STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345572	A. BUILDING _____ B. WING _____	C 09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARDINAL AT NORTH HILLS	311 GARDEN AT NORTH HILLS STREET RALEIGH, NC 27609

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E 000	Initial Comments An unannounced recertification and complaint investigation survey were conducted on 9/19/23 through 9/21/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #ZAI611.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 9/19/23-9/21/23. Event ID# ZAI611. The following intake was investigated: NC00194881. 2 of the 2 complaint allegations did not result in deficiency.	F 000		
F 689 SS=G	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 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interviews, interview with the Medical Director, and record review, the facility failed to safely transfer a dependent resident from bed to wheelchair using a mechanical lift. On 6/13/23 during a transfer by Nurse Aide (NA) #1, the resident (Resident #6) fell out of the lift and onto the floor resulting in a cervical (neck) fracture of the first and second cervical vertebrae. Resident #6 required a cervical collar (used to support the neck and spine and limit head	F 689	POC for F-689 How corrective action (s) will be accomplished for those resident found to have been affected by the deficient practice: On June 13, 2023 at approximately 8:00 AM nurse aide #1 was removed from the care area. Resident #6 was transferred to ED by paramedics who assisted resident from the floor to gurney. During the	10/16/23

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

Electronically Signed | 10/15/2023

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F 689	Continued From page 1 movement after an injury) and no surgical intervention for the injury. This deficient practice affected 1 of 1 resident reviewed for accidents. Findings included: Resident #6 was admitted to the facility on 12/16/20. Diagnosis included, in part, Alzheimer's Disease. A physician (MD) order dated 12/16/20 stated a mechanical lift was to be used for transfers. The quarterly Minimum Data Set (MDS) assessment dated 5/10/23 revealed Resident #6 had no speech and was rarely understood by others. She exhibited impaired memory and her daily decision making skills were severely impaired. She required extensive assistance with the help of two people for transfers. The MDS further indicated Resident #6 was not on an anti-coagulant medication. The care plan, updated 5/26/23, included a focus area of risk for falls. Care plan interventions stated, "Review information on past falls and attempt to determine cause of falls, record possible root causes and educate resident/family/caregivers as to causes." The NA Care Kardex, located at the nurse's desk was reviewed and stated Resident #6 required a mechanical lift for transfers and needed two staff members to complete bed mobility and mechanical lift transfers. An Incident Report dated 6/13/23 and completed by the Staff Development Nurse stated the following: At 7:19 AM on 6/13/23 the resident had	F 689	interview with nurse aide #1, it was identified that an improper Hoyer sling was used to transfer resident #6 and only 1 staff member was present upon transfer from bed to wheelchair. Nurse aide #6 stated that she forgot to get another staff member to assist her. Nurse aide #1 was suspended at this time and improper Hoyer sling was removed from care area. All staff working on that day were immediately re-educated on the use of the two people for all mechanical lift transfers on 6/13/23. How the facility will identify other resident□s having the potential to be affected by the same deficient practice and what corrective action will be taken: Director of Nursing completed an audit on all residents who use mechanical lift equipment for transfers were identified, care plans, and care cards were updated to reflect two person assists for all mechanical lift transfers. This was completed on 10/16/23. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice dose not recur: On June 14, 2023, education was initiated by Registered Nurse for all associates working in skilled/EAL units to ensure correct mechanical lift usage with two persons for all transfers. Education included the use of 2 staff members for all mechanical lift transfers. All current certified and licensed nursing staff will complete a competency assessment	

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F 689	Continued From page 2 a fall in her room while she was being transferred from bed to wheelchair from the mechanical lift. NA #1 was present during the incident. The report further stated Resident #6 was transported to the hospital by Emergency Medical Services (EMS) and the MD and family member were notified. Resident #6 returned to the facility on 6/13/23 with a cervical collar. NA #1 was removed from the floor during the investigation and was no longer employed at the facility. An emergency department note dated 6/13/23 stated, in part, Resident #6 "presented to the ED with reports of a mechanical fall. Patient is non-verbal, typically bedbound (although gets up in a wheelchair for a few hours each day) and has contracted extremities ...Family arrived shortly after patient did and is able to provide some further history that the patient is not on anticoagulants." She confirmed that Resident #6 was "at her baseline mental and physical status." The note further indicated a review of systems was limited since Resident #6 had dementia and was non-verbal. An assessment of Resident #6's neck in the ED revealed a cervical collar was in place and the resident "winces with midline palpation." A computerized tomography (CT) cervical spine scan was completed on 6/13/23 and revealed a closed nondisplaced fracture of the first and second cervical vertebrae. According to the ED note, "there was no acute, life-threatening, or emergently surgical condition identified after evaluation." Resident #6 was sent back to the facility on 6/13/23 with a cervical collar and a recommendation to follow up with her primary care provider within one week. A MD order dated 6/14/23 revealed, "Hydrocodone/acetaminophen 7.5 milligrams	F 689	completed by the Director of Nursing or Designee on mechanical lift transfer by June 23,2023. Mechanical lift training will continue to be incorporated into each new associate orientation and competency verified by Director of Nursing or Designee. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. Mechanical lift random transfer audits are to be completed by Director of Nursing or Designee to ensure two persons are being utilized for all mechanical lift transfers. The monitoring schedule is as follows: 3 times weekly for 1 month, then weekly for 2 months then biweekly for 2 months beginning June 15,20 23. Results of audits will be submitted to QAPI for ongoing evaluation and assessment of plan.	

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(mg)/325mg every six hours." The medication was discontinued on 9/6/23.

A MD order dated 7/19/23 revealed the cervical collar was to be discontinued.

The quarterly MDS assessment dated 8/2/23 revealed Resident #6 had no speech and was rarely understood by others. She exhibited impaired memory and her daily decision making skills were severely impaired. She required extensive assistance with the help of two people for transfers. A staff assessment of pain indicated the resident did not have any non-verbal indicators of pain.

Attempts to interview NA #1 by telephone were unsuccessful.

In an interview with NA #2 on 9/21/23 at 11:33 AM, she explained she looked at a resident's paper chart or the CNA Kardex book for their transfer status or received the information during shift report. NA #2 had worked with Resident #6 in the past and stated her transfer status was a mechanical lift. She further explained two staff were required to operate the mechanical lift and this had always been the protocol for mechanical lift transfers for every resident in the facility.

Interviews were conducted with Nurse #1 on 9/20/23 at 9:18 AM and 11:32 AM. She was at the nurse's desk when Resident #6 fell. She recalled NA #1 came out of Resident #6's room and told her the resident fell. Nurse #1 said she went to Resident #6's room, entered and saw the resident on the floor at the foot of the bed. Nurse #1 observed the mechanical lift positioned behind Resident #6's feet. Nurse #1 stated NA #1 told

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F 689	Continued From page 4	F 689		

her the resident had fallen from the lift. Nurse #1 reported she immediately assessed Resident #6, obtained vital signs and called 911. She added the resident had not appeared to be in distress during the assessment. She explained information about a resident's transfer status was in the Kardex book located at the nurse's desk and titled "CNA Care Kardex." Additionally, nurses also told staff what the transfer status was for each resident. She added if a mechanical lift was required for transfers there needed to be two staff who assisted with the transfer. Nurse #1 stated there were other staff members on the hall that day (NAs and nurses) who could have helped NA #1 with the transfer. She revealed Resident #6 returned from the emergency department with a neck collar and an order for pain medication. She said she had not observed Resident #6 with any non-verbal indicators of pain or discomfort following the fall and return from the emergency department. She added Resident #6 had not "fidgeted" with the cervical collar, and added, at times, Resident #6's family member removed the collar when she visited the resident. Nurse #1 shared the resident's typical routine prior to her fall was to get up in the morning for breakfast (ate in her room) and then was put back to bed after breakfast where she remained the rest of the day. Nurse #1 said she had not observed a disruption in Resident #6's normal routine when she wore the cervical collar.

A review of pain assessments from 6/13/23-9/20/23 revealed Resident #6 did not display any non-verbal indicators of pain.

During an interview with Occupational Therapist (OT) #1 on 9/20/23 at 9:42 AM, she stated the therapy department determined the safest

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method of transfer for a resident and made recommendations. She explained Resident #6 was totally dependent on staff for care and was unable to follow directions. OT #1 added the resident had always needed a mechanical lift for transfers since her admission to the facility and said two staff members were required to operate the mechanical lift.

On 9/19/23 at 4:23 PM an interview was conducted with the Staff Development Nurse who stated when she came to the facility on 6/13/23 she was told Resident #6 was being sent out to the hospital. The Staff Development Nurse immediately went to the floor where Nurse #1 told her NA #1 used the mechanical lift by herself and dropped Resident #6 on the floor. The Staff Development Nurse said she went down to the resident's room and observed NA #1 behind the mechanical lift. Resident #6 was on the floor and both feet were over the leg of the mechanical lift. She said the resident's head was on the floor and she was on her back. The Staff Development Nurse explained that nursing staff were educated during orientation to use two people to transfer with a mechanical lift and that NA #1 knew there needed to be two staff members when Resident #6 was transferred with the mechanical lift.

A joint interview was conducted with the Director of Nursing (DON) and Staff Development Nurse on 9/21/23 at 11:42 AM. The DON shared the facility protocol was whenever a resident needed a mechanical lift for transfers it required two staff members to operate the lift. She added Resident #6 was assessed as needing a mechanical lift for all transfers. She stated no other staff member witnessed Resident #6's fall from the mechanical lift. The DON said she interviewed NA #1 as part

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F 689	Continued From page 6 of the fall investigation and when she asked NA #1 why she had not used a second person to assist with the mechanical lift, NA #1 told her she had forgot to get a second person. The DON added NA #1 told her she normally did not operate the mechanical lift by herself and had not felt rushed when she provided care to Resident #6. The DON stated there were three other NAs and two nurses who could have helped NA #1 with the transfer that morning. She explained after the fall, all staff members were re-educated that two staff members were required when using a mechanical lift. In an interview with the Medical Director on 9/20/23 at 9:34 AM, he shared Resident #6 had end stage dementia and was non-verbal. She required total assistance with all her care. He stated he was informed by staff that one NA attempted to transfer the resident with a mechanical lift and she fell from the lift and sustained a non-displaced cervical fracture. The Medical Director further stated it was important that two staff members operated a mechanical lift to prevent falls and injuries for both residents and staff members.	F 689		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by	F 851		10/13/23

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CMS.

§483.70(q)(1) Direct Care Staff.
Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).

§483.70(q)(2) Submission requirements.
The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:
(i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);
(ii) Resident census data; and
(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).

§483.70(q)(3) Distinguishing employee from agency and contract staff.
When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.

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F 851	Continued From page 8 §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to successfully submit payroll data to the Centers for Medicare and Medicaid Services (CMS) and failed to follow up that the information submitted on the Payroll Based Journal (PBJ) report was accepted by CMS. Findings included: The CMS Submission Report, PBJ Final File Validation Report was reviewed for Fiscal Year Quarter 3, 2023 (April 1-June 30). The report indicated PBJ data for Quarter 3, 2023, was submitted on 8/13/23 at 8:10 PM. Further review of the report revealed the entire file was rejected by CMS. The noted reason for rejection in the message column of the report stated, "A value submitted for employee identification in the Staffing Hours section must match an existing value for employee identification in the PBJ system. If a match cannot be found, the PBJ submission will be rejected." An interview was conducted with the Executive Director on 9/20/23 at 2:02 PM. He shared he was responsible for submitting PBJ data to CMS and submitted the data once a quarter. He stated	F 851	POC for F -851 How corrective action (s) will be accomplished for the deficient practice: The Executive Director attempted to submit Payroll Based Journal reporting for most recent quarter on 8/13/23 to the portal. The file was rejected due to employee ID numbers not matching. The Corporate support representative was on vacation at the time and was not able to correct the file prior to the deadline for submission. What corrective action will be taken: Employee Identification numbers have been corrected as of August 17, 2023. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice dose not recur: The Executive Director will review the Staffing Data Submission Payroll Based Journal guidelines from CMS.gov by October 11, 2023. How the facility plans to monitor its	

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F 851	Continued From page 9 PBJ data was not correctly submitted for the past 3 submissions (each submission covered 90 days). He acknowledged there was some confusion on how data was submitted to CMS. He explained the Human Resources department sent all labor data to the home office who then compiled zip files. Once the zip files were completed, the Executive Director sent them to CMS. He explained he submitted the data on time but on the first 2 submissions "we were missing a zero on the facility identification number (ID) and therefore CMS did not accept the data. The Executive Director added he didn't know he was supposed to go into the PBJ system within 48 hours to verify the data was received and accepted. He said the PBJ site notified him what the error was with the submissions. The third time he submitted data he learned the employee ID numbers were different than what was in the CMS system and the home office representative was on vacation and could not update the employee ID numbers.	F 851	performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The Payroll Based Journal report will be submitted no later than the 30th day after the close of the quarter by Executive Director. The Executive Director will verify acceptance of Payroll Based Journal reporting by logging into the electronic portal within 2 days of original submission. Timely submission and acceptance shall be audited each quarter for 6 months with audit results submitted to QAPI for effectiveness and evaluation of plan.	