STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Durham Nursing & Rehabilitation Center	411 S Lasalle Street Durham, NC 27705

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38077 Based on record review and staff and physician interviews the facility failed to safely transfer a resident when utilizing a sit to stand lift for 1 of 3 residents reviewed for accidents (Resident #1). This unsafe transfer resulted in Resident #1 sustaining a mildly displaced left medial malleolus (boney presence on the inner side of the ankle) fracture and pain of 5 on a scale of 1 to 10 (10 being the worst pain). Finding included: Resident #1 was admitted to the facility on [DATE] with diagnoses that included cerebral palsy, contractures to right hand, contractures to right knee and contractures to left knee. Review of Resident #1's care plan (revised date 10/9/23) revealed the focus area for a risk for Activities of Daily Living (ADL) self-care performance deficit related to cerebral palsy, contracture to right hand, right knee and left knee and bipolar disorder. One of the interventions was recommended transfers with stand lift. Resident was total assist with transfer. Review of the nursing note dated 11/30/23 at 5:54 PM indicated the assigned nurse (Nurse #1) was notified by the assigned Nurse Aide #1 # (NA) that Resident #1's ankle got caught up in his wheelchair while trying to transfer him to bed. The note also read in part Upon assessment no bruises or deformity noted at site, the resident complained of pain to the area. Nursing note indicated, as needed (PRN) Acetaminophen (Tylenol) pain medication was administered per physician orders. Physician orders received for X-rays. Review of the Medication administration note dated 11/30/23 at 10:09 PM read in part Acetaminophen Tablet 325 milligram (MG), Give 2 tablet by mouth every 6 hours as needed for pain. PRN (as needed) Administration was: Effective. Follow-up Pain Scale was: 0. Review of the X-ray report dated 12/1/23 indicated fracture to left distal tibial with no displacement. There was associated soft tissue swelling. (continued on next page)

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.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Physician note dated 12/1/23 revealed Resident #1 was examined by the Physician in his room. The resident did not appear to be in acute distress. Per Physician note the resident's ankle got caught in his wheelchair while transferring him from his wheelchair to his bed. The resident had no gross deformity noted at the site and had some complaints of pain to the area. The resident's x-ray came back positive for acute left distal tibial fracture without any displacement. Resident was sent to emergency room (ER) for further evaluation. Note indicated Resident #1 had history of previous left knee fusion surgery. Documentation of Nursing note dated 12/1/23 at 1:33 PM by Nurse assigned to the resident (7 AM - 3PM shift) indicated Resident #1 had an x-ray of left ankle. The result displayed fracture of the distal tibia. Per Physician orders the resident was sent to the hospital for further evaluation. Resident# 1 was in no apparent distress at that time. Review of Pain scale documentation indicated on 11/30/23 at 4:43 PM, Resident #1's pain was documented as a 5 out of 10. On 11/30/23 at 10:09 PM was 0. On 12/1/23 at 9:15 AM was document as 7 and on 12/1/23 at 12:40 PM was 0. Physician Order dated 12/1/23 read in part Oxycodone HCl Oral Tablet 5 (Milligrams) MG (Oxycodone HCl) Give 5 mg by mouth every 6 hours as needed for pain for 5 Days. Physician Order dated 12/4/23 read in part Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl) Give 5 mg by mouth every 6 hours as needed for pain/fracture for 14 days. Review of the Medication Administration Record revealed Acetaminophen Tablet 325 milligram (MG) Give 2 tablet by mouth every 6 hours as needed for pain was administered on 11/30/23 at 4:43 PM and pain level indicated as a 5 and on 12/123 at 9:15 AM and pain level indicated as a 7. As needed Oxycodone HCL was marked as administered as ordered by the physician starting 12/2/24 and pain levels were indicated at the time of administration. Hospital emergency room (ER) records dated 12/1/23 indicated Resident #1 was presented to the ER for a fall brought in by Emergency Medical services (EMS). The resident was being transferred from wheelchair (w/c) to bed when his legs got tangled under him. He endorses left ankle pain and right lower leg pain. He was unable to rotate his left ankle and states pain radiates from left ankle up to the middle of his calf. Facility performed X-rays and states he has a tibial fracture. Right foot X-ray does not show any fracture. The left tibia fibula x-ray shows mildly displaced left medial malleolus (boney presence on the inner side of the ankle) fracture. The resident was seen by ortho and recommended: non weight bearing, can be in CAM (Controlled Ankle Motion) boot while transferring, no need for boot when in bed; no further orthopedic surgery needed. Resident sent back to facility from ER the same day. Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 was assessed as cognitively intact and was dependent on staff for toileting, showers, personal hygiene, and chair/ bed to chair transfer. Assessment indicated the resident used a motorized wheelchair for mobility. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 5/8/24 at 3:51 PM, Nurse Aide (NA)#1 stated he no longer worked for the facility, but recalls he was assigned to Resident #1 during the 3 PM - 11 PM shift (the date of the incident unknown). He further stated he was transferring the resident using a lift when the incident occurred. NA #1 did not recall what kind of mechanical lift he was using to transfer the resident. NA #1 indicated he was transferring the resident from his wheelchair to his bed and the resident's leg got caught on the plate on his wheelchair. NA #1 stated he did not realize that the resident's leg was caught on the plate until the resident was safely transferred to the bed. NA #1 further stated the resident had complained about pain and the assigned nurse was immediately notified about the incident. The NA indicated the nurse had assessed the resident and X-rays were ordered by the physician. NA #1 further indicated the assigned Nurse administered pain medication and the resident did not complain of pain later that night. NA #1 stated he was agency staff and worked sporadically at the facility. He indicated when he returned to the facility after few days, he was asked about the incident by management staff (name unknown) and received in-service and training on mechanical lift transfers. NA #1 further indicated was not assigned to the resident after the incident. During a telephone interview on 5/8/24 at 3:17 PM, Nurse #1 stated she was assigned to Resident #1 on 3 PM -11 PM shift. The nurse was unsure of the date of incident and vaguely remembered the incident. Nurse #1 stated the incident details were written in her note. The Nurse indicated she recollects the NA (name unknown) had informed her about the resident's leg got caught in the wheelchair while the resident has been transferred from his wheelchair. The resident had complained of pain. Nurse indicated she assessed the resident and notified the Physician. An X-ray was ordered. The resident was also administered as needed pain medication for pain management. Nurse further indicated the resident was transferred using a mechanical lift and unsure which type. During a telephone interview on 5/8/24 at 1:43 PM, the Physician stated he was made aware that Resident #1's leg got caught in his wheelchair while been assisted with transfer by the NA. The resident was complaining of leg pain. The Physician further stated X-rays were ordered and had come back positive for non-displaced fracture. The Physician indicated the resident was sent to the emergency room for further evaluation. The resident was evaluated by the Orthopedic in the ER and discharged to the facility in a CAM (Controlled Ankle Motion) boot and on as needed Oxycodone medication for 14 days for pain management. The Physician stated the resident had brittle bones, multiple contractures, and history of multiple fusion surgeries to legs and ankles and sometimes a complex movement like a transfer could cause a fracture. The Physician stated the resident recovered well. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/9/24 at 11:56 AM, the Director of Nursing (DON) stated the resident needed staff assistance for transfer. Resident #1 was assisted by the NA using a sit to stand lift for transfer. During the process of transfer the resident had complained about pain. The resident's nurse was notified. Nurse received Physician order for X-rays. X-ray result indicated the resident had a fracture. DON further stated the resident was sent to ER for further evaluation. The resident was on as needed medication for pain management and his pain was managed. The resident had existing co-morbidities making him more susceptible to fracture. DON indicated Resident #1 was discharged from the hospital the same day. No major treatment was done in the ER, and he came back to the facility with CAM boot that were needed to be worn during transfer. The DON stated per therapy recommendations, the resident was changed from sit to stand lift transfer to mechanical lift transfer after the incident. DON indicated as the facility had no other resident on sit to stand lift for transfer, the nurse aides were retrained on mechanical lift transfers. DON stated the following interventions were put in place: X- ray performed when resident complained of pain, based on X-ray results the resident was sent to ER, therapy was referred, and staff educated on mechanical lift transfers to ensure all residents were safely transferred when using a mechanical lift for transfers. Resident #1 was transfers were with mechanical lift and care plan was reviewed to reflect mechanical lift. During an interview on 5/9/24 at 12:30 PM the Administrator stated he was also made aware of the incident and the facility followed all the protocols to ensure the resident was safe. The Administrator stated he reviewed the interventions put in place. The interventions were currently working as there was no further incidence.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 38077 Based on record review and interviews with staff and the physician, the facility's Quality Assessment and Assurance (QAA) committee failed to self-identify the need for the development and implementation of an effective plan to achieve and sustain compliance in the area of supervision to prevent accidents (F689). This was evidenced by a repeat issue with staff failing to transfer residents safely related to an incident that occurred on 11/30/23 and an incident that occurred on 2/14/24. This repeat failure shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag is cross-referenced to: F689 - Based on record review and staff and physician interviews the facility failed to safely transfer a resident when utilizing a sit to stand lift for 1 of 3 residents reviewed for accidents (Resident #1). This unsafe transfer resulted in Resident #1 sustaining a mildly displaced left medial malleolus (boney presence on the inner side of the ankle) fracture and pain of 5 on a scale of 1 to 10 (10 being the worst pain). During a previous complaint investigation on 3/6/24, the facility failed to safely transfer a resident using a total mechanical lift on 2/14/24 for 1 of 1 resident reviewed for accidents. The resident was lowered to the floor by two staff members without injury as the mechanical lift tipped to one side. During an interview on 5/9/24 at 3:44 PM the facility's Administrator stated the facility's Quality Assurance and Performance Improvement (QAPI)/QAA committee was scheduled to meet at least quarterly. However, the Administrator noted the QAA committee typically met about once a month. The Administrator stated the resident was transferred using a sit to stand lift when the incident occurred on 11/30/23. The Administrator stated upon return to the facility the resident has been using a mechanical lift for transfers versus a sit to stand lift. He explained there were no other residents using a sit to stand lift in the facility so there was performance improvement plan after the incident on 11/30/23. He indicated the incident on 2/14/24 occurred when the resident was transferred using a mechanical lift.