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	345505	A. BUILDING _____ B. WING _____	C 08/21/2024

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CAROLINA REHAB CENTER OF CUMBERLAND	4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 8/20/24 to 8/21/24. Event ID# PJXQ11. The following intakes were investigated NC00220664; NC 219800; NC218543; NC 218648; and NC 220856 The six complaint allegations did not result in a deficiency. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity of "D"	F 000		
F 689 SS=D	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 record review, and interviews with staff and physician, the facility failed to ensure a Nurse Aide followed a resident's plan of care while transferring the resident. This was for one (Resident # 2) of six sampled residents. The findings included: Record review revealed Resident # 2 was admitted to the facility on 6/7/18. The resident's diagnoses in part included Alzheimer's disease, contractures, and failure to thrive.	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 08/23/2024

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Resident # 2's quarterly Minimum Data Set assessment, dated 7/9/24, coded the resident as severely cognitively impaired and as being totally dependent on staff for transfers.

Resident # 2's care plan, dated 7/7/24, directed staff to use two staff members and transfer the resident with a mechanical lift. This had been originally added to the care plan on 4/17/24 and remained part of the resident's active care plan.

Resident # 2's weight records included documentation on 8/7/24 that the resident weighed 78 pounds.

On 7/18/24 Nurse # 1 noted in a nursing entry that Resident # 2's foot was bluish and swollen. There were no abrasions or outward injuries noted. The physician was notified and an order for x-ray obtained.

On 7/19/24 Resident # 2's x-ray of her right ankle was completed. The x-ray report included the notation that Resident # 2's "bony structures are osteoporotic." At that time there was no fracture or dislocation identified on the x-ray per the documented report.

Nurse # 1 was interviewed on 8/20/24 at 2:10 PM and reported the following information. She had worked with Resident # 1 on 7/18/24 from 7 AM to 7 PM. The resident had not been having problems with her foot in prior days of which she was aware. The assigned Nurse Aide (NA) asked her to look at Resident # 2's foot during the shift. At the time the resident was in bed. The foot appeared reddish and swollen. The physician ordered an x-ray. The resident did not appear to be in any pain.

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On 8/6/24 at 7:37 PM Nurse # 1 documented the following information. Resident # 2's NA had reported a lump to the resident's right lower extremity. When assessed, the affected area of the leg appeared bluish, swollen, and warm to the touch. The Nurse Practitioner (NP) was notified and ordered an x-ray. After an hour passed, the lump had appeared to increase in size. The NP was again notified and ordered the extremity be elevated.

Review of Resident # 2's 8/7/24 x-ray report revealed the resident was identified to have a mildly displaced oblique fracture of the distal diaphysis of the tibia and fibula. (The diaphysis is the long part of a bone. The distal diaphysis of the tibia fibula is the part of the long bone that is closest to the ankle).

On 8/8/24 Resident # 2 was ordered to have a splint to the fractured leg for treatment.

During the interview with Nurse # 1 on 8/20/24 at 2:10 PM, Nurse # 1 further reported the following information. She had also cared for Resident # 2 on the date of 8/6/24. Earlier on 8/6/24 Resident # 2 had been up in a geri chair. Later in the day, NA # 1 asked her (Nurse # 1) to look at Resident # 2's leg. At that time, Resident # 2 was in bed. There was some swelling in the middle of the resident's right lower leg. NA # 1 did not know how the swelling had happened. When she (Nurse # 1) palpated around the swollen area, the resident did not appear to be in pain. She (Nurse # 1) notified the physician.

NA # 1 was interviewed on 8/20/24 at 2:24 PM and reported the following information. She had

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not noticed anything wrong with Resident # 2 until after she had placed her in bed on the evening of 8/6/24. She (NA # 1) could not find anyone to help her use the mechanical lift to put Resident # 2 back in bed. Resident # 2 was so tiny that she had at other times lifted the resident back in the bed by cradling her in her arms. She also knew other Nurse Aides had lifted her into bed. On the evening of 8/6/24 that was the way she transferred Resident # 2. While doing so, she had put the geri chair right beside the bed and gently lifted her into the bed. None of Resident # 2's extremities hit against anything, and she (NA # 1) did not think lifting her into the bed had anything to do with her leg being broken. She further reported she sincerely cared for Resident # 2 and had taken care of her for a long time. She would never have done anything she thought would have hurt the resident and was always very careful. NA # 1 also further reported the following information. Prior to putting Resident # 2 back to bed, the resident had been sitting in the television room. When NA # 1 had placed Resident # 2 in the television room initially, there were no stacked chairs around her. When she returned later to roll the resident back to her room and place her back to bed, she found several rows of stacked chairs in the television room in the vicinity of the resident. NA # 1 reported that at times Resident # 2 would dangle one of her feet off the side of the geri chair and questioned if the resident's leg could have inadvertently been hit at some time while she was up in the geri chair.

Interview with Unit Manager # 1 on 8/20/24 at 3:15 PM revealed NA # 1 should have used a mechanical lift per the resident's plan of care when transferring Resident # 2 to bed on 8/6/24 and there had been staff available that day.

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Care Plan Nurse # 1 and Care Plan Nurse # 2 were interviewed simultaneously on 8/21/24 at 3:12 PM and reported the following information. The care plan is devised from an interdisciplinary team and the mode of transfer that is placed on a resident's care plan originates from recommendations made by therapy staff. The care plan then generates the Kardex which Nurse Aides reference so they will know specific directions for the resident.

The facility's rehabilitation director was interviewed on 8/21/24 at 2:40 PM and reported the following information. By profession she (the rehab director) was a licensed occupational therapist. Due to Resident # 2's small size/weight she (the rehab director) would not say that lifting and cradling a resident could be considered an incorrect transfer. At times firemen do a lift and carry for individuals in that manner and it can be done safely. With Resident # 2 she was in a semi- fetal position which might indicate the lift could be done. In developing care plans for transfers, the therapy staff take into consideration what is easiest and safest for both the staff performing the transfer and for the resident who is being transferred.

Resident # 2's physician, who also serves as the facility's medical director, was interviewed on 8/21/24 at 11:10 AM and reported the following information. Resident # 2 was advanced in age and her bones were brittle due to osteoporosis. There was not anyway to know how the fracture actually occurred. Her legs crossed over due to contractures and just in turning she could have sustained a fracture even if staff were providing correct care. According to the physician

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something could have happened in July 2024 when the resident's foot was swollen. The tibia and fibula connect into the ankle joint where the resident initially had swelling in July 2024. Therefore, it could not be determined that any trauma on 8/6/24 definitively contributed to the fracture. The fracture may have further manifested itself on that date. The resident had not needed any further treatment other than splinting, and it was a mild fracture.

The Administrator was interviewed on 8/20/24 at 11:05 AM and again on 8/21/24 at 2:15 PM and reported the following information. They had completed an investigation into the fracture. It had been determined that NA # 1 had not followed the care plan and transferred Resident # 1 with a mechanical lift, but it could not be definitively proven that this caused her fracture. Staff had been trained to follow the care plan generated Kardex for all transfers prior to 8/6/24. The Administrator provided documentation that NA # 1 had been trained to follow the care plan and had ignored her training prior to the incident. According to the Administrator, the administrative staff randomly and unannounced did observations of transfers prior to the incident occurring. It was her policy that any staff who were not transferring residents according to the care plan would no longer be employed by the facility. Following the identification of Resident # 2's fracture, the facility completed a plan of correction.

On 8/21/24 the Administrator presented the facility had completed a corrective action plan. The corrective action plan included the following:

How corrective action will be accomplished for

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those residents found to have been affected by the deficient practice;
" The facility failed to ensure Nursing Assistant #1 followed the care plan related to transfers for resident #2 on 8/6/2024.
" Resident # 2 skin was assessed 8/6/2024 by charge nurse, MD and RP were notified. The care plan was reviewed on 8/6/2024 and was found to be correct with no changes made to transfers. Staff were educated on 8/6/2024 to ensure they understood resident # 2's transfer needs.

How the facility will identify other residents having the potential to be affected by the same deficient practice;
" Skin assessments for all current residents were completed 8/9/2024 by unit managers. Any residents found to have bruising were investigated and linked to a known origin.
" Care Plans were reviewed for accuracy of how to transfer a resident including mode of transfer and how many staff members it requires on all current residents 8/12/2024. This was completed by the unit manager with the input of the therapy manager.
" All residents are at risk for this deficient practice of not following the care plan.

The measures that will be put into place or systemic changes made to ensure that the deficient practice will not recur.
" The Quality Assurance Committee (Regional Director of Clinical Services, Assistant Administrator, Therapy Manager, Director of Nursing and medical director) met on 8/9/2024 to review the findings and initiated a plan.
" All nursing staff were educated on checking the care plan generated Kardex prior to transfer.

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This was completed 8/12/2024 by Director of Nursing or designee.
" All new hires will receive this education in orientation by the staff development coordinator during training.
" Any employee who has not received the education will not work until completed.

How the facility plans to monitor its performance to make sure that solutions are sustained.
" The unit manager or designee will observe 3 transfers daily Monday-Friday x 4 weeks, 2 transfers 3x a week x 4 weeks, and then 1 transfer weekly x 4 weeks to ensure they are following the care plan.
" Results will be reported monthly to Quality Assurance committee for review and compliance. Once the Quality Assurance committee determines the problem no longer exists then review will be completed on a random basis.

Date of compliance is August 13th 2024

The following was done to validate the facility's corrective action plan.

During an initial tour of the facility which began on 8/20/24 at 10:00 AM, residents were interviewed and multiple residents reported no problems with staff following their plan of care. These interviews included interviews with residents who required assistance with transfers.

The facility presented documentation to validate they had completed inservice training and audits per their plan of correction.

Staff interviews were conducted and validated that staff attended training and were aware they

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F 689	Continued From page 8 were always to follow a resident's plan of care. On 8/21/24 the facility's plan of correction date of 8/13/24 was validated.	F 689		