffuse [spread or dispersing in many direction] severe osteopenia."

Resident #1 was interviewed on 5/8/23 at 9:25 AM. She was in bed with a knee immobilizer on her right leg. She stated that she had the immobilizer since she fractured her leg and the Orthopedic Doctor had told her she would continue wearing the immobilizer for 4 more weeks. She reported that she fractured her right leg during transfer from the wheelchair to bed (on 4/18/23). She explained it was after lunch when she requested to be transferred back to bed. The 2 NAs (NA #1 and NA #2) transferred her, and during the transfer her right leg got caught under the bed. She heard a pop and her leg started to hurt badly. She screamed for pain and the NA stated she would let the nurse know. The resident indicated that she could not bear weight on her legs and the staff always use the mechanical lift for transfer.

The written statement of NA #1 dated 4/20/23 was reviewed. The statement indicated that with the help of NA #2, she transferred Resident #1 from the bed to the wheelchair ready for her appointment. After the transfer, they left the room and started passing out breakfast trays. After breakfast, they started picking up breakfast trays when Resident #1 reported that she was sick and wanted to go back to bed. The statement indicated that NA #1 and NA #2 transferred the resident back to bed. NA #1 indicated that she was never told that Resident #1 was a mechanical lift for transfer.

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NA #1, an agency employee, was interviewed on 5/8/23 at 2:25 PM. She reported that 4/18/23 was her 3rd or 4th time working at the facility and she did not receive any orientation. She indicated she did not have access to the facility's kiosk, and she was not aware of the Kardex that was available at the nurse's station. She stated that on 4/18/23, after picking up the lunch trays, she assisted NA #2 in transferring Resident #1 back to bed by using the stand pivot transfer. She stated nothing happened during the transfer, and she did not hear the resident complain of pain.

NA #2, an agency employee, was interviewed on 5/8/23 at 2:45 PM. NA #2 reported that 4/18/23 was her first day working at the facility and she did not receive any orientation. She was assigned to Resident #1. She stated she did not have access to the facility's kiosk, and she was not aware of the Kardex that was available at the nurse's station. She reported she was told that Resident #1 was two persons assist with transfers. She indicated that right after lunch, Resident #1 requested to be transferred back to bed from the wheelchair. NA #1 assisted her with the transfer using the stand pivot transfer. She reported that during the transfer, Resident #1 kept saying "my leg hurts, my leg hurts" and she told the resident that she would inform the nurse. NA #2 stated she did not inform the Nurse thinking that NA #1 did. NA #2 indicated she did not notice Resident #1's leg got caught under the bed during the transfer. NA #2 reported that she put a pillow under the resident's right leg since the resident was saying it hurt.

The DON was interviewed on 5/8/23 at 10:05 AM. She reported she investigated the incident that

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happened on 4/18/23 with Resident #1. She interviewed Resident #1 on 4/19/23 and the resident reported that the 2 NAs transferred her from the wheelchair to bed. During the transfer, her right leg got caught under the bed. The resident indicated she screamed for pain and the NA told her she would inform the nurse. When in bed, a pillow was placed under her right leg. The DON indicated that the resident was alert and oriented to person, place and time and was reliable. The DON reported she interviewed NA #1 on 4/20/23 and obtained a written statement. NA #1 stated she was never informed that Resident #1 needed a mechanical lift for transfer. The DON reported she did not interview NA #2 since the NA had already left the building on 4/18/23 and she informed the agency not to send her back to work.

A follow up interview was conducted with the DON on 5/9/23 at 11:05 AM. The DON revealed the resident's care summary including the resident's transfer status was posted in the kiosk, and the Kardex was available at the nurse's station. She reported the Staff Development Coordinator (SDC) was responsible for making sure all staff including agency staff had access to the kiosk and the Kardex at the nurse's station. She stated that if the agency staff did not know the transfer status of the resident, they should ask the nurse.

The SDC was unavailable for interview.

The Physician was interviewed on 5/9/23 at 11:53 AM. He stated Resident #1 had throat cancer and was on radiation therapy. She has a diagnosis of severe osteopenia and was a high risk for

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fractures. Using the lift for transfer could or could have not prevented the fracture. He indicated that minimal movement of resident with severe osteopenia could have caused spontaneous fracture. He stated that he expected the staff to use the appropriate transfer method for all residents to prevent injuries and to notify the nurse of any concerns voiced by the residents or any accident/injuries as they occur to the resident.

The Administrator was interviewed on 5/9/23 at 10:15 AM. He stated he had just started as the administrator of the facility when the incident with Resident #1 happened. He reported the facility had plans to get rid of all the agency staff. He stated the incident was investigated by the DON, and a Quality Assurance and Performance Improvement (QAPI) was completed.

A follow-up interview was conducted with the Administrator on 5/9/23 at 6:10 PM. He stated it was difficult to keep up with the agency staff. The facility received different staff from the agency every day, and it was unrealistic to educate each of them as they came. He reported the facility had planned to stop using agency staff.

The corrective action with a compliance date of 4/25/23 was as follows:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome because of the non- compliance:

The facility failed to ensure staff provided transfer per care plan and failed to report the incident to the nurse. NA #1 and NA #2 transferred resident

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using stand pivot instead, when resident was care planned for a 2-person mechanical lift. On 4/19/2023 resident #1's care plan was updated to reflect transfer status by the Regional Minimum Date Set (MDS) Nurse.
On 4/20/2023 interview with NA #1 on 4/20/2023 informed the Director of Nursing that on 4/18/2023 she and NA #2, were assisting Resident #1 from wheelchair to bed as resident had asked to return to bed because she was sick. During a stand pivot transfer resident stated," I heard a pop. "NA #1 and NA #2 continued to assist resident #1 to bed. Resident told staff that her leg hurt, and NA #1 and NA #2 placed a pillow under Resident #1's leg and resident appeared to be comfortable. NA #1 stated she didn't know Resident #1 was a lift transfer. Resident stated this was sometime between 11:00 am and 1:00 pm when this happened.
Nursing Assistant #2 stated, "On April 18th I was given the 200-hall assignment with Resident #1. I was given an assignment run down by NA #1. NA# 1 and was told Resident #1 was a two person assist. I was notified that she was getting a shower because she had an appointment. On update of the resident 200 hall. I was only aware of one Hoyer lift patient. NA #1 and I were informed by the nurse that Resident #1's appointment had been canceled and to lay her down after lunch. After lunch NA #1 and I went to transfer resident #1 to the bed and she stated, "that her leg was hurting" and we continued to transfer her to bed. Once we got her to bed, we asked if she needed the nurse, and she said yes. NA #1 said she would notify the nurse."
On 4/18/2023 around 4:00 pm NA# 3 entered the room to change the roommate and states that when she completed the roommate's care, she decided to do Resident #1's care. Nurse #1

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entered resident #1 room to obtain a urine sample as NA #3 assisted. The nurse removed the pillow under resident #1's right leg and resident #1 asked her to put it back. The nurse replaced the pillow and asked Resident #1 if she had any pain, at that time Resident #1 stated, "she felt pain from her knee to her ankle." Resident #1 reported a pain scale of 3, on a 0-10 scale. This was the first time the Nurse was made aware of pain. Resident #1 made the NAs aware earlier when the CNAs had to position the resident's leg on a pillow for the resident's comfort. The nurse proceeded to ask Resident #1 had anything happened. Resident #1 informed the nurse when NA # 1 and NA #2 were putting her to bed her foot got caught under the bed and she heard a pop. At this time Nurse #1 reported the incident to the Director of Nursing and Physician. Nurse #1 assessed Resident #1 and noted swelling to the right leg, orders were received to send Resident #1 to the hospital. Emergency Medical Services (EMS) were called, and Resident #1 agreed to go out to the hospital. X-rays were obtained at the hospital and the results showed a fracture of Tibial plateau. Resident #1 returned on 4/18/2023 with orders for orthopedic follow up, a knee immobilizer and order for Percocet 5-325 Milligrams (MG) take 1 tablet by mouth as needed every 6 hours for pain. As of 4/19/2023 Nursing Assistant (NA) #1 and NA #2 were suspended pending investigation by the Director of Nursing. Director of Nursing notified the agency of the incident involving NA #1 and NA #2 and to remove them from the scheduling of this facility. The Agency was informed on 4/19/2023 by Director of Nursing that NA #1 and NA #2 were a do not return to the facility.

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F 689	Continued From page 10 How you will identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken; All residents requiring assistance with transfers are at risk of being affected by this deficient practice when receiving care. Director of Nursing and/or Nurse Managers completed complete audit of all resident's transfer status as of 4/19/2023 and updated care plan as needed. All residents with a change in status are referred to the Rehab Department by nurse for further evaluation and transfer status change. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. As of 4/19/2023 4-point plan has been started to correct failing to follow proper transfers and reporting incident during transfer. Administrator and Director of Nursing completed 4-point Quality Assurance Improvement Plan (QAPI) as of 4/23/2023 to determine cause of incident. Investigation determined that re-education of care plan location and reporting of incident and accidents was needed. As of 4/19/2023 the Director of Nurses started education to ensure all licensed nurses and certified nursing assistants (full-time, part-time, as needed and agency) employees who do not complete the in-service training on transfers, resident transfer status and reporting change in condition related to pain will not be allowed to work until the training is completed. Staff Development Coordinator will ensure all new staff and agency staff have been educated. All nursing staff to include agency staff, must complete general orientation prior to working with residents. All staff, including agency staff, are	F 689		

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given access to a kiosk prior to starting their shift.
As of 4/23/2023 Director of Nursing and/or Staff Development Coordinator educated all licensed, non-licensed Nursing Staff and agency staff on proper transfer per care plan, resident transfer status location and reporting of resident pain or any change in condition. All employees to include agency staff, must complete general orientation prior to working with residents. AS of 4/23/2023 the Administrator, Director of Nursing and staffing coordinator will review staffing sheets daily to ensure staff scheduled have been educated and staff who have not been educated prior to starting their assignment receive education.
As of 4/19/2023 Director of Nursing and or Nurse Manager will monitor 5 certified nursing assistants daily Monday- Friday for 4 weeks then 3 certified nursing assistants weekly for 3 weeks and then 3 certified nursing aides bi-weekly for 4 weeks to observe they are completing the transfer per care plan and reporting of any pain or change in condition.
On 4/24/2023 Universal Healthcare at Ramseur conducted a QAPI meeting to review the findings of QAPI action plan and monitoring tools for effectiveness and any needed changes or improvements. Team consisted of Administrator, Director of Nursing, Nurse Managers, Social Worker, Rehab Director.
Alleged Date of Compliance: 4/25/2023

On 5/16/23, as part of the validation process, the corrective action plan was reviewed and verified.

Evidence of 100% auditing of residents' correct transfer and lift status on 4/19/23 and evidence of 100% all staff education on resident transfers, mechanical lifts and the Kardex on 4/19/23 was

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F 689	Continued From page 12 reviewed and verified. The facility provided evidence of daily Quality Assurance auditing of proper use of lifts and correct lift status starting 4/19/23 and ongoing. Observations revealed correct transferring method and correct use of mechanical lift during resident care. Interviews with agency and in-house aides reported they were able to access the Kardex and location of written Kardex and were educated on immediately reporting any resident accidents or resident pain during or after a transfer to the nurse. The validation process verified the facility's date of compliance as 4/25/23.	F 689		