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PINEY GROVE NURSING AND REHABILITATION CENTER	728 PINEY GROVE ROAD KERNERSVILLE, NC 27284

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 2/13/19-2/15/19. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity (J). CFR 483.35 at tag F726 at a scope and severity (J). The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 1/23/19 and was removed on 2/15/19. A partial extended survey was completed. On 3/12/19, the 2567 was amended to make corrections to the dates when the immediate jeopardy began and removed. The correct date of the immediate jeopardy beginning was 1/22/19 and not 1/23/19. The immediate jeopardy was removed on 2/14/19 and not 2/15/19.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	F 656		3/15/19

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

Electronically Signed | 03/11/2019

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F 656	Continued From page 1 describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, the facility failed to develop a care plan that addressed discharge goals and plans for 1 of 3 residents (Resident #2) reviewed for discharge planning. Findings included:	F 656	Piney Grove Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and	

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F 656	Continued From page 2 Resident #2 was admitted to the facility on 3/15/18 with diagnoses that included, in part, hemiplegia following cerebral infarction and aphasia. A review of the quarterly Minimum Data Set (MDS) assessment dated 12/29/18 revealed Resident #2 was cognitively intact. Further review of the MDS assessment revealed there was an active discharge plan in place for Resident #2 to return to the community. A review of the care plan updated 1/3/19 revealed there was no care plan that addressed discharge planning. On 2/13/19 at 10:23 AM an interview was completed with Resident #2. She stated she was on a waiting list for an apartment in the community through a state program that assisted residents with housing. On 2/14/19 at 9:42 AM an interview was completed with the facility Social Worker. She stated Resident #2's discharge plan was to return to an apartment in the community and Resident #2 had applied to five different housing communities and was on their waiting lists. The Social Worker reported that although the interdisciplinary team had addressed discharge planning with Resident #2 they had not included it in the comprehensive care plan. On 2/14/19 at 10:06 AM an interview was completed with the MDS Nurse. She stated that discharge plans and goals were typically not addressed on the comprehensive care plan. She said she was unaware discharge planning was	F 656	provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Piney Grove Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Piney Grove Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding On 2/29/19 the Social Worker updated the care plan for Resident #2 to include discharge plan. On 2/15/19 the Minimum Data Set (MDS) Nurse audited the last 7 days of admissions to ensure the baseline care plans included discharge plans. Discharge baseline care plans were place in the four new residents care plans that were admitted in the last 7 days. On 2/26/19 the facility consultant audited 100% of care plans to ensure discharge plans are present on all care plans.	

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F 656	Continued From page 3 supposed to be included in the care plan. On 2/14/19 at 3:28 PM an interview was completed with the Administrator. She stated she expected discharge plans and goals be included in a resident's comprehensive care plan.	F 656	MDS Nurses were proactively in-serviced by the DON on 2/26/19 on care plan development, including discharge plans, and inclusion on the baseline care plan. On 2/27/19 the administrator proactively in-serviced the social worker in the care plan development, including discharge plans and the inclusion on the baseline care plan. This in-service was completed on 2/27/19. All newly hire MDS Nurse or Social Worker will receive this in-service during orientation. The DON and/or designee will audit new admission and readmission baseline care plans to ensure the discharge plans are included on care plans for 3 months. The DON and/or designee will audit 100% of all comprehensive care plans monthly x 3 months to ensure that discharge plans are addressed on each care plan. The Administrator will be responsible for implementing this plan of correction to ensure any issues of developing and implementing a discharge baseline care plan will be addressed through additional root cause analysis, process correction, training, and monitoring.	
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	F 689		3/15/19

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F 689	Continued From page 4 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and physician interviews, the facility failed to ensure repositioning techniques were followed when repositioning a resident in his wheelchair by pulling him under his arms for 1 of 3 sampled residents (Resident #1) reviewed for supervision to prevent accidents. The failure to properly reposition Resident #1 resulted in Resident #1 sustaining a large hematoma (an abnormal collection of blood), experiencing blood loss and severe bruising to his chest. Resident #1 was sent to the hospital on 1/26/19 and diagnosed with hematoma of chest wall and acute blood loss anemia. Resident #1 returned to the facility on 1/30/19. Immediate jeopardy began on 1/22/19 when nursing assistant (NA) #1 repositioned Resident #1 up in his wheelchair by pulling him under his arms which resulted in injury. Immediate Jeopardy was removed on 2/14/19 when the facility implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a scope and severity level of "D" (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) for the facility to ensure monitoring systems put into place are effective. Findings included: Resident #1 was admitted to the facility on 7/22/14. The resident's diagnosis included: cerebral infarct, dementia and atrial fibrillation.	F 689	On 1/30/19 resident #1 was re-admitted to the facility from acute care hospital and remains stable at this time. Residents that require assistance with ADL's including transferring have the potential to be affected. On 1/29/29 a 100% audit of Resident Care Guides for accuracy in guidance for transfer assistance of dependent residents was completed by the facility consultant. All resident care guides were accurate for guidance in care delivery. Beginning 1/29/19, the staff facilitator (SF) initiated in-service for 100% of licensed nurses, nursing assistants, including agency staff, on appropriate transfers and gait belt use. In-service completed on 2/14/19. This in-service was added to new staff orientation including agency staff. Yearly proactive education for licensed nurses, and nursing assistants, including agency staff, will occur starting in 2019 with this training and will be scheduled yearly thereafter. This in-service will ensure licensed nurses and certified nursing assistants, including agency, are aware of the expectations related to safe transfers and gait belt use. This will ensure staff are competent related to resident transfers. The Interdisciplinary Team (IDT) will	

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F 689	Continued From page 5 Review of Resident #1's care plan, updated on 12/19/18, revealed Resident #1 required assistance of one person to maintain maximum function of self-sufficiency for transferring from one position to another related to: unsteady gait. The care plan goal was for Resident #1 to receive the necessary physical assistance to transfer. Interventions included: assistance of one person, two if fatigued. A Quarterly Minimum Data Set (MDS) dated 1/1/19 indicated Resident #1 had moderately impaired cognition and required extensive assistance with one person for bed mobility and transfers and utilized a wheelchair. Resident #1 had limitation in range of motion on his right and left sides. A review of a progress note by the physician dated 1/23/19 revealed, "Seen for acute visit due to bruise on left chest and slight cough. Patient described bruise on his chest to be result of a tug of him by nursing staff. Noted a large non elevated bruise of the right axillary fossa. There is noted a deep bruise right axilla. The bruise in right axilla had not changed however there was a significant elevated soft mass over the entire right pectoralis major, was a bleeding mass, was soft and non-fluctuant, view of the extensive amount of edema noted and the fact that it had developed within 24 hours since my initial evaluation of him, Doppler and stat labs ordered." An interview with the facility physician on 2/13/19 at approximately 10:30 AM revealed he examined Resident #1 on 1/22/19 for increased confusion and ordered a chest x-ray and a urinalysis. He stated he did not see any swelling or bruising to Resident #1's right chest area that day but	F 689	review changes of Condition and incidents during am IDT meeting. The review will include appropriate investigation, interventions, notification of attending physician and responsible party. The results of the review will be shared with the QAPI team on a monthly basis for 3 months. The DON, and ADON will present the in-service comments, supervision observations, and audit trends to the IDT weekly as needed and monthly QAPI committee for three months. The IDT and QAPI committee will focus on improving staff competency, including with resident transfers. The results of the audits for Supervision for accidents utilizing the Incident audit tool will be shared with the QAPI team by the DON or QI nurse on a monthly basis for 3 months. Results of the on-going audits will be presented to the QAPI meeting x 3 months or until a time determined by the QAPI members for sustained compliance. The Administrator will be responsible for implementing this plan of correction to ensure any issues of staff competency will be addressed through additional root cause analysis, process correction, training, and monitoring.	

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examined him again on 1/23/19 and observed the large swollen area and bruising and ordered a Doppler study and a complete blood count. The physician stated invasive intervention would not be considered due to the risk for infection and Resident #1's cardiac status and diagnosis of dementia.

An interview on 2/13/19 at 10:40 AM with Nurse #1 who rounds with the physician stated the physician saw Resident #1 on 1/22/19 for increased confusion and there was no bruising. When the physician saw Resident #1 on 1/23/19, there was swelling and bruising to the right chest area. She stated the nurses were monitoring and applying ice to the area.

A record review revealed a physician's order dated 1/22/19 for a chest x-ray.

A record review revealed a physician's order dated 1/23/19 for a Doppler study and a complete blood count.

A review of the chest x ray results revealed "interval development of right perihilar and bibasilar infiltrates since 11/22/2018" called to physician assistant, new orders received and initiated for Augmentin 875 milligrams by mouth for 10 days, probiotic 1 cap by mouth daily for 21 days, mucinex 600 milligrams by mouth and nebulizer treatments as needed.

A review of the Doppler results done on 1/23/19 revealed "fluid collection 9.65 x 5.71 x 5.46 centimeters -differential included organizing hematoma, cyst or abscess".

A review of the complete blood count results

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dated 1/23/19 revealed a hemoglobin level of 12.9.

A review of a progress note by the nurse practitioner dated 1/24/19 revealed she saw Resident #1 for follow up on hematoma formation to right upper chest. The progress note revealed the right upper chest had a raised, firm area, extending from the sternum to under the arm pit with some yellowing and light bruising to area. A dark echymotic area on right rib cage was noted. The results of the compete blood count and Doppler ultrasound results were reviewed.

A statement by nurse aide (NA) #1 dated 1/25/19 taken by the Director of Nursing (DON) via telephone revealed NA#1 had been assigned to care for Resident #1 on 1/22/19 and she asked Restorative Aide #1 to help her pull Resident #1 up in the chair. The statement revealed Restorative Aide #1 came to assist her and NA #1 pulled Resident #1 up in the chair by pulling him under his arm.

An interview on 2/13/19 at 1:13 PM with NA #1 revealed she was assigned to Resident #1 on 1/22/19 on first shift (7AM -3PM). She stated when she went into Resident #1 ' s room on 1/22/19 in the morning to transfer him from the bed to the wheelchair, she got him to sit on the side of the bed because he was able to stand and pivot. NA #1 stated that she transferred Resident #1 from his bed to his wheelchair without any assistance. She stated Resident #1 was sliding down in his wheelchair so she asked Restorative Aide #1 to assist her to reposition him. She stated she couldn't remember if she pulled Resident #1 up under his arms to reposition him in his wheelchair. She recalled that she did not

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have a gait belt. She stated she did not remember seeing any swelling or bruising on Resident #1's body.

A review of a statement by Restorative Aide #1 on 1/25/19 revealed she was asked by NA #1 to assist her to pull up Resident #1 on 1/22/19 in his wheelchair. She entered the room to assist and observed NA #1 pulling Resident #1 back in the wheelchair with her arm under his left arm. She stated she instructed NA #1 not to do that.

An interview on 2/13/19 at 1:30 PM with Restorative Aide #1. She stated on 1/22/19, she entered Resident #1's room after NA #1 asked for help to pull Resident #1 up in his wheelchair. She observed Resident #1 sliding down in his wheelchair and assisted NA #1 to pull him up in his wheel chair. She stated she got to the left side toward the back of Resident #1 and pulled him up by the back of his pants. She assumed NA #1 would do the same thing on the other side of the resident, but when she looked up, she observed NA #1 pulling Resident #1 up under his arms. She told NA #1 that was wrong and they were never supposed to lift residents under their arms. She did not observe any swelling or bruising on Resident #1.

Record review revealed no documentation of bruising or swelling for Resident #1 until 1/25/19.

On 1/25/19 a nurse ' s note was written indicating a family member was visiting and was concerned about the swelling and bruising on Resident #1.

An interview on 2/14/19 at 2:17 PM with Nurse #2 revealed she was the nurse assigned to Resident #1 on 1/26/19 when the resident was sent to the

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hospital. She stated she couldn't remember exactly what happened or why she sent him to the hospital, but she recalled he was in a lot of pain in his shoulder.

A physicians order dated 1/26/19 revealed Resident #1 was sent to the Emergency Department for pain and increased swelling and bruising on right chest and right side per family request.

A review of the hospital discharge summary dated 1/30/19 revealed Resident #1 "presented to the emergency department after son noted swelling to the chest wall that occurred 3 days ago. Resident #1 was in atrial fibrillation with heart rate of 150, complaining of chest wall pain and shoulder pain. Hemoglobin was down 4 grams from baseline on admission and stabilized at 8.9. He remained hemodynamically stable. He received parenteral iron and will discharge on iron supplement with follow up as an outpatient. Troponin is elevated but not consistent with ischemia and most likely related to trauma.

An attempt to interview the hospital physician on 2/14/19 at 1:32 PM was unsuccessful.

An interview on 2/14/19 at approximately 11:00 AM with Physical Therapist (PT) #1 revealed he was very familiar with Resident #1 and had worked with him often. He stated prior to Resident #1 going to the hospital on 1/26/19, he had variable levels of functioning and could some days stand and pivot with stand by assistance, and other days required more hands on assistance. PT #1 stated Resident #1 could be resistant to getting out of bed and needed encouragement and Resident #1 had chronic

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right shoulder pain and needed to be encouraged and reminded to lay on his back or left side. He stated it was important for staff to explain what they were doing and give Resident #1 time to process things as he did have impaired cognition. PT#1 stated staff should utilize gait belts to transfer residents to prevent injury.

An observation of Resident #1 on 2/13/19 at 10:45 AM revealed Resident #1 lying in bed on back with eyes open. There was swelling observed to Resident #1's right chest and bruising in various stages of healing observed to Resident #1's chest at midline, toward axilla and on right side. The resident was unable to state how the bruising and swelling on his chest occurred.

An interview on 2/13/19 at 1:35 PM with the director of nursing (DON) revealed the Administrator told her about the bruising on 1/25/19 and she began an investigation. She interviewed NA #1 and Restorative Aide #1 and it was determined that the swelling and bruising on Resident #1's chest occurred from the improper transfer/repositioning

A follow up interview with the DON on 2/14/19 revealed she didn't remember when she was informed about the swelling and bruising. She stated it was never acceptable to transfer a resident by pulling them under their arms and all staff should have a gait belt and use gait belts to transfer residents properly to prevent injuries.

An initial interview on 2/13/19 at 1:40 PM with the Administrator revealed she became aware of the swelling and bruising to Resident #1 on 1/25/19 when a family member called her concerned

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about it. She stated she talked to the family member about the swelling and bruising and the investigation into how it occurred. A follow up interview with the Administrator on 2/14/19 revealed she knew about bruising on the 24th because she made notes about it in her planner on that day and Resident #1 was discussed in team meeting.

On 2/14/19 at 1:00 PM, the facility's Administrator and Corporate Nurse were informed of the Immediate Jeopardy. The facility provided an acceptable credible allegation of Immediate Jeopardy removal on 2/15/19 at 11:06 AM.

The allegation of immediate jeopardy removal was as follows:

How corrective action will be accomplished for those residents found to have been affected by the deficient practice:
On 1/22/19 resident # 1 was transferred by certified nursing assistant #1 without use of gait belt, using resident's chest and arms to assist due to failure to follow transfer procedure as a result of knowledge deficit.

On 1/22/19 resident # 1 received a chest x-ray in facility for cough.

On 1/23/19 abnormal chest x-ray results of "interval development of right perihilar and bibasilar infiltrates since 11/22/2018" called to physician assistant, new orders received and initiated for Augmentin 875 mg x 10 days, Probiotic 1 cap daily x 21 days, Mucinex 600 mg PO and Neb treatment ordered as needed.

On 1/23/19 resident # 1 was discussed by the

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clinical team (DON, ADON, MDS, administrator, Therapy) during morning meeting (Cardinal IDT) for change in condition related to cough, and antibiotics. Physician note from 1/23/19 indicating the bruise not available at time of review.

On 1/23/19 resident # 1 was seen by physician, medical director, in facility for follow-up to abnormal chest x-ray. Progress note reflected resident to also have bruise on left chest. New order received for ultrasound of chest area, CBC, Vitamin B-12, Vitamin D, and BMP. Progress note for visit not received by facility until 1/24/19.

On 1/24/19 resident # 1 was discussed by the clinical team (DON, ADON, MDS, administrator, Therapy) during morning meeting (Cardinal IDT) for abnormal chest x-ray, diet downgrade, and hematoma (bruise). During Cardinal IDT, administrator instructed director of nursing and assistant director of nursing to start interviewing staff to determine cause of hematoma (bruise).

On 1/24/19 director of nursing and assistant director of nursing began contacting staff for interviews related to bruising on resident #1.

On 1/25/19 director of nursing and assistant director of nursing obtained statements from two certified nursing assistants that indicated resident #1 was not transferred according to transfer procedure.

On 1/25/19 resident #1 was discussed by director of nursing, assistant director of nursing, and therapy manager regarding change in transfer ability. Discussion resulted in a resident being changed to a 2 person mechanical lift until therapy services could evaluate formally.

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F 689	Continued From page 13 On 1/25/19 resident #1's care plan was updated to reflect change in transfer technique to 2 person mechanical lift by the minimum data set nurse. Residents care plan includes the care guide (ICSP) which communicates to nursing staff including certified nursing assistants and agency staff a resident's transfer technique. On 1/26/19 resident # 1 was sent to emergency room for evaluation of increased size of bruising, swelling and pain on left side of chest. On 1/29/19 certified nursing assistant # 1 was provided in-service training by assistant director of nursing on transfers and gait belt use which included residents in a chair and poor position, return demonstration of resident transfer completed. Nursing assistant # 1 was provided with gait belt. Extra gait belts are available at nurse's stations and staff facilitator office. On 1/30/19 resident #1 was re-admitted to facility from acute care hospital. On 1/31/19 resident was evaluated and added to caseload for physical, speech, and occupational therapy for treatment as appropriate, including change in transfer ability. As a result of the therapy evaluation resident was picked up by therapy services for physical, occupational, and speech services on 1/31/19. Therapy goals include resident will be 1 person assistance with bed mobility, transfer stand- pivot, resident will have a tolerable pain level with range of movement. On 1/29/19 the interdisciplinary team (DON, ADON, administrator, and therapy) utilized	F 689		

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investigation and the "5 whys" to determine the root cause of the resident injury was staff failure to follow procedure related transfers due to knowledge deficit.

How the facility will identify other residents having the potential to be affected by the same deficient practice:

On 1/29/19 the director of nursing (DON) and assistant director of nursing (ADON) completed an audit of resident care guides for all residents currently in facility for proper transfer status based on each resident's current status. All care guides were correct with no negative findings noted. This audit was documented on a census.

On 1/29/19 the DON and ADON completed transfer observations of all residents currently in the facility to ensure transfer observed was completed per care guide. No negative findings noted. This audit was documented on a census.

On 1/29/19, the ADON initiated in-service for 100% of licensed nurses, and nursing assistants, including agency staff and certified nursing assistant #1, on appropriate transfers with and without gait belt, including not repositioning residents using arms, use of draw sheet when gait belt not appropriate and resident in bed, and gait belt use. This in-service was added to new staff orientation, including agency staff. In-service 100% complete with all nursing staff (CNAs, licensed nurses, and agency staff) on 2/14/19. To ensure in-service is effective beginning 2/13/19 the DON, and/or ADON will complete random audits of 5 resident transfers 5 times weekly, to include all halls, all shifts, and agency staff, for transfer observation. The audit will be completed

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by observing the transfer and ensuring transfer technique is correct based on the resident care plan and facility procedure including correct use of gait belt when gait belt use is appropriate. The audit will be documented on the transfer audit tool.

On 1/29/19 the interdisciplinary team discussed any other resident incidents or occurrences related to resident transfer technique. No other issues noted.

What measures will be put into place or systemic changes made to ensure the deficient practice will not occur:

On 1/29/19, the ADON initiated in-service for 100% of licensed nurses, and nursing assistants, including agency staff and certified nursing assistant #1, on appropriate transfers with and without gait belt, including not repositioning residents using arms, use of draw sheet when gait belt not appropriate, and gait belt use. This in-service was added to new staff orientation, including agency staff. In-service was 100% complete with all nursing staff (CNAs, licensed nurses, and agency staff) on 2/14/19. To ensure in-service is effective beginning 2/13/19 the DON, and/or ADON will complete random audits of 5 resident transfers 5 times weekly, to include all halls, all shifts, and agency staff, for transfer observation. The audit will be completed by observing the transfer and ensuring transfer technique is correct based on the resident care plan and facility procedure including use of gait belt when appropriate. The audit will be documented on the transfer audit tool.

Gait belts are provided to nursing staff during

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orientation and are also available at nursing stations, and staff development.

On 2/14/19 the DON, and/or ADON began reviewing all progress notes entered for any resident (all residents) 5x weekly (to include all shifts, all halls) x 12 weeks to ensure new skin areas, including bruising have been followed up on and investigated if needed. This audit will be documented on the skin audit tool. This audit will ensure any bruising has been investigated timely when appropriate.

On 2/14/19 the DON, ADON, and/or MDS nurse will review POC skin alerts 5x weekly(to include all shifts, all halls) x 12 weeks to ensure skin alerts, including bruising, have been followed up on and investigated if needed. This audit will be documented on the skin audit tool. This audit will ensure any bruising has been investigated timely when appropriate.

The performance improvement plan was discussed and approved by the quality assurance performance improvement (QAPI) committee on 1/28/19. The medical director was made aware of the plan on 1/28/19 and is in agreement with plan.

How the facility plans to monitor its performance to make sure solutions are sustained.

Beginning 1/28/19, the facility increased communication in the form of: verbal communication to nursing staff by in-service and daily interdisciplinary team (IDT) meetings, written education, and audit forms to ensure the facility provides residents with supervision to prevent accidents by providing safe transfers. The IDT, QAPI committee will continue to monitor the

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facility to identify other factors contributing to failure to supervise to prevent accidents.

Beginning 1/28/19, the DON, and ADON will present the in-service comments, supervision observations, and audit trends to the IDT weekly as needed and monthly QAPI committee for six months. The IDT and QAPI committee will focus on improving residents' safety through prevention of accidents, including resident transfers.

The administrator and/or DON will present the recommendations of the daily IDT and monthly QAPI committee to the quarterly QAPI committee for additional recommendations for monitoring and continued compliance.
The administrator will be responsible for implementing this plan of removal of immediate jeopardy to ensure any issues of failure to provide supervision to prevent accidents will be addressed through additional root cause analysis, process correction, training, and monitoring.
Piney Grove Nursing and Rehabilitation alleged removal of IJ as of 2/14/19.

The facility's credible allegation of Immediate Jeopardy removal was validated on 2/15/19 at 1:30 PM. The validation was evidenced by interviews with both licensed and non-licensed nursing staff on gait belt use and when not to use, where to locate them not positioning under arms and using draw sheet when appropriate. Review of on-going inservice records revealing licensed and non-licensed staff were in-serviced on gait belt use and when not to use, where to locate them not positioning under arms and using draw sheet when appropriate. Review of Resident #1's updated care plan and care guide reflecting change in transfer status. Review of on-going

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F 689	Continued From page 18 audits, documented review of audit of all residents to ensure care guides correct and transfer status correct.	F 689		
F 726 SS=J	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by:	F 726		3/15/19

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F 726	Continued From page 19 Based on observation, record review and staff and physician interviews, the facility failed to ensure an agency nursing assistant was trained and competent before allowing the nursing assistant to work for 1 of 3 (NA #1) agency nursing assistants reviewed. The failure to ensure NA #1 was trained and competent resulted in an improper transfer and repositioning of Resident #1 when NA #1 lifted Resident #1 under his arms to reposition Resident #1 in his wheelchair, resulting in injury. Resident #1 sustained a large hematoma (an abnormal collection of blood), experiencing blood loss and severe bruising to his chest. Resident #1 was sent to the hospital on 1/26/19 and diagnosed with hematoma and acute blood loss anemia. Resident #1 returned to the facility on 1/30/19. Immediate jeopardy began on 1/22/19 when nursing assistant (NA) #1 repositioned Resident #1 up in his wheelchair by pulling him under his arms which resulted in injury. Immediate Jeopardy was removed on 2/14/19 when the facility implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a scope and severity level of "D" (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) for the facility to ensure monitoring systems put into place are effective. Findings included: Resident #1 was admitted to the facility on 7/22/14. Diagnoses included: cerebral infarct, hemiplegia, dementia and atrial fibrillation. Review of Resident #1's care plan, updated on 12/19/18, Resident #1 required assistance of one	F 726	On 1/30/19 resident #1 was readmitted to the facility from an acute care hospital and currently remains in the facility in stable condition. Resident that require assistance with ADL's including transferring have the potential to be affected. On 1/29/19 a 100% audit of Resident care guides for accuracy in guidance for transfer assistance of dependent residents was completed by the facility consultant. All residents care guides were accurate for guidance in care delivery. On 1/29/19, the Assistant Director of Nursing (ADON) initiated proactive in-service for 100% of licensed nurse, nursing assistants, and certified nursing assistant #1, on appropriate transfers, not repositioning residents using arms, and gait belt use. In-service was completed on 2/14/19. This in-service was added to new staff orientation, including agency staff. Return demonstration competency will be accomplished through observation audits by the DON and/or ADON. Beginning 1/29/19, the staff facilitator (SF) Initiated in-service for 100% of licensed nurses, nursing assistants, including agency staff, on appropriate transfers and gait belt use. In-service completed on 2/14/19. This in-service was added to new staff orientation, including agency staff. Yearly proactive education for licensed nurses, and nursing assistants, including agency staff, will occur starting 2019 with this training and will be	

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person to maintain maximum function of self-sufficiency for transferring from one position to another related to: unsteady gait, hemiparesis. The care plan goal was for Resident #1 to receive the necessary physical assistance to transfer. Interventions included: assistance of one person, two if fatigued.

A Quarterly Minimum Data Set (MDS) dated 1/1/19 indicated Resident #1 had moderately impaired cognition and required extensive assistance with one person for bed mobility and transfers and utilized a wheelchair. Resident #1 had limitation in range of motion on his right and left sides.

A review of a progress note by the physician dated 1/23/19. "Seen for acute visit due to bruise on left chest and slight cough. Patient described bruise on his chest to be result of a tug of him by nursing staff. Noted a large non elevated bruise of the right axillary fossa. There is noted a deep bruise right axilla. The bruise in right axilla had not changed however there was a significant elevated soft mass over the entire right pectoralis major, was a bleeding mass, was soft and non-fluctuant view of the extensive amount of edema noted and the fact that it had developed within 24 hours since my initial evaluation of him, Doppler and stat labs ordered."

A review of the Doppler results done on 1/23/19 revealed "fluid collection 9.65 x 5.71 x 5.46 centimeters -differential included organizing hematoma, cyst or abscess".

A statement by nurse aide (NA) #1 dated 1/25/19 taken by the Director of Nursing (DON) via telephone revealed NA#1 had been assigned to

scheduled yearly thereafter.

The in-service will ensure licensed nurses and certified nursing assistants, including agency, are aware of the expectations related to safe transfers and gait belt use. This will ensure staff are competent related to resident transfers.

On 1/2/9/19 the DON, and/or ADON began random observation audits of resident transfers 5 times weekly x 4 weeks and then weekly x 8 weeks. The audit will be completed by observing the transfer and ensure transfer technique is correct based on the resident care plan and facility procedure. This will ensure staff is competent in transfer procedure. The audit will be documented on the transfer audit tool. The results of the audits will be shared with the QAPI committee monthly for three months.

Results of the observation audits will be brought to stand down meeting on-going for discussion with the Interdisciplinary Team members (IDT) and to the monthly QAPI meeting. Results of the on-going audits will be presented to the QAPI Meeting x 3 months or until a time determined by the QAPI members for sustained compliance.

The IDT members are responsible for the Plan of Correction and the Administrator is responsible for sustained compliance.

The Administrator will be responsible for implementing this plan of correction to

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F 726	Continued From page 21 Resident #1 on 1/22/19 on the 7AM - 3 PM shift and she asked Restorative Aide #1 to help her pull Resident #1 up in the chair. The statement revealed Restorative Aide #1 came to assist her and NA #1 pulled Resident #1 up by pulling him under his arm. An interview on 2/13/19 at 1:13 PM with NA #1 revealed she was assigned to Resident #1 on 1/22/19 on first shift (7AM -3PM). She stated when she went into Resident #1's room on 1/22/19 in the morning to transfer him from the bed to the wheelchair, she got him to sit on the side of the bed because he was able to stand and pivot. NA #1 stated that she transferred Resident #1 from his bed to his wheelchair without any assistance. She stated Resident #1 was sliding down in his wheelchair so she asked Restorative Aide #1 to assist her to reposition him. She stated she couldn't remember if she pulled Resident #1 up under his arms to reposition him in his wheelchair. She recalled that she did not have a gait belt. She stated she did not remember seeing any swelling or bruising on Resident #1's body. A review of a statement by Restorative Aide #1 on 1/25/19 revealed she was asked by NA #1 to assist her to pull up Resident #1 on 1/22/19 in his wheelchair. She entered the room to assist and observed NA #1 pulling Resident #1 back in the wheelchair with her arm under his left arm. She stated she instructed NA #1 not to do that. An interview on 2/13/19 at 1:30 PM with Restorative Aide #1. She stated on 1/22/19, she entered Resident #1's room after NA #1 asked for help to pull Resident #1 up in his wheelchair. She observed Resident #1 sliding down in his	F 726	ensure any issues of staff competency will be addressed through additional root cause analysis, process correction, training, and monitoring.	

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wheelchair and assisted NA #1 to pull him up in his wheel chair. She stated she got to the left side toward the back of Resident #1 and pulled him up by the back of his pants. She assumed NA #1 would do the same thing on the other side of the resident, but when she looked up, she observed NA #1 pulling Resident #1 up under his arms. She told NA #1 that was wrong and they were never supposed to lift residents under their arms. She did not observe any swelling or bruising on Resident #1.

A physicians order dated 1/26/19 revealed Resident #1 was sent to the Emergency Department for pain and increased swelling and bruising on right chest and right side per family request.

A review of the hospital discharge summary dated 1/30/19 revealed Resident #1 "presented to the emergency department after a family member noted swelling to the chest wall that occurred 3 days ago. Resident #1 was in atrial fibrillation with heart rate of 150, complaining of chest wall pain and shoulder pain. Hemoglobin (responsible for transporting oxygen in the blood; normal range 13.5 - 17.5) was down 4 grams from baseline on admission and stabilized at 8.9. He remained hemodynamically stable. He received parenteral iron and will discharge on iron supplement with follow up as an outpatient. Troponin level (a laboratory test to differentiate between myocardial infarction and unstable angina) is elevated but not consistent with ischemia (reduced blood flow) and most likely related to trauma".

An interview on 2/14/19 at approximately 11:00 AM with Physical Therapist (PT) #1 revealed staff should utilize gait belts to transfer residents to

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prevent injury.

An observation of Resident #1 on 2/13/19 at 10:45 AM revealed Resident #1 lying in bed on back with eyes open. There was swelling observed to Resident #1's right chest and bruising in various stages of healing observed to Resident #1's chest at midline, toward axilla and on right side. The resident was unable to state how the bruising and swelling on his chest occurred.

An interview on 2/14/19 at 8:50 AM with the Staff Development Coordinator revealed orientation for new hires included a video about transfers and lifting. It included information about using gait belts for transfers and she stated every staff member should receive one during orientation and have it with them at all times when working. She stated there was an orientation for agency staff as well with a check list that included a review of the safe resident handling and movement policy which stated "staff will follow the movement and handling safety interventions/procedures for each resident as individually determined through the admission/re-entry admission process", including, "use approved resident handling aids, i.e. gait belts, in accordance with instructions and training".

An interview on 2/14/19 at 10:02 AM with NA #1 revealed the only orientation she received when she started working at the facility was orientation on the time clock. She stated she never watched a video about transfers and lifting.

An interview on 2/14/19 at 2:30 PM with the Assistant Director of Nursing revealed NA #1's

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	345354	A. BUILDING _____ B. WING _____	C 02/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY GROVE NURSING AND REHABILITATION CENTER	728 PINEY GROVE ROAD KERNERSVILLE, NC 27284

(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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orientation checklist wasn't completed. She stated she called NA #1 on the phone on 2/14/19 and completed the orientation checklist. Positioning/repositioning wasn't completed.

On 2/14/19 at 1:00 PM, the facility's Administrator and Corporate Nurse were informed of the Immediate Jeopardy. The facility provided an acceptable credible allegation of Immediate Jeopardy removal on 2/14/19. The allegation of immediate jeopardy removal was as follows:

How corrective action will be accomplished for those residents found to have been affected by the deficient practice:
On 1/22/19 resident # 1 was transferred by certified nursing assistant #1 without use of gait belt, using resident's chest and arms to assist due to failure to follow procedure.
On 1/23/19 resident # 1 was noted to have bruise on left chest.
On 1/26/19 resident # 1 was sent to emergency room for evaluation of increased size of bruising, swelling and pain on left side of chest.
On 1/26/19 resident # 1 was admitted to acute care hospital from emergency room.
On 1/29/19 certified nursing assistant # 1 was provided in-service training by assistant director of nursing on transfers and gait belt use.
On 1/26/19 resident # 1 was admitted to acute care hospital from emergency room with primary diagnosis of atrial fibrillation with rapid ventricular response and secondary diagnosis including hematoma of chest wall.
On 1/30/19 resident #1 was re-admitted to facility from acute care hospital.
On 1/29/19 the interdisciplinary team (DON, ADON, administrator, and therapy) utilized investigation and the "5 whys" to determine the

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root cause of the resident injury was staff failure to follow procedure related to transfers due to knowledge deficit.

How the facility will identify other residents having the potential to be affected by the same deficient practice:

On 1/29/19, the ADON initiated in-service for 100% of licensed nurses, and nursing assistants, including agency staff and certified nursing assistant #1, on appropriate transfers, not repositioning residents using arms, and gait belt use. In-service was completed on 2/14/19. This in-service was added to new staff orientation, including agency staff. Return demonstration competency will be accomplished through audits as outlined below.

Beginning 1/29/19 the DON, and/or ADON will complete random audits of resident transfers 5 times weekly x 12 weeks. The audit will be completed by observing the transfer and ensure transfer technique is correct based on the resident care plan and facility procedure. This audit will ensure staff is competent in transfer procedure. The audit will be documented on the transfer audit tool.

On 1/29/19 the interdisciplinary team discussed any other resident incidents or occurrences related to resident transfer technique. No other issues noted.

What measures will be put into place or systemic changes made to ensure the deficient practice will not occur:

On 1/29/19, the staff facilitator (SF) initiated

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in-service for 100% of licensed nurses, nursing assistants, including agency staff, on appropriate transfers and gait belt use. In-service completed on 2/14/19. This in-service was added to new staff orientation, including agency staff. Yearly proactive education for licensed nurses, and nursing assistants, including agency staff, will occur starting in 2019 with this training and will be scheduled yearly thereafter.
This in-service will ensure licensed nurses and certified nursing assistants, including agency, are aware of the expectations related to safe transfers and gait belt use. This will ensure staff are competent related to resident transfers.

The performance improvement plan was discussed and approved by the quality assurance performance improvement (QAPI) committee on 1/28/19. The medical director was made aware of the plan on 1/28/19 and is in agreement with plan.

How the facility plans to monitor its performance to make sure solutions are sustained.
Beginning 1/28/19, the facility increased communication in the form of: verbal communication by in-service to nursing staff by the DON, ADON, and/or staff facilitator and daily interdisciplinary team (IDT) meetings, written education, and audit forms to ensure the facility provides residents with supervision to prevent accidents by providing safe transfers. The IDT, QAPI committee will continue to monitor the facility to identify other factors contributing staff competency including with resident transfers.
Beginning 1/28/19, the DON, and ADON will present the in-service comments, supervision observations, and audit trends to the IDT weekly as needed and monthly QAPI committee for six months. The IDT and QAPI committee will focus

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on improving staff competency, including with resident transfers.
The administrator and/or DON will present the recommendations of the daily IDT and monthly QAPI committee to the quarterly QAPI committee for additional recommendations for monitoring and continued compliance.
The administrator will be responsible for implementing this plan of immediate jeopardy removal to ensure any issues of staff competency will be addressed through additional root cause analysis, process correction, training, and monitoring.
Piney Grove Nursing and Rehabilitation alleges removal of IJ as of 2/14/19.

The facility's credible allegation of Immediate Jeopardy removal was validated on 2/15/19 at 1:30 PM. The validation was evidenced by interviews with both licensed and non-licensed nursing staff on gait belt use and when not to use, where to locate them not positioning under arms and using draw sheet when appropriate. Review of on-going in-service records revealing licensed and non-licensed staff were in-serviced on gait belt use and when not to use, where to locate them not positioning under arms and using draw sheet when appropriate. Review of Resident #1's updated care plan and care guide reflecting change in transfer status. Review of on-going audits, documented review of audit of all residents to ensure care guides correct and transfer status correct.