

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/18/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345280	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2020
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF RAEFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 N FULTON STREET RAEFORD, NC 28376		
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F 689 SS=G	<p>Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)</p> <p>§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</p> <p>§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, staff interviews and physician interview, the facility failed to utilize a mechanical lift to transfer a dependent resident from her wheelchair to her bed for 1 of 3 sampled residents reviewed for supervision to prevent accidents (Resident #1). Resident #1 was manually transferred by two nursing assistants instead of using a mechanical lift for the transfer, which resulted in the resident's foot getting caught in the rails on the bed and the resident sustained a fractured left femur.</p> <p>The findings included:</p> <p>A review of the facility's Resident Handling and Proper Body mechanics Training revealed Nursing Assistant #2(NA #2) had been trained on 08/12/19 and Nursing Assistant #1 (NA #1) had been trained on 10/17/19. The training indicated the nursing assistants had been proficiently trained on proper mechanics and mechanical lifts for resident transfers and repositions. By signing the training, the nursing assistants indicated they understood they were only allowed to manually lift a resident in an emergency.</p> <p>Resident #1 was admitted to the facility on</p>	F 689	Past noncompliance: no plan of correction required.	1/24/20	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

01/24/2020

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 689	<p>Continued From page 1</p> <p>01/21/10 with diagnoses which included unspecified dementia with behavioral disturbance, age-related osteoporosis, abnormal posture, chronic pain, muscle weakness and lack of coordination.</p> <p>Resident #1's quarterly Minimum Data Set (MDS), dated 11/14/19, revealed Resident #1 was severely cognitively impaired and required the total assistance of staff with transfers. The MDS indicated Resident #1 had impairment on both sides of her lower extremities, was not steady during transfers and had only been able to stabilize with staff assistance when performing surface-to-surface transfers.</p> <p>Resident #1's Care Plan, which was in place on 12/11/19, revealed Resident #1 was at risk for falls related to a history of falls, impaired mobility, weakness, short- and long-term memory deficit and being non-ambulatory. Interventions included the use of a total lift for transfers using a two-person assist.</p> <p>Resident #1's incident report, dated 12/12/19 at 3:39 p.m., revealed Nurse #1 reported the following, "On 12/11/19, this nurse was called to resident's room around 8:50 p.m. by care staff ...resident alert. Resident grimacing and making verbal sounds of pain and trying to hold her left knee. Resident stated, 'my knee hurts.' No other sign of injury noted on resident; resident's level of awareness appears within normal limits ...nurse called resident's medical doctor (MD) to notify and left a message; nurse called Director of Nursing (DON) and received permission to order a mobile x-ray; mobile x-ray contacted and x-ray ordered STAT (immediately); after resident calmed, she no longer complained of pain, but</p>	F 689			

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F 689	<p>Continued From page 2</p> <p>began to complain again at 10:00 p.m.; Tylenol given per her orders at that time ..."</p> <p>Resident #1's mobile radiology report revealed the x-rays taken on 12/11/19 of her left lower extremity noted a fracture in the femur (the bone that extends from the hip to the knee) closer to the knee.</p> <p>A nurse progress note, written by Nurse #2 on 12/12/19 at 3:54 a.m., indicated that she had notified the MD of Resident #1's x-ray results at 2:15 a.m. The nurse had received orders from the MD to send Resident #1 to the Emergency Room (ER) for evaluation and treatment. Nurse #2 indicated the resident left the facility with Emergency Medical Services (EMS) at 2:48 a.m.</p> <p>Resident #1's hospital discharge summary indicated resident had been admitted to the hospital on 12/12/19 and discharged on 12/17/19. Her discharge diagnoses included a closed fracture of the distal end of femur. The history of present illness related she had been sent to the ER from her nursing facility with complaints of leg pain. The emergency department provider stated Resident #1 had made statements to EMS saying that she had been pushed by a staff member which caused her to injure her left leg. X-ray of her femur showed left distal femur fracture and she had been hospitalized. An x-ray of her left femur taken at the hospital, revealed 1) acutely mildly displaced comminuted transverse fracture involving the distal shaft of the left femur with no evidence for intra-articular extension; 2) no additional acute fracture or dislocation; 3) severe degenerative changes left hip; and 4) osteopenia. The hospital records indicated she had been seen by orthopedics and no surgery had been</p>	F 689			

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F 689	<p>Continued From page 3</p> <p>recommended and had been managed with pain control and supportive care. Resident #1 had also been seen by the hospital physical therapy department staff for consultation and no further physical therapy had been recommended. Resident #1 had been found to be at her baseline needing a total lift for transfers. The hospital records indicated Resident #1 had been discharged back to the skilled nursing facility as per the family's wishes.</p> <p>During an interview with NA #1 on 01/08/20 at 2:20 p.m., the NA stated she had been the NA assigned to care for Resident #1 on 12/11/19 from 3:00 p.m. to 11:00 p.m. NA #1 stated she had no knowledge of the facility having a "no-lift" policy and stated she had thought if she got assistance from another nursing assistant, she could provide a stand-pivot transfer on a resident even if the resident had been assessed for needing a total lift for transfers. NA #1 stated it had been her intention to get Resident #1 into her bed so she would be able to provide incontinent care before the next shift began. NA #1 stated when she and NA #2 performed a stand-pivot transfer, Resident #1's left foot got caught in the bed's side rails. NA #1 explained she had lowered the bed's side rails to the down position and then lowered the bed as far as it would go to the floor and by doing this, the bottom of the side rails had been very close to the floor. NA #1 stated Resident #1 had been seated in her wheelchair and the wheelchair had been facing the bed. NA #1 stated she and NA #2 got on either side of Resident #1 and lifted her and pivoted her body so that she would be seated on the side of the bed. NA #1 stated when Resident #1 had become seated on the bed she had noticed the resident's foot had become caught</p>	F 689			

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F 689	<p>Continued From page 4</p> <p>under the rail of the bed and stated it did not look right to her because it appeared twisted and stated she knew she needed to get it out from the rail. NA #1 stated she got the resident's foot free as fast and as gentle as she could. NA #1 stated the resident said, "my leg, my leg." NA #1 stated she then picked up her legs while NA #2 got behind her back and together they positioned her on the bed. NA #1 stated she immediately got the resident's nurse, Nurse #1. NA #1 stated Nurse #1 came into the room and had assessed the resident and then left the room to call the doctor. When asked why her initial story had involved the resident being up in the total lift, NA #1 stated she had found out the facility was a "no-lift" facility and she had been initially scared to tell the truth about the injury.</p> <p>During an interview with NA #2 on 01/09/20 at 3:01 p.m. NA #2 stated she had been assigned to work at the facility on 12/11/19 from 3:00 p.m. to 11:00 p.m. NA #2 stated she had not been assigned to care for Resident #1 during that shift, however, she and NA #1 often worked together getting residents ready for bed and assisting each other. NA #2 stated NA #1 had asked for her assistance getting Resident #1 into bed and stated together they went into the room and "two-manned" the resident. When asked what "two-manned" meant, NA #2 stated they each got on one side of the resident and lifted the resident and provided a stand-pivot transfer from the wheelchair to the bed. NA #2 stated the side rails on the bed had been in the down position and felt they must have lowered the bed too low to the floor. NA #2 stated while she and NA #1 provided the stand-pivot transfer, Resident #1 had acted like she was going to sit down. NA #2 stated she had known an assist to the floor was considered</p>	F 689			

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F 689	<p>Continued From page 5</p> <p>a fall by the facility policy and they had not wanted that to occur, so they quickly pivoted the resident to the side of the bed. NA #2 stated NA #1 immediately noticed Resident #1's foot had been caught in the bed's side rails and had removed it. NA #2 stated as soon as they had placed Resident #1 in the bed Resident #1 had begun complaining about pain in her left leg. NA #2 stated prior to the two of them providing incontinent care to Resident #1 the resident's nurse, Nurse #1, had entered the room to administer medications to the resident. NA #2 stated Nurse #1 assessed Resident #1 and had asked her what was wrong and eventually left the room to call the doctor. NA #2 stated she had been assigned to care for Resident #1 in the past and while they sometimes had used the mechanical lift for transfers, they often "two-manned" her because the facility only had one working lift at the time and there had been other staff using it on other residents.</p> <p>During an interview with Nurse #1 on 01/08/20 at 3:39 p.m., Nurse #1 stated she had been assigned to care for Resident #1 on 12/11/19 from 7:00 a.m. until 11:00 p.m. Nurse #1 stated she had been out in the hall preparing residents' medications for administration when she got called to Resident #1's room by NA #1 and NA #2. Nurse #1 stated when she entered Resident #1's room, the resident had been guarding her left leg. Nurse #1 stated the two NAs initially told her they had injured her leg while using the total lift. Nurse #1 stated she had observed there was no lift pad in place underneath the resident at this time. Nurse #1 stated she had assessed Resident #1 who had been fine with the exception of her guarding her left leg which concerned her, and she left to contact the doctor. Nurse #1</p>	F 689			

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F 689	<p>Continued From page 6</p> <p>stated she had been unable to get in touch with the doctor in a timely manner and stated she had contacted the DON and received instructions to have their mobile x-ray company come and get an x-ray of the leg. Nurse #1 stated she ordered the x-ray STAT (immediately). Nurse #1 stated she observed Resident #1 closely after the accident and her pain had appeared to ease a bit however the resident did begin complaining of pain around 10:00 p.m. which resulted in her administering acetaminophen to the resident. Nurse #1 stated the mobile x-ray got to the facility close to the end of her shift and the results of the x-ray had not been available until the next shift.</p> <p>During an interview with Nurse #2 on 01/09/20 at 2:41 p.m., Nurse # 2 stated she had been assigned to care for Resident #1 on 12/11/19 from 11:00 p.m. until 7:00 a.m. Nurse #2 stated she had received report from Nurse #1 there had been an incident involving Resident #1 and a lift during a transfer. Nurse #2 stated Nurse #1 had explained an x-ray had been taken by their mobile x-ray company and acetaminophen had been given to the resident for pain. Nurse #2 stated when she had entered Resident #1's room, she found her lying in her bed and stated when the resident had noticed her, she began rubbing her knee. Nurse #2 stated Resident #1 had told her they (the nursing assistants) had dropped her on the bed. Nurse #2 stated Resident #1 had been known to have confusion secondary to her dementia, so she had not really thought about the difference of how the injury occurred from what Nurse #1 had reported to her versus what the resident had been saying at the time. Nurse #2 stated she had received Resident #1's x-ray results and had called the doctor and had received orders to send the resident out to the</p>	F 689			

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F 689	<p>Continued From page 7</p> <p>hospital. Nurse #2 stated she began the transfer process which included calling 911 and preparing the paperwork required.</p> <p>During an interview with the facility's medical director (MD) on 01/09/20 at 9:33 a.m. the MD stated the actions of NA #1 and NA #2 were the likely cause of Resident #1's left femur fracture. The MD stated Resident #1 had many factors that caused her to be a high risk for fractures, including having been bed-bound, osteoarthritis, chronic pain and very stiff contractures to both of her lower legs. The MD stated Resident #1 had been sent to the hospital after the mobile x-ray taken at the facility had revealed the fracture and stated because of Resident #1's overall condition had not been a candidate for a surgical correction of the fracture. The MD stated the orthopedic surgeons at the hospital had indicated Resident #1's fracture had been in fairly good position and had felt it could be managed with an immobilizer for approximately six weeks.</p> <p>During an interview with the Administrator and the DON on 01/09/20 at 1:57 p.m., the administrator stated he had no explanation for the reason the two nursing assistants had deviated from Resident #1's plan of care which included using a total lift for her transfers. The administrator stated he had never been given a clear excuse as to why the nursing assistants provided a stand-pivot transfer versus using the total lift. The administrator stated he and the DON had reviewed the surveillance video of the date and time in question and had noted the mechanical lift had been parked right outside of Resident #1's room. The DON explained the surveillance video only kept video for a certain number of days and 12/11/19 was no longer available to be reviewed</p>	F 689			

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F 689	Continued From page 8 however they both agreed they had watched the video many times and a time line of the events from the surveillance video which included, in part the following: "Timeline 12/11/19 8:38 p.m. - Resident #1 left the room and entered into the hallway stopping to talk with the nurse at the cart. 8:51 p.m. - NA #2 entered the room 8:52 p.m. - Resident was escorted into the room by NA #1 8:52 p.m. - NA #1 left out of the room and went down the hallway 8:53 p.m. - NA 1 went back into the room with linen in hand 8:58 p.m. - NA #1 retrieved the lift from the hall (and brought it into the resident's room) 9:00 p.m. - Nurse #1 was called to the room 9:01 p.m. - Nurse #1 came out of the room 2:38 a.m. - EMS in facility 2:48 a. m. - EMS left the facility (with resident) via stretcher and 2 EMS" The interview with the administrator and DON continued. The administrator stated he had become aware of the fracture of 'Resident #1's left leg when he had arrived at the facility early on the morning of 12/12/19 and had spoken with Nurse #2. The administrator stated he informed the DON when she had arrived at the facility on 12/12/19. The DON stated when she had been called the previous night by Nurse #1, she had been told Resident #1 had bumped her leg on the total lift during a transfer performed by the two nursing assistants and had planned on discussing the incident during their usual morning meeting on 12/12/19. The DON stated she had even called the two nursing assistants back to the facility to have them do a demonstration of how Resident #1 had bumped her leg in the lift during	F 689			

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F 689	Continued From page 9 the transfer. The DON stated after their interviews and the return demonstration, they had suspended the two nursing assistants pending further investigation. The administrator stated after the nursing assistants left the facility, he had just felt like things were not adding up and they kept reviewing the surveillance video. The administrator stated he and the DON had agreed it just did not make sense the two nursing assistants could have placed Resident #1 in a sling, connected the sling to the mechanical lift and then place her in the bed and just 2 minutes later call for Nurse #1 to come into the room. The administrator stated he and the DON brought the two nursing assistants back to the facility on 12/13/19 for further clarification and stated during these interviews the nursing assistants had decided to tell the truth about how the injury had occurred. The DON stated all nursing staff received training during their new employee orientation to the facility which included the use of mechanical lifts. The DON explained nursing assistants were supposed to review residents' care guides prior to beginning a shift which indicated how a resident transferred and other changes that may have occurred since an employee had last worked. When asked, the DON stated she had thought the two nursing assistants had attempted to save time by performing a stand-pivot transfer versus using the total lifting device when transferring Resident #1 to the bed from her wheelchair. During this interview, the administrator stated it was his expectation the nursing staff never deviate from the facility's policies and procedures when transferring residents. The DON stated it was her expectation nursing staff follow residents' plan of care when transferring residents.	F 689			

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F 689	<p>Continued From page 10</p> <p>The facility's corrective action plan for past non-compliance, dated 12/13/19 included:</p> <ol style="list-style-type: none"> Identify those recipients who have suffered or likely to suffer as a result of the noncompliance: Resident #1 was assessed by the nurse on 12/11/2019 after resident complained of pain to the left leg after a transfer to bed. Medical Director and Director of Nursing were notified on 12/11/2019 and an order was obtained for a mobile x-ray. Tylenol was administered for pain on 12/11/2019 at 11:00 pm with relief and re-administered at 2:00 a.m. on 12/12/2019 with no further complaints of pain prior to going to the hospital. X-ray results were reported to the MD at 2:15 a.m. on 12/12/2019. Resident was sent to the ER for evaluation and treatment via EMS at 0248 on 12/12/2019. RP was notified of injury and transfer status. Staff interviews began on 12/11/2019 and it was determined on 12/13/2019 that resident #1 sustained an injury while being transferred from the wheelchair to the bed. During staff interviews on 12/13/2019 the two CNAs that were present admitted that they did not transfer the resident using the resident specific transfer status. Residents likely to suffer a serious adverse outcome as a result of the noncompliance: All alert and oriented residents were interviewed as it relates to how they are transferred on 12/13/2019 with no issues identified. All residents that were not alert and oriented had a skin assessment completed on 12/13/2019 to ensure there were no un-identified injuries, with no issues identified. All Kardex were reviewed on 12/13/2019 to ensure that each resident had a resident specific transfer status listed and any 	F 689			

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NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF RAEFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 N FULTON STREET RAEFORD, NC 28376		
(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 689	<p>Continued From page 11 identified issues were corrected.</p> <p>3. The action the entity will take to alter the process/system failure to prevent an adverse outcome from occurring or reoccurring:</p> <p>All clinical staff were re-educated on Safe Resident Handling as it relates to following the designated transfer status including lift competencies and checking the Kardex for the resident specific transfer status prior to transferring a resident on 12/13/2019. All newly hired clinical staff will be educated on Safe Resident Handling as it relates to following the designated transfer status including lift competencies and checking the Kardex for the resident specific transfer status prior to transferring a resident on orientation. No employee will be allowed to work until all education and competencies have been completed.</p> <p>Five random resident interviews asking if they are being transferred appropriately will be conducted 5 days a week for 4 weeks then 3 days a week for 4 weeks and then weekly for 4 weeks. DON/designee will also do 3 random transfer observations 5 days a week for 4 weeks, then 3 days a week for 4 weeks and then weekly for 4 weeks. All interviews and transfer observations will be discussed weekly in the interdisciplinary team (IDT) meeting and monthly in Quality Assurance (QA) meeting. Changes will be made to the corrective action plan if the IDT team identifies issues.</p> <p>4. Action Complete Date -12/13/2019. The Administrator will be the person responsible for implementing the Quality Assessment and Performance Improvement (QAPI) plan.</p>	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 12 As part of the validation process on 01/09/20, the entire plan of correction was reviewed including re-education of staff. Interviews of the nurse aides and nurses revealed they were aware of proper usage of the mechanical lift for the transfer of residents at the facility. A review of the monitoring tools revealed the facility had completed 100% in-service of the use of mechanical lift and return demonstration on 12/13/19. The facility had initiated a QAPI meeting on 12/13/19 which included the medical director, administrator, DON, social services, MDS nurses, dietary manager and business office manager. A review of the facility's Lift/Transfer audit tool revealed they had completed the audits as planned through 01/03/20. A review of the facility's resident interview audit tool revealed the facility had completed audits as planned through 01/06/20.	F 689			