STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345516	A. BUILDING _____ B. WING _____	07/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONOVER NURSING AND REHAB CTR	920 4TH STREET SOUTHWEST CONOVER, NC 28613

(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 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to provide a safe transfer for a resident with hemiplegia. During the transfer, Resident #172 sustained a skin tear when her arm scrapped against a bed rail for 1 of 4 sampled residents. The findings included:	F 323	1. Resident #172 received immediate medical treatment for the skin tear. Resident #172's lift status was reviewed and the magnet was corrected to accurately reflect the care plan. 2. A lift status audit was conducted for all residents 7/28/2017 and all residents were being transferred correctly. The Director of Nursing reviewed incident reports for Quarter 3 and found no trends or injuries	8/17/17

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

Electronically Signed | 08/07/2017

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F 323	Continued From page 1 Resident #172 was admitted to the facility on 06/30/17 with diagnoses that cerebral vascular accident affecting her left side. The Admission Minimum Data (MDS) dated 07/07/17 specified the resident's cognition was intact and she required 2 person assistance with bed mobility and transfers. The Care Area Assessment (CAA) for falls specified the resident needed extensive two person assistance with transfers. A care plan for ADL specified staff were to assist the resident as needed with help. Nurses' noted dated 07/21/17 made by Nurse #1 specified Resident #172 was alert and oriented times 2 and needed frequent reminders of left arm awareness due to risk of injury. The nurse also documented the resident required 2 person assistance for transfers. On 07/22/17 at 11:13 AM Nurse #2 documented nurse aide (NA) #1 reported Resident #172 had sustained a skin tear to her left forearm during a transfer. A physician's order dated 07/22/17 specified cleanse skin tear, pat dry and apply steri strips and replace as needed until healed. An incident report dated 07/22/17 specified the resident sustained a 3.0 inch x 3.0 inch x 0.1 centimeter skin tear to her left forearm during a transfer when her left arm scraped against the bed rail.	F 323	related to unsafe transfers of residents with hemiplegia. NA#1 received disciplinary action and retraining for safely transferring residents with hemiplegia. 3. Direct Care staff were inserviced by Staff Development Coordinator and Physical Therapist on 8/9/2017 on providing safe transfers for residents with hemiplegia as well as how to communicate a change in lift status. 4. Physical Therapist or designee will monitor two transfers of residents with hemiplegia per week for three consecutive months to ensure residents with hemiplegia are safely transferred. ADON or designee will conduct weekly lift status audit for all residents to ensure resident lift status system is communicated accurately for three consecutive months. Results of both audits will be monitored by Quality Assurance Committee.	

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F 323	Continued From page 2	F 323		

On 07/23/17 Nurse #2 documented a late entry for 07/22/17 that specified Resident #172 continued to work with therapy 5 days a week for strengthening, gait training, safety awareness and the required 2 person assistance with all activities of daily living.

On 07/25/17 at 8:58 AM an interview was conducted with Resident #172. The resident's forearm was noted to have steri strips. The Resident explained that she had a skin tear from a staff member that tried to get her out of bed but her arm got caught in the top assist bar attached to the bed.

On 07/25/17 at 2:34 PM NA #1 was interviewed and explained that she worked in the facility part-time and as needed but recalled that she was assigned to Resident #172 on 07/22/17 during the 7 AM to 3 PM shift. The NA added that when transferring the resident from the bed to the wheelchair, the resident's left arm scrapped against the bed rail attached to the top of the bed. The NA reported that she failed to lower the head of bed. The NA also stated she was confused about the resident's transfer status because the "kiosk" (a computerized instruction system for each resident) said the resident could transfer with 1 person but the "number magnet" (a magnet placed over the resident's bed) specified "2" meaning two people were needed to transfer the resident. The NA also explained that she did not verify with the nurse but made the decision to transfer the resident without any assistance because she had done so in the past. The NA

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F 323	Continued From page 3	F 323		

stated that she had been trained to rely on the "number magnet" to know a resident's transfer status. NA #1 described that when transferring the resident out of the bed, she had the resident stand and pivot and failed to protect the Resident's left side which caused her arm to scrape against the bed rail. The NA stated she had not been told she could transfer the resident with 1 person and was not aware to protect the resident's arm during a transfer.

On 07/25/17 at 5:13 PM Nurse #2 was interviewed on the telephone and reported Resident #172 required two person assistance for transfers. The Nurse stated that when she was treating Resident #172's skin tear she observed the "number magnet" to be a "2" meaning the resident was to be transferred with two people. The nurse added she spoke to NA #1 to verify the resident was not transferred using two people. Nurse #2 stated that if the NA had lowered the head of the bed and used two people to transfer the resident, the skin tear would have not occurred.
On 07/26/17 at 1:39 PM Nurse #1 was interviewed and reported that she worked Monday through Friday 7 AM to 3 PM on the rehab unit. The nurse explained that transfer status was determined upon admission by physical therapy and status was communicated to staff using a magnet system. She added that magnet was placed over the resident's bed for staff to reference before transferring a resident. The nurse stated that therapy would communicate changes in transfer status to nursing so they could update the magnet as needed. Nurse #1 sated that Resident #172 was able to be managed as one person assistance.

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F 323	Continued From page 4	F 323		

On 07/27/17 at 9:17 AM the Physical Therapist (PT) was interviewed and explained that at admission transfer status was determined by the therapy department and communicated to nursing. He added that therapy and nursing communicated with each other when changes in a resident's ability changed. The PT described Resident #172 needing two person assistance with transfers after her admission but had recently been changed to one person assistance. The PT added that if one person was going to transfer the resident, the resident's left arm should be protected by tucking the affected arm underneath the armpit of the staff person. The PT also stated that for a safe transfer, the staff member would need to be on the left side of the resident and the head of the bed should be lowered. The PT stated he couldn't recall when Resident #172's transfer status changed from 2 to 1 but he stated he told staff, but could not recall who. The PT explained he did not document in therapy notes changes in transfer status and communicated changes to the nurse and nurse aide working with the resident that day.

On 07/27/17 at 9:51 AM the Director of Nursing (DON) was interviewed and explained she had reviewed the incident report for Resident #172 and felt the injury could have been prevented if NA #1 had lowered the head of the bed and followed the safety guidelines described by the PT to protect Resident #172's left arm. The DON reported that the magnet system was updated when changes were made in a resident's transfer status by nursing; but Resident #172's magnet at the time of the incident on 07/22/17 had not been

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F 323	Continued From page 5 changed to reflect 1 person assistance with transfers.	F 323		