| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| GRACE HEIGHTS HEALTH & REHABILITATION | 109 FOOTHILLS DRIVE MORGANTON, NC 28655 |

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| E 000 | Initial Comments<br><br>An unannounced recertification survey was conducted on 11/18/2019 through 11/21/2019. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 1XN511. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification and compaint investigation survey was completed on 11/18/19 through 11/21/19. There were a total of 4 allegations investigated and one was substantiated. Event ID# 1XN511. | F 000 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for the area of discharge status for 1 of 3 sampled residents' closed records reviewed (Resident #100).<br><br>Findings included:<br><br>Resident #100 was admitted to the facility on 08/04/19 from an acute hospital with diagnoses that included aftercare following a hip replacement, muscle weakness, and pain.<br><br>A review of the admission Minimum Data Set (MDS) dated 08/11/19 indicated that Resident #100 was marked for cognitive impairment and was admitted to the facility for rehabilitation | F 641 | 1.For resident #100 the MDS Coordinator recognized the error as an oversight and modification to MDS was completed during<br>survey visit 11/21/19.<br><br>The Director of Nursing or designee shall complete a MDS focused audit for MDS accuracy of discharge destination on all residents<br>discharged in November 2019.<br><br>The Director of Nursing or designee shall complete monthly MDS audits beginning 12/19/19<br>for accuracy of discharge destination on all residents | 12/19/19 |

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

Electronically Signed | 12/11/2019

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| F 641 | Continued From page 1<br>services.<br><br>The MDS coded for discharge dated 08/27/2019 revealed that Resident #100 was being discharged to an acute care hospital.<br><br>A review of the progress notes from 08/27/19 revealed that Resident #100 had been discharged to the community on 08/27/19.<br><br>On 11/21/19 at 12:51 PM an interview was conducted with MDS Nurse #1. MDS Nurse #1 verified that Resident #100 had been discharged home with family and indicated the discharge information was coded incorrectly on the resident's 08/27/19 MDS. MDS Nurse #1 revealed a modification assessment would be completed to accurately reflect the correct coding for discharge to the community. According to MDS Nurse #1, she was probably in a hurry and hit the wrong code.<br><br>An interview was completed with the Director of Nursing (DON) on 11/21/19 at 12:55 PM and she reported that she expects MDS assessments to be coded correctly and that it was probably just accidental but it should be done correctly.<br><br>In an interview with the Administrator on 11/21/19 at 1:01 PM she indicated that it was her expectation for the MDS assessments to be correctly and accurately coded. According to the Administrator, she felt the inaccurate coding of the discharge information was an oversight on the part of the MDS Nurse. | F 641 | discharged during the prior month. Audits shall<br>be continued until 100% accuracy is achieved for<br>2 consecutive months.<br><br>The Director of Nursing is the person responsible for implementing the acceptable<br>plan of correction and shall ensure audit results and corrective actions taken are presented at monthly Quality Assurance Performance Improvement (QAPI) meetings for a<br>minimum of 3 months, or as determined by the QAPI<br>team should more time be needed.<br>The QAPI team shall ensure corrective actions<br>are achieved and maintained. | |
| F 688 SS=D | Increase/Prevent Decrease in ROM/Mobility<br>CFR(s): 483.25(c)(1)-(3) | F 688 | | 12/19/19 |

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| F 688 | Continued From page 2<br>§483.25(c) Mobility.<br>§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and<br><br>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, and staff interviews, the facility failed to apply ordered palm guards and heel raisers for 1 of 3 sampled resident reviewed for position, mobility (Resident #83).<br><br>The findings included:<br><br>Resident #83 was admitted to the facility on 2/7/18 with a diagnosis of hemiplegia and hemiparesis following a cerebral vascular accident (CVA) affecting the left dominant side.<br><br>The most recent annual MDS (Minimum Data Set) dated 9/26/19 indicated that Resident #83's cognition was severely impaired, and she was non-verbal. Resident #83 had functional limitations in Range of Motion (ROM) of her upper and lower extremities on both sides. | F 688 | 2.For resident #83 the Nurse Manager recognized the oversight,<br>educated the staff, and splints were applied as<br>recommended by therapy and per order during<br>survey visit 11/19/19. The care plan was updated with<br>splint intervention. All splints were checked on all<br>residents for proper placement and for proper<br>care plan interventions as ordered.<br>Communication procedure was reviewed with the team as follows,<br>Therapy recommendations for splints are handed to the<br>Nurse Manager and orders are obtained from the MD, | |

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| F 688 | Continued From page 3<br><br>The care plan dated 10/7/19 read in part that resident had self-care deficits related to weakness, hemiplegia, and aphasia. Interventions included: Staff would anticipate the resident's needs and provide for her needs. She was to be out of bed to her chair in her room with palm guards to bilateral hands to prevent nails from cutting into palms, and heel raisers to float heels in bed as tolerated. The use of arm splints was not mentioned in the care plan.<br>An Occupational Therapy order dated 11/3/19 indicated that bilateral hand splints and foot positioning/guard aids were to be on at all times except during hygiene care. Check skin and circulation every shift.<br><br>An initial observation on 11/18/19 0:900 AM revealed resident to be in a reclining chair in her room. She was wearing white socks but had no heel raisers on. She was not wearing any splints or palm guards.<br><br>Observed resident in reclining chair on 11/19/19 at 08:45 AM with no heel raisers or palm guards on.<br>On 11/19/19 at 11:05 AM Resident #83 was observed in chair without splints, palm guards, or heel raisers in place. NA #1 was present in the room at the time and stated that the heel raisers were supposed to be worn in bed. NA #1 indicated she was aware that the resident had arm splints and that she needed to locate them as the resident was supposed to have them on. When asked about the palm guards NA #1 located the palm guards in resident's room and proceeded to put them on the resident at that time. | F 688 | Care plans are updated, and staff are notified of change in treatment.<br><br>The Director of Nursing or designee shall complete an audit weekly X 1 month on all resident splints beginning 12/19/19, to insure<br>proper placement (per care plan intervention)<br>and then monthly for a minimum of 2 months.<br><br>The Director of Nursing is the person responsible for implementing the acceptable<br>plan of correction and shall ensure audit results and corrective actions taken are presented at monthly Quality Assurance Performance Improvement (QAPI) meetings<br>for a minimum of 3 months or longer should the<br>QAPI team require more reviews.<br>The QAPI team shall ensure corrective actions<br>are achieved and maintained. | |

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| F 688 | Continued From page 4 | F 688 | | |

At 11:32 AM on 11/19/19, an interview was conducted with the Nurse Manager (NM) about the protocol for placing splints and guards on residents with contractures. The nurse manager said the Occupational Therapy/Restorative orders are emailed to the NM who placed the orders for residents into the notebook as indicated. She stated that she had a book with a list of those residents receiving restorative care and confirmed Resident #83 was on restorative list and needed, "heel raisers to BLE (bilateral lower extremities) as tolerated/float heels & moonboots" and palm guards on at all times. The NM indicated that residents with restorative care needs were seen by restorative aides and that any ordered protective devices/splints would be placed on residents by restorative aides who rounded daily on the residents. NM said the restorative aides document in the computer when they rounded on the residents and provided care. The NM was unable to locate any documentation entered by a restorative aide in the computer system regarding Resident #83.

An interview was conducted with Director on Nursing at 2:55 PM p.m. on 11/19/19. She indicated there was some confusion about who was to place splints and provide repositioning of residents and directed me back to the nurse manager to discuss the outcome of the discrepancy.

A follow up interview with the NM on 11/19/19 at 3:05 PM revealed there was confusion about the orders for splint and prosthetic placements on residents as discussed earlier. She stated it was her new understanding after talking with the restorative aide manager is that the restorative aides only provided this when the orders

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| F 688 | Continued From page 5<br>indicated residents would wear a prosthetic during the first shift hours. She stated that for those residents who needed around the clock splints, it would be up to nursing to ensure placement of any prosthetics. When asked how splint placement would be communicated to nursing, she stated she would have to enter new orders in the computer to ensure the nurses were aware they were responsible for the continuous use of splints/prosthetics. The interview further revealed the system breakdown occurred because the NM who initiated and updated the book after she received orders from the restorative aides (RA's), thought the RA's were taking care of the splint placement. However, they were not, and she was not aware that the RA's were not doing it.<br><br>Interview with the Restorative Care Manager on 11/19/19 at 3:46 PM confirmed that nursing was to place splints on the residents with continuous orders for splints. She explained the rationale to be due to nursing being there 24 hours a day, whereas restorative aides are only there on day shift.<br><br>At 12:54 PM on 11/21/19 a follow up interview was conducted with the Director of Nursing regarding Resident #83. She acknowledged there was a breakdown in communication between nursing and the restorative care aides. She stated that regardless of the communication issues, if the resident had orders for the splints and prosthetics to be applied, then they should have been supplied by any of the caregivers providing care. She stated that going forward, they would analyze this to ensure communication is clear. | F 688 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices | F 689 | | 12/19/19 |

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| F 689 | Continued From page 6<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews, the facility failed to transfer a resident with a mechanical lift and 2 person assist which resulted in a hematoma to the resident's lower for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #452).<br><br>The findings included:<br><br>Resident #452 was admitted to the facility on 07/08/11 with diagnoses that included muscle weakness, contractures, and osteoarthritis.<br><br>A review of Resident #452's most recent quarterly Minimum Data Set Assessment dated 09/20/18 revealed Resident #452 to be cognitively impaired and required extensive assistance with transfer.<br><br>A review of Resident #452's care plan dated 09/20/18 revealed Resident #452 had a self-care deficit and the inability to perform ADLs (Activities of Daily Living) independently. Intervention included to follow posted transfer recommendations, which were for Resident #452 to be transferred with a mechanical lift.<br><br>A review of facility provided incident/accident logs | F 689 | NA#1 was terminated 11/30/18 and did not return to the facility. Resident #452 was monitored by nursing with bruise noted to resolve without complication. NA#1 was reported to the Health Care Personnel Registry on 11/29/18 with neglect substantiated against NA#1 per letter received 3/11/19.<br><br>All residents in the care of NA#1 were inspected by the DON on 11/29/18 with no further issues or concerns noted.<br><br>Facility nurse managers shall conduct weekly observations of all residents with total lift transfers beginning 12/19/19, for a minimum of 3 months, and report findings at the weekly Risk Team meeting.<br><br>The Director of Nursing is the person responsible for implementing the acceptable plan of correction and shall ensure audit results and corrective actions are presented monthly at the QAPI meetings, for a minimum of 3 months, or longer should the QAPI team require more reviews. The QAPI team shall | |

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| F 689 | Continued From page 7<br>from November 2018 to present revealed Resident #452 had an incident on 11/29/18 in which she was noted with a 4 cm (centimeter) x 9 cm hematoma (bruise) after a shower was provided by Nurse Aide #1 (NA #1). Further review of the incident report revealed it was determined that NA #1 had transferred Resident #452 into a shower chair without using a mechanical lift. Per the incident report NA #1 was subsequently terminated 11/30/19 for unnamed reasons unrelated to the incident.<br><br>An interview with NA #1 was attempted by phone on 11/21/19 but she was unavailable and did not return the phone call.<br><br>On 11/21/19 at 12:36 PM an interview with Nurse Aide #2 (NA #2), revealed she had worked on the same hall with NA #1 the night of the incident (11/29/18) and was familiar with Resident #452. She reported Resident #452 required the assistance of a mechanical lift for transfers and the facility indicated what type of lift assistance a resident required by a sign over the resident's doorway. She stated earlier that night she had spoken with NA #1 about how they wanted to handle getting the residents on the hall ready for bed and indicated they discussed the need for Resident #452 to get a bath before bed. She reported NA #1 never came and asked her for assistance with transferring Resident #452.<br><br>During an interview with NA #3 on 11/21/19 at 1:02 PM, she reported she worked on the connected hall of where Resident #452 resided the night of the incident. She reported Resident #452 required total assistance with the use of a mechanical lift for transfers. NA #3 stated that not only were transfer statuses posted above | F 689 | ensure corrective actions are achieved and maintained.<br><br>Preparation and/or execution of this plan of correction does not constitute admissions or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of the deficiencies. The Plan of Correction is prepared in/or executed solely because the provision of the Federal and State Law require it. | |

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| F 689 | Continued From page 8 | F 689 | | |

resident doors, but that hall nurses also discussed them with hall nurse aides before every shift to ensure everyone was aware of the proper transfer assistance required. She reported the night of the incident, NA #1 did not come and ask her for assistance with transferring Resident #452. She also reported it was the facility's expectation that 2 nurse aides be present during mechanical lift transfers to assist in preventing injury to residents.

During an interview with Nurse #1 on 11/21/19 at 10:51 AM she reported she was working the night of the incident on the hall where Resident #452 resided. She stated Resident #452 was due for a bath and NA #1 reportedly provided her a bath that evening and after the bath, NA #1 came to her and reported a new injury to Resident #452's right lower leg. She assessed the injury to Resident #452's leg and determined that it had recently occurred due to redness, continued swelling and that the injury was warm to the touch. She reported when she was assessing the injury, she noted there was no sling pad (a pad used for lifting a resident with a mechanical lift) under Resident #452 and there was no sign of a mechanical lift in her room, outside her room, or anywhere in the vicinity of Resident #452's room. Nurse #1 reported it was facility policy that sling pads be left under residents who require total assistance by mechanical lift for transfers. When she questioned NA #1 about the injury and how it occurred NA #1 became belligerent and defensive. Nurse #1 did not remember if NA #1 explicitly denied not using a lift.

During an interview with the Director of Nursing (DON) on 11/21/19 at 1:14 PM, she reported she was in the building at the time of the incident and

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| F 689 | Continued From page 9<br>it was brought to her attention by NA #3. She reported as she was walking down the hall, she heard NA #1 yelling at Nurse #1. She reported when she went to speak with NA #1 about the incident, NA #1 remained defensive and belligerent before leaving the building. She reported NA #1 did not return to the facility. The DON reported she went and assessed Resident #452's leg and began an investigation into how the injury occurred. She reported based on her investigation, she determined that NA #1 had not used a mechanical lift to transfer Resident #452 resulting in a hematoma to her right lower leg. She reported the facility utilized a numerical system of 1-4; 1 required little assistance and 4 required total assistance. She reported she believed Resident #452 was either a 3 or a 4 but that both those numbers required a mechanical lift and 2 nurse aides to assist in the transfer of the resident. She stated it was her expectation that facility staff use the appropriate lift for residents and if there was any confusion to either speak to a nurse or look at the lift designation above the resident's door. | F 689 | | |