| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345557 | A. BUILDING _____ B. WING _____ | C 05/15/2014 |

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| AZALEA HEALTH & REHAB CENTER | 3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412 |

| (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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| F 309 SS=G | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews the facility failed to ensure that staff reported an incident when a resident ' s leg was caught under the bed during a transfer resulting in delayed treatment for a fractured leg for 1 (Resident #1) of 3 sampled residents reviewed for transfers and fall related injuries.<br><br>The findings included:<br><br>Resident #1 was admitted to the facility on 3/21/14 with diagnoses that included a history of Polio, Paralysis, Diabetes and Coronary Artery Disease.<br><br>The Care Plan initiated 3/21/14 revealed the resident was to be transferred with the assist of one to two persons.<br><br>The Admission Minimum Data Set (MDS) assessment dated 4/1/14 revealed the resident had short and long term memory loss and was moderately cognitively impaired. The MDS revealed the resident required extensive assistance of one person for transfers. The MDS revealed that with surface to surface transfers the | F 309 | This plan of correction is prepared because it is required by State and Federal law and not because Azalea Health and Rehabilitation Center agrees with the allegations and citations on this Statement of Deficiencies . Azalea Health and Rehabilitation Center does not admit any deficiency is present. Further the submission of a Plan of Correction and the changes in any policy, procedure or activity is not an admission of a deficiency.<br><br>This plan of correction shall operate as Azalea Health and Rehab written credible allegation of compliance effective 5/30/14<br><br>**F309**<br>At the time of the complaint survey, Res. # 1 had already received treatment for his injury Facility had conducted thorough investigation starting on 5-2-14. Internal investigation determined a C.N.A used an inappropriate transfer and failed to report to the nurse. The C.N.A was terminated 5-6-14<br>In-service to nursing staff on requirement to report immediately any incident or unusual 5-30-14<br>CNA's were re-educated via their job description on reporting all changes in resident's condition, incident and accidents via the Stop & Watch tool (Interact) 8/20/14<br>DON will audit 24 ° risk report and review all Stop and Watch Tool as indicated for 4 weeks and PRN.<br>24° Reports and the Stop & Watch tools will be taken to QA/QI for review and with any variances the plan of correction will be revised. 5/31/14 | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ramon Wike | TITLE: Administrator | (X6) DATE: 5/30/14

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 309 | Continued From page 1<br>resident was not steady and only able to stabilize with staff assistance. The MDS revealed the resident used a wheelchair for mobility and had experienced no recent falls.<br><br>The Care Area Assessment (CAA) for Falls dated 4/2/14 revealed the resident did not attempt to get out of bed, had a long history of Polio with Paralytic Syndrome and had been bed bound for many years.<br><br>A Witness Statement of Incident/Accident or Injury of Unknown Origin by the Administrator dated 5/2/14 revealed the RP for Resident #1 came to the administrator ' s office on the morning of 5/2/14 saying the staff had broken the resident ' s foot. The statement revealed the RP stated the resident told her his foot got caught in the wheelchair and the NAs did not stop to dislodge it but kept pulling until his foot was free. The statement revealed the RP stated she told the nurse last night on the 3PM-11PM shift. The statement revealed the RP was accompanied to the nurse ' s station by the administrator and the resident ' s nurse was questioned about an incident with the resident ' s foot but the nurse was not aware of such an incident.<br><br>A nursing progress note dated 5/2/14 at 10:23 AM revealed at 8:30 that morning the resident ' s Responsible Party (RP) reported that Resident #1 had swelling and pain in the left foot that increased with movement. The Nurse documented the resident had pain of the left lower extremity at a level of 4 on a pain scale of 0-10, 0 being no pain and 10 being unbearable pain. The progress note revealed the administrator and the physician ' s assistant (PA) was notified. | F 309 | **F309** At the time of the complaint survey, Res. # 1 had already received treatment for his injury Facility had conducted thorough investigation starting on 5-2-14. Internal investigation determined a C.N.A used an inappropriate transfer and failed to report to the nurse. The C.N.A was terminated 5-6-14<br>In-service to nursing staff on requirement to report immediately any incident or unusual 5-30-14<br>CNA's were re-educated via their job description on reporting all changes in resident's condition, incident and accidents via the Stop & Watch tool (Interact) 8/20/14<br>DON will audit 24 ° risk report and review all Stop and Watch Tool as indicated for 4 weeks and PRN.<br>24° Reports and the Stop & Watch tools will be taken to QA/QI for review and with any variances the plan of correction will be revised. 5/31/14 | |

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| F 309 | Continued From page 2<br><br>A physician ' s progress note dated 5/2/14 revealed Resident #1 stated he got his left lower leg stuck under the bed during an assisted transfer from his wheelchair to the bed. The note revealed the resident was unsure as to when it happened or the name of the staff member assisting him at the time. The note revealed a STAT x-ray of the lower leg and ankle was done that revealed a non-displaced mid shaft tibia fracture.<br><br>A nursing progress note dated 5/2/14 at 12:19 PM revealed the PA had assessed Resident #1 and ordered a STAT x-ray of the left lower extremity. The note revealed the resident stated he thought his lower extremity got caught when he was being transferred back to bed the night before. The note revealed a positive x-ray and that an order had been given to send the resident to the Emergency Department (ED) for evaluation and treatment.<br><br>A physician ' s progress note dated 5/5/14 revealed Resident #1 was seen on follow-up of an ED visit. The note revealed the resident was sent to the ED on 5/2/14 with a complaint of severe left lower extremity pain due to a mid-shaft tibia fracture. The note revealed the RP stated the resident got his foot caught under the bed while being transferred from the bed to the chair. The note revealed the resident returned from the ED with an order for pain medication and a soft immobilizer and that a follow-up appointment with an orthopedist was being scheduled.<br><br>Review of the record for the resident revealed Resident #1 had a follow-up visit with an orthopedist on 5/9/14. The orthopedist note revealed the resident had a spiral non-displaced | F 309 | | |

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| F 309 | Continued From page 3 | F 309 | | |

fracture of the left tibia. The note revealed repeat x-rays were done during the visit that showed a non-displaced fracture with excellent alignment.

On 5/14/14 at 2:35 PM an interview was conducted with the nurse assigned to Resident #1 on 5/1/14 on the 3PM to 11PM shift. Nurse #1 stated the resident ' s RP frequently asked for pain medication for the resident. The Nurse stated when she would assess the resident for pain he would say he had no pain or would not say anything. The Nurse stated on 5/1/14 the RP told her the resident ' s ankle was swollen and asked if he could have anything for pain. The Nurse stated there were PRN (as needed) pain medications ordered for the resident. The Nurse stated she assessed the ankle and leg by palpating the area and inspecting for redness, swelling and heat. The Nurse stated there was no obvious swelling of the ankle or leg and when she moved the leg the resident did not complain of pain. The Nurse stated the RP grabbed the resident ' s leg and the resident winced but she thought it had to do with the way the RP grabbed the leg. The Nurse stated she was not aware of an injury to the resident ' s ankle or leg.

NA #1 stated in a telephone interview on 5/14/14 at 3:20 PM that during a transfer on 5/1/14 the resident ' s leg was stuck under the bed. The NA stated the resident denied pain and told her he was OK. The NA stated she was going to tell the nurse about the incident but something came up with another resident and she forgot.

The Director of Nursing (DON) stated in an interview on 5/14/14 at 3:30 PM that as part of their plan of correction, the nursing staff had been in-serviced that the NAs (nursing assistants) were

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| F 309 | Continued From page 4<br>to report immediately any injury or medical concerns to the nurse and the nurse was to report any injury of unknown origin to the DON or the administrator. The DON stated the staff monitored care on a daily basis but did not include specific monitoring in the plan of correction. The DON stated she had added monitoring the plan of correction and provided a copy of the plan of correction with handwriting at the top that read: " Revised 5/14/14 to include monitoring. " | F 309 | | |
| F 323 SS=G | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews the facility failed to ensure that staff transferred a resident per physical and occupational therapy instructions resulting in a fractured leg for 1 of 3 sampled residents (Resident #1) reviewed for transfer and fall related injuries.<br><br>The findings included:<br><br>Resident #1 was admitted to the facility on 3/21/14 with diagnoses of Paralysis and Diabetes.<br><br>The Care Plan dated 3/21/14 revealed the | F 323 | **F323** Res. # 1 had already been reassessed for appropriate transfer method to mechanical lift prior to the complaint survey 5/7/14<br>Resident care cards were reviewed at the time of the notification of the incident on 5/2/14 and have been re-audited for appropriate transfer status 5-30-14<br>Nursing staff has been re-educated on the requirement to use a gait belt/mechanical lift to ensure proper and safe transfer.<br>Re-education was provided on utilization of resident care cards on 5/2/14 and has been re-educated as a result of the survey.<br>5-30-14<br><br>The facility has implemented transfer education, care card utilization and return demonstration of gait belt utilization, transfer and mechanical lift as a part of the orientation process for new hires.<br>DON/designee will monitor 9 random transfers/ week for 4 weeks. 5/30/14<br>Observation audits will be taken to QA/QI for review and with any variances the plan of correction will be revised. 5/30/14 | |

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| F 323 | Continued From page 5<br>resident was to be transferred with the assist of one to two persons.<br><br>The Admission Minimum Data Set (MDS) assessment dated 4/1/14 revealed the resident had short and long term memory loss and was moderately cognitively impaired. The MDS revealed the resident required extensive assistance of one person for transfers. The MDS revealed that with surface to surface transfers the resident was not steady and only able to stabilize with staff assistance. The MDS revealed the resident used a wheelchair for mobility and had experienced no recent falls.<br><br>The Care Area Assessment (CAA) for Falls dated 4/2/14 revealed the resident did not attempt to get out of bed, had a long history of Polio with Paralytic Syndrome and had been bed bound for many years.<br><br>A Record of In-Service form revealed transfer training for Resident #1 was initiated on 4/17/14 with the staff based on physical and occupational therapy evaluations. The record listed the following: Gait belt must be used. Must be two person assist. (Name of mechanical lift) if necessary. The signature sheet revealed NA (nursing assistant) #1 attended the in-service on 4/21/14.<br><br>An Occupational Therapy Discharge Summary for Resident #1 dated 4/23/14 under Discharge Status and Recommendations revealed caregiver education was complete and staff training focused on mobility and transfers. The summary revealed the resident required maximum assist of 2 persons for transfers and used a wheelchair for mobility. | F 323 | | |

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| F 323 | Continued From page 6<br><br>A Physical Therapy Discharge Summary for Resident #1 dated 4/30/14 under Discharge Status and Recommendations revealed the resident was totally dependent on staff for transfers and that in-service training was performed with the NAs with instruction on positioning, use of gait belt, transfer with assist of 2 persons at all times and use of (name of mechanical lift) if necessary to decrease the risk of caregiver and patient injury. The summary revealed the NAs had signed an in-service form in the medical record to acknowledge agreement.<br><br>A Witness Statement of Incident/Accident or Injury of Unknown Origin by the Administrator dated 5/2/14 revealed the RP came to the administrator ' s office on the morning of 5/2/14 saying the staff had broken the resident ' s foot. The statement revealed the RP stated the resident told her his foot got caught in the wheelchair and the NAs did not stop to dislodge it but kept pulling until his foot was free. The statement revealed the RP stated she told the nurse last night on the 3PM-11PM shift. The statement revealed the RP was accompanied to the nurse ' s station by the administrator and the resident ' s nurse was questioned about an incident with the resident ' s foot but the nurse was not aware of such an incident. The note revealed the PA was in the facility at the time and saw the resident and a portable x-ray was done which showed an acute fracture. The note revealed the resident was sent to the ED and the RP was informed that an investigation would be conducted.<br><br>A nursing progress note dated 5/2/14 at 10:23AM revealed at 8:30 that morning the resident ' s | F 323 | | |

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| F 323 | Continued From page 7<br>Responsible Party (RP) reported that Resident #1 had swelling and pain in the left foot that increased with movement. The Nurse documented the resident had pain of the left lower extremity at a level of 4 on a pain scale of 0-10, 0 being no pain and 10 being unbearable pain. The progress note revealed the administrator and the physician ' s assistant (PA) was notified.<br><br>A nursing progress note dated 5/2/14 at 12:19 PM revealed the PA had assessed the resident and ordered a STAT x-ray of the left lower extremity. The note revealed the resident stated he thought his lower extremity got caught when he was being transferred back to bed the night before. The note revealed a positive x-ray and an order had been given to send the resident to the Emergency Department (ED) for evaluation and treatment.<br><br>A physician ' s progress note dated 5/2/14 revealed Resident #1 stated he got his left lower leg stuck under the bed during an assisted transfer from his wheelchair to the bed. The note revealed the resident was unsure as to when it happened or the name of the staff member assisting him at the time. The note revealed a STAT x-ray of the lower leg and ankle was done that revealed a non-displaced mid shaft tibia fracture (There are 2 bones in the leg between the knee and the ankle, the larger of the two being the tibia).<br><br>Review of the resident ' s record revealed Resident #1 had a follow-up visit with an orthopedist on 5/9/14. The orthopedist note revealed the resident had a spiral non-displaced fracture of the left tibia. | F 323 | | |

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| F 323 | Continued From page 8<br>An interview was conducted with the Administrator and the Director of Nursing (DON) on 5/14/14 at 1:50 PM. The DON stated the NAs had been in-serviced to transfer Resident #1 with a gait belt and 2 persons. The DON stated Resident #1 gave several variations of the incident. The DON stated Resident #1 described the NA that transferred him when his leg was injured and described NA #1 who was assigned to the resident on the 3PM to 11PM shift on 5/1/14. The DON stated that she interviewed NA #1 on three separate occasions and the NA ' s story changed each time she interviewed her. The DON stated on the initial interview with NA #1 on 5/2/14, the NA stated she was not aware of the problem with the resident ' s foot until the RP told her the resident ' s foot was broken. The DON stated the NA did not mention she transferred the resident or that anything happened during a transfer. The DON stated the NA was off on the weekend and she called her back in on Monday 5/5/14. The DON stated NA #1 told her that she and another NA pulled the resident up in the bed and noted his foot was caught between the wheels of the bed. The DON stated the NA stated she could not remember who assisted her to pull the resident up in bed. The DON stated the NA told her the resident was OK and was not injured. The DON stated she asked NA #1 to demonstrate how she transferred the resident and the NA put her arm under the DON ' s arm and held onto the waist band of her pants for the transfer. The DON stated the NA did not refer to the positioning of another staff member assisting with the transfer. The DON stated the NA told her she forgot to tell the nurse that the resident ' s leg got caught during the transfer. The DON provided written statements from the NAs working on 5/1/14 and according to | F 323 | | |

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the statements all the NAs wrote they did not assist NA #1 to transfer Resident #1 on 5/1/14. The DON stated that NA #1 was suspended on 5/5/14 pending results of the investigation. The DON stated she interviewed NA #1 again on 5/6/14 and the NA denied that she ever transferred Resident #1 on 5/1/14. The DON stated the NA had received training in April 2014 to transfer Resident #1 with a gait belt and 2 person assist and NA #1 signed the in-service signature sheet. The DON stated the x-ray showed the resident had a spiral fracture of the tibia and the resident ' s physician told her the fracture was no more than 24 hours old. The DON stated that based on the investigation, she believed NA #1 transferred Resident #1 independently and caused the fracture of the resident ' s leg.

On 5/14/14 at 2:35 PM an interview was conducted with Nurse #1 who worked the 3PM to 11PM shift on 5/1/14. Nurse #1 stated on the evening of 5/1/14, the RP told her she thought the resident ' s ankle was swollen and could he have something for pain. The Nurse stated she did an assessment of the ankle and leg by inspecting the extremity for redness, swelling and heat and palpated the area. The Nurse stated she moved the resident ' s leg and he did not complain of pain. The Nurse stated there was no obvious problem with the extremity. The Nurse stated the RP grabbed his leg and the resident winced but thought it had to do with the way the RP grabbed his leg. The Nurse stated the RP did not say anything about an injury to the resident ' s foot or leg. The Nurse stated she observed no obvious swelling of the leg or ankle and was not aware of an injury to the resident ' s foot or leg.

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| F 323 | Continued From page 10<br>NA #1 stated in a telephone interview on 5/14/14 at 3:20 PM that she did not transfer Resident #1 by herself on 5/1/14 but could not remember who assisted her with the transfer. The NA stated during the transfer the resident ' s leg was stuck under the bed and when the resident was back in bed the resident denied pain and said he was OK. The NA stated she was going to tell the nurse about the incident but something came up with another resident and she forgot.<br><br>Review of the facility ' s investigation of the incident revealed the facility filed a 24 hour and 5 day report to the state. The DON stated in an interview on 5/14/14 at 3:30 PM that in-services had been provided for the nursing staff regarding proper transfer procedures for residents and information provided regarding the NA ' s responsibility to report immediately any injury or medical concerns to the nurse and the responsibility of the nurse to report any injury of unknown origin to the DON or Administrator. The DON stated the NAs were required to use a gait belt when manually transferring residents and according to NA #1 ' s demonstration, the NA did not use a gait belt for the transfer. The DON stated all resident care guides were reviewed to ensure they had proper instructions for transferring the residents. The DON stated that orientation of all nursing staff would include a return demonstration that the staff could successfully use the gait belt to transfer residents. The DON stated the staff were always monitoring resident care but did not institute a specific monitoring plan in the plan of correction. The DON stated she had spoken with the medical director and the physician ' s assistant about the incident but did not include the incident in their last Quality Improvement (QI) meeting on | F 323 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345557 | A. BUILDING _____ B. WING _____ | C 05/15/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AZALEA HEALTH & REHAB CENTER | 3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412 |

| (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 |
|---|---|---|---|---|
| F 323 | Continued From page 11<br>5/13/14. The DON stated she planned to include the information in the next QI meeting along with the monthly statistics.<br><br>Occupational Therapist Assistant (OTA) #1 stated in an interview on 5/15/14 at 8:36AM that he conducted an in-service for the NAs in April 2014 regarding transfers for Resident #1. The OTA stated the NAs were instructed to use 2 persons and a gait belt for manual transfer and if the resident was not assisting with the transfer to use the (name of mechanical lift). The OTA stated that the staff were to always use 2 persons when using a (name of mechanical lift) to transfer a resident. | F 323 | | |