STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	C 05/09/2024

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DURHAM NURSING & REHABILITATION CENTER	411 S LASALLE STREET DURHAM, NC 27705

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F 000	INITIAL COMMENTS A Complaint investigation survey was conducted from 05/08/24 through 05/09/24. Event ID# BYYS11. The following intake was investigated - Intake # NC00216244. 1 of the 7 complaint allegations was substantiated resulting in deficiencies.	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 and staff and physician interviews the facility failed to safely transfer a resident when utilizing a sit to stand lift for 1 of 3 residents reviewed for accidents (Resident #1). This unsafe transfer resulted in Resident #1 sustaining a mildly displaced left medial malleolus (boney presence on the inner side of the ankle) fracture and pain of 5 on a scale of 1 to 10 (10 being the worst pain). Finding included: Resident #1 was admitted to the facility on 3/18/21 with diagnoses that included cerebral palsy, contractures to right hand, contractures to right knee and contractures to left knee.	F 689	F-689 (1) How corrective action will be accomplished for resident(s) found to have been affected: On 11/30/2023 the nurse assessed resident #1 and no bruises or deformities noted at the site. Resident #1 complained of pain in the area and PRN Tylenol was given as per order and was noted to be affective. MD was notified and an order was given for an X-ray of the left ankle. On 12/1/2023 X-ray results noted left ankle fracture. As a result, resident #1 was taken to Duke Regional Hospital. Resident #1 returned to the facility the same day and denies any pain at this	5/23/24

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

Electronically Signed | 05/24/2024

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F 689	Continued From page 1 Review of Resident #1's care plan (revised date 10/9/23) revealed the focus area for a risk for Activities of Daily Living (ADL) self-care performance deficit related to cerebral palsy, contracture to right hand, right knee and left knee and bipolar disorder. One of the interventions was recommended transfers with stand lift. Resident was total assist with transfer. Review of the nursing note dated 11/30/23 at 5:54 PM indicated the assigned nurse (Nurse #1) was notified by the assigned Nurse Aide #1 # (NA) that Resident #1's ankle got caught up in his wheelchair while trying to transfer him to bed. The note also read in part "Upon assessment no bruises or deformity noted at site, the resident complained of pain to the area." Nursing note indicated, as needed (PRN) Acetaminophen (Tylenol) pain medication was administered per physician orders. Physician orders received for X-rays. Review of the Medication administration note dated 11/30/23 at 10:09 PM read in part "Acetaminophen Tablet 325 milligram (MG), Give 2 tablet by mouth every 6 hours as needed for pain. PRN (as needed) Administration was: Effective. Follow-up Pain Scale was: 0." Review of the X-ray report dated 12/1/23 indicated fracture to left distal tibial with no displacement. There was associated soft tissue swelling. Review of the Physician note dated 12/1/23 revealed Resident #1 was examined by the Physician in his room. The resident did not appear to be in acute distress. Per Physician note the resident's ankle got caught in his wheelchair	F 689	time. Residents #1□s transfer status was changed from a sit to stand lift for transfers to a Hoyer lift for transfers. Resident #1 to continue Occupational Therapy per plan of care. The interventions are currently working, for resident #1 has not had any other incidences. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: On 12/1/2023 the Administrator and the Director of Nursing reviewed all incidents/accidents for the past 60 days to ensure no other incidents regarding the sit to stand lift had occurred. Audit revealed that no other residents had been affected. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: On 12/1/2023 The Maintenance Director checked all sit to stand lifts to ensure proper functioning. All sit to stand lifts were noted to be functioning properly. On 12/1/2023 all sit to stand lifts were taken out of use as they are no longer clinically indicated for any residents at this time. In the event that a sit to stand lift transfer becomes clinically indicated and back in use, re-education and return demonstration to all direct care nursing staff will be required before permitted to	

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F 689	Continued From page 2 while transferring him from his wheelchair to his bed. The resident had no gross deformity noted at the site and had some complaints of pain to the area. The resident's x-ray came back positive for acute left distal tibial fracture without any displacement. Resident was sent to Emergency Room (ER) for further evaluation. Note indicated Resident #1 had history of previous left knee fusion surgery. Documentation of Nursing note dated 12/1/23 at 1:33 PM by Nurse assigned to the resident (7 AM - 3PM shift) indicated Resident #1 had an x-ray of left ankle. The result displayed fracture of the distal tibia. Per Physician orders the resident was sent to the hospital for further evaluation. Resident# 1 was in no apparent distress at that time. Review of Pain scale documentation indicated on 11/30/23 at 4:43 PM, Resident #1's pain was documented as a 5 out of 10. On 11/30/23 at 10:09 PM was "0". On 12/1/23 at 9:15 AM was document as "7" and on 12/1/23 at 12:40 PM was "0". Physician Order dated 12/1/23 read in part "Oxycodone HCl Oral Tablet 5 (Milligrams) MG (Oxycodone HCl) Give 5 mg by mouth every 6 hours as needed for pain for 5 Days." Physician Order dated 12/4/23 read in part "Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl) Give 5 mg by mouth every 6 hours as needed for pain/fracture for 14 days." Review of the Medication Administration Record revealed Acetaminophen Tablet 325 milligram (MG) Give 2 tablet by mouth every 6 hours as	F 689	use. This education will be done by the Director of Nursing, Unit Manager, or designee. 4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: The Administrator, Director of Nursing, or designee monitored for 12 weeks during clinical morning meeting to see if any new referrals were made from therapy for the use of a sit to stand lift. In the event that a sit to stand lift transfer becomes clinically indicated and back in use, monitoring will take place by observing 3 sit to stand lift transfers weekly for 4 weeks and 10 sit to stand lift transfers monthly for 2 months. Monitoring will be done by the Director of Nursing, Unit Manager, or designee. In addition, once back in use, the Maintenance Director or Maintenance Assistant will check all sit to stand lifts to ensure proper functioning. Monitoring will take place weekly for 12 weeks. The Administrator, Director of Nursing, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.	

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F 689	Continued From page 3	F 689	The facility alleges compliance on 5/23/2024	

needed for pain was administered on 11/30/23 at 4:43 PM and pain level indicated as a 5 and on 12/123 at 9:15 AM and pain level indicated as a 7. As needed Oxycodone HCL was marked as administered as ordered by the physician starting 12/2/24 and pain levels were indicated at the time of administration.

Hospital Emergency Room (ER) records dated 12/1/23 indicated Resident #1 was presented to the ER for a fall brought in by Emergency Medical services (EMS). The resident was being transferred from wheelchair (w/c) to bed when his legs got tangled under him. He endorses left ankle pain and right lower leg pain. He was unable to rotate his left ankle and states pain radiates from left ankle up to the middle of his calf. Facility performed X-rays and states he has a tibial fracture. Right foot X-ray does not show any fracture. The left tibia fibula x-ray shows mildly displaced left medial malleolus (boney presence on the inner side of the ankle) fracture. The resident was seen by ortho and recommended: non weight bearing, can be in CAM (Controlled Ankle Motion) boot while transferring, no need for boot when in bed; no further orthopedic surgery needed. Resident sent back to facility from ER the same day.

Review of the Annual Minimum Data Set (MDS) assessment dated 12/1/23 revealed Resident #1 was assessed as cognitively intact and was dependent on staff for toileting, showers, personal hygiene, and chair/ bed to chair transfer. Assessment indicated the resident used a motorized wheelchair for mobility.

During a telephone interview on 5/8/24 at 3:51 PM, Nurse Aide (NA)#1 stated he no longer

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F 689	Continued From page 4	F 689		

worked for the facility, but recalls he was assigned to Resident #1 during the 3 PM - 11 PM shift (the date of the incident unknown). He further stated he was transferring the resident using a lift when the incident occurred. NA #1 did not recall what kind of mechanical lift he was using to transfer the resident. NA #1 indicated he was transferring the resident from his wheelchair to his bed and the resident's leg got caught on the plate on his wheelchair. NA #1 stated he did not realize that the resident's leg was caught on the plate until the resident was safely transferred to the bed. NA #1 further stated the resident had complained about pain and the assigned nurse was immediately notified about the incident. The NA indicated the nurse had assessed the resident and X-rays were ordered by the physician. NA #1 further indicated the assigned Nurse administered pain medication and the resident did not complain of pain later that night. NA #1 stated he was agency staff and worked sporadically at the facility. He indicated when he returned to the facility after few days, he was asked about the incident by management staff (name unknown) and received in-service and training on mechanical lift transfers. NA #1 further indicated was not assigned to the resident after the incident.

During a telephone interview on 5/8/24 at 3:17 PM, Nurse #1 stated she was assigned to Resident #1 on 3 PM -11 PM shift. The nurse was unsure of the date of incident and vaguely remembered the incident. Nurse #1 stated the incident details were written in her note. The Nurse indicated she recollects the NA (name unknown) had informed her about the resident's leg got caught in the wheelchair while the resident has been transferred from his wheelchair. The

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F 689	Continued From page 5	F 689		

resident had complained of pain. Nurse indicated she assessed the resident and notified the Physician. An X-ray was ordered. The resident was also administered as needed pain medication for pain management. Nurse further indicated the resident was transferred using a mechanical lift and unsure which type.

During a telephone interview on 5/8/24 at 1:43 PM, the Physician stated he was made aware that Resident #1's leg got caught in his wheelchair while been assisted with transfer by the NA. The resident was complaining of leg pain. The Physician further stated X-rays were ordered and had come back positive for non-displaced fracture. The Physician indicated the resident was sent to the Emergency Room for further evaluation. The resident was evaluated by the Orthopedic in the ER and discharged to the facility in a CAM (Controlled Ankle Motion) boot and on as needed Oxycodone medication for 14 days for pain management. The Physician stated the resident had brittle bones, multiple contractures, and history of multiple fusion surgeries to legs and ankles and sometimes a complex movement like a transfer could cause a fracture. The Physician stated the resident recovered well.

During an interview on 5/9/24 at 11:56 AM, the Director of Nursing (DON) stated the resident needed staff assistance for transfer. Resident #1 was assisted by the NA using a sit to stand lift for transfer. During the process of transfer the resident had complained about pain. The resident's nurse was notified. Nurse received Physician order for X-rays. X-ray result indicated the resident had a fracture. DON further stated the resident was sent to ER for further evaluation.

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F 689	Continued From page 6 The resident was on as needed medication for pain management and his pain was managed. The resident had existing co-morbidities making him more susceptible to fracture. DON indicated Resident #1 was discharged from the hospital the same day. No major treatment was done in the ER, and he came back to the facility with CAM boot that were needed to be worn during transfer. The DON stated per therapy recommendations, the resident was changed from sit to stand lift transfer to mechanical lift transfer after the incident. DON indicated as the facility had no other resident on sit to stand lift for transfer, the nurse aides were retrained on mechanical lift transfers. DON stated the following interventions were put in place: X- ray performed when resident complained of pain, based on X-ray results the resident was sent to ER, therapy was referred, and staff educated on mechanical lift transfers to ensure all residents were safely transferred when using a mechanical lift for transfers. Resident #1 was transfers were with mechanical lift and care plan was reviewed to reflect mechanical lift. During an interview on 5/9/24 at 12:30 PM the Administrator stated he was also made aware of the incident and the facility followed all the protocols to ensure the resident was safe. The Administrator stated he reviewed the interventions put in place. The interventions were currently working as there was no further incidence.	F 689		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring.	F 867		5/23/24

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F 867	Continued From page 7	F 867		

A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

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F 867	Continued From page 8 §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance	F 867		

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F 867	Continued From page 9 improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff and the physician, the facility's Quality Assessment and Assurance (QAA) committee failed to self-identify the need for the development and implementation of an effective plan to achieve and sustain compliance in the area of supervision to prevent accidents (F689). This was evidenced by a repeat issue with staff	F 867	F-867 (1) How corrective action will be accomplished for resident(s) found to have been affected: F-689- On 11/30/2023 the nurse assessed resident #1 and no bruises or deformities noted at the site. Resident #1 complained	

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F 867	Continued From page 10 failing to transfer residents safely related to an incident that occurred on 11/30/23 and an incident that occurred on 2/14/24. This repeat failure shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag is cross-referenced to: F689 - Based on record review and staff and physician interviews the facility failed to safely transfer a resident when utilizing a sit to stand lift for 1 of 3 residents reviewed for accidents (Resident #1). This unsafe transfer resulted in Resident #1 sustaining a mildly displaced left medial malleolus (boney presence on the inner side of the ankle) fracture and pain of 5 on a scale of 1 to 10 (10 being the worst pain). During a previous complaint investigation on 3/6/24, the facility failed to safely transfer a resident using a total mechanical lift on 2/14/24 for 1 of 1 resident reviewed for accidents. The resident was lowered to the floor by two staff members without injury as the mechanical lift tipped to one side. During an interview on 5/9/24 at 3:44 PM the facility's Administrator stated the facility's Quality Assurance and Performance Improvement (QAPI)/QAA committee was scheduled to meet at least quarterly. However, the Administrator noted the QAA committee typically met about once a month. The Administrator stated the resident was transferred using a sit to stand lift when the incident occurred on 11/30/23. The Administrator stated upon return to the facility the resident has been using a mechanical lift for transfers versus a	F 867	of pain in the area and PRN Tylenol was given as per order and was noted to be affective. MD was notified and an order was given for an X-ray of the left ankle. On 12/1/2023 X-ray results noted left ankle fracture. As a result, resident #1 was taken to Duke Regional Hospital. Resident #1 returned to the facility the same day and denies any pain at this time. Residents #1's transfer status was changed from a sit to stand lift for transfers to a Hoyer lift for transfers. Resident #1 to continue Occupational Therapy per plan of care. The interventions are currently working, for resident #1 has not had any other incidences. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: F-689- On 12/1/2023 the Administrator and the Director of Nursing reviewed all incidents/accidents for the past 60 days to ensure no other incidents regarding the sit to stand lift had occurred. Audit revealed that no other residents had been affected. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: F-689- On 12/1/2023 The Maintenance Director checked all sit to stand lifts to ensure proper functioning. All sit to stand lifts were noted to be functioning properly. On 12/1/2023 all sit to stand lifts were	

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F 867	Continued From page 11 sit to stand lift. He explained there were no other residents using a sit to stand lift in the facility so there was performance improvement plan after the incident on 11/30/23. He indicated the incident on 2/14/24 occurred when the resident was transferred using a mechanical lift.	F 867	taken out of use as they are no longer clinically indicated for any residents at this time. In the event that a sit to stand lift transfer becomes clinically indicated and back in use, re-education and return demonstration to all direct care nursing staff will be required before permitted to use. This education will be done by the Director of Nursing, Unit Manager, or designee. F-867- To protect residents from similar occurrences, on 5/23/2024 the Regional Director of Clinical Services re-educated the Quality Assurance and Performance Improvement Committee on maintaining implemented procedures and monitoring interventions that the committee puts into place. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: F-689- The Administrator, Director of Nursing, or designee monitored for 12 weeks in clinical morning meeting to see if any new referrals were made from therapy for the use of a sit to stand lift. In the event that a sit to stand lift transfer becomes clinically indicated and back in use, monitoring will take place by observing 3 sit to stand lift transfers weekly for 4 weeks and 10 sit to stand lift transfers monthly for 2 months. Monitoring will be done by the Director of Nursing, Unit Manager, or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	C 05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 12	F 867	In addition, once back in use, the Maintenance Director or Maintenance Assistant will check all sit to stand lifts to ensure proper functioning. Monitoring will take place weekly for 12 weeks. The Administrator, Director of Nursing, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. F-867- Monitoring will be done by the Administrator and/or the Director of Nursing to ensure that through observation and review, all implemented QAPI plans that were put into place are maintained. This monitoring process will take place weekly for 4 weeks then monthly for 6 months. The Administrator, Director of Nursing, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 5/23/2024	