STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345337	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - ALAMANCE, INC	**215 COLLEGE STREET GRAHAM, NC 27253**

(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 323 SS=G	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to safely transfer a resident from the wheelchair to the bed using a mechanical lift resulting in a deep leg laceration that required surgical repair for one of three residents reviewed for accidents (Resident #1). Findings included:	F 323	The Staff Development Coordinator will in-service all nurses and CNA's on the use of the mechanical lifts to ensure competency with use and safety and to ensure that all extremities are free and clear of obstruction during the transfer by 11/6/17. All newly hired nurses and CNA's will receive this education during the orientation process.	11/7/17

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

Electronically Signed | 10/30/2017

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F 323	Continued From page 1 Resident #1 was admitted to the facility on 07/11/17 with diagnoses that included encephalopathy, cirrhosis of the liver, heart failure, and atrial fibrillation. Resident #1's admission Minimum Data Set (MDS) dated 07/18/17 revealed the resident had a BIMS (Brief Interview of Mental Status) score of 12 which indicated intact cognition. The resident needed extensive assistance from staff for bed mobility, dressing and hygiene. The resident did not walk on admission. Balance was not steady for sitting to standing position changes, turning around, and moving on and off the toilet. The resident was only able to stabilize with staff assistance. The resident used a wheelchair for mobility. Behavioral symptoms not directed toward others was noted during the look-back period. The resident was totally dependent on the assistance of two staff members for transfer, locomotion, bathing and toileting. The resident weighed 293 pounds (lb) on admission. The resident was coded as needing the use of mechanical lift for transfer. The resident's care plan did not have specific instructions regarding the use of mechanical lift to transfer the resident. The Weekly Skin Check dated 08/03/17 noted scars and pigment changes near antecubital regions (anterior region of the elbow) bilaterally. "Skin remains intact." On 08/03/17 at 4:40 p.m. Nurse #1 entered a nursing progress note to indicate that Resident #1 was being transferred by nursing assistants (NA) and hit her leg against the wheelchair. The NAs called Nurse #1 to the room and the nurse observed a laceration to the left lower leg. The	F 323	The DON, Unit Managers, and Staff Development Coordinator will audit 3 transfers a week for 4 weeks, then 3 transfers a month for 3 months. The audit will be documented on the skills validation report for using a lift. This will begin on 11/6/17. Results of the audit will be reported to the QAPI committee to determine the effectiveness and duration of the audits. The facility administrator and regional nurse consultant will in-service the DON, SDC, and Unit Managers on the policy and procedure of reviewing and investigating incidents and accident reports to ensure a root cause analysis is completed, a thorough investigation is done, and appropriate interventions are in place to prevent reoccurrences. This will be completed by 11/1/17. The Director of Nursing and Staff Development Nurse will educate all nurses on the procedure for investigating and reporting incidents and accidents. The education provided will include, but not limited to, obtaining witness statements, assessment and documentation of injury, and completion of the incident and accident summary of investigation form. All newly hired nurses will be provided this education on orientation. This will be completed by 11/6/17. The Director of Nursing, Staff	

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F 323	Continued From page 2 nurse applied pressure and notified the medical doctor (MD) and the supervisor. The supervisor advised the nurse to send the resident to the emergency room and notify the resident representative. A Skin Tear/Laceration Report of 8/3/17 was completed by Nurse #1 described the depth of the wound as "deep" with "controlled bleeding." The pain on a 10-point scale with 10 being high was estimated as "6." Measurements of the wound were not documented. The resident was transferred to the Emergency Department of Hospital #1. The treating physician (Physician #1) conducted a physical exam of the resident that revealed "large laceration to the left lower extremity with subcutaneous fat exposed." The physician documented the size of the wound as "25 cm [centimeters or 9.8 inches] long." On 08/03/17 at 10:07 p.m. the wound was sutured and there were no foreign bodies/material noted and no underlying fracture. The physician described the "large wound defect with muscle exposure." An Orthopedist was consulted and recommended that the resident be transferred to another hospital "for plastic surgery." The resident was accepted by another acute care facility on 08/03/17 at 11:02 p.m. Final diagnoses included "laceration of left leg" and "avulsion (an injury in which the body structure is forcibly detached from the normal points of insertion caused by trauma or surgery) of soft tissue of lower leg, left." Resident #1 was transferred to Hospital #2 and seen in the emergency department at 08/04/17 at 12:09 a.m. The clinician (Clinician #1) documented a "patient with complicated and	F 323	Development Nurse, Unit Managers, and MDS nurses will perform a quality audit on all incident accident events, to ensure event is complete, all documentation is present, and appropriate notifications and interventions to prevent reoccurrence are in place. In addition, the Director of Nursing, Unit Managers and MDS nurses will perform a quality audit of all summary of investigation reports to ensure all incident and accident have been reviewed, a root cause analysis has been completed, witness statements have been obtained and appropriate steps have been taken to ensure supervision and prevention of incidents and accidents. These audits will be completed daily Monday through Friday for any incident/accident that has occurred the prior day. The audit will be documented by the signature of the Director of nursing on each summary of investigation. The administrator will collect these documents and sign off on daily to ensure completion. This will begin on 11/6/17 and continue on an ongoing basis. Results of the quality audits will be reported to the QAPI committee to determine the effectiveness and duration of the audits.	

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complex left lower leg laceration that does not violate through fascia (connective tissue) into bone." "She exhibits no edema."

A Trauma specialist was consulted for wound assessment. Devitalized tissues were resected, and subcutaneous tissues were approximated to cover the fascia. Wet-to-dry dressings was ordered twice a day.

In an interview on 10/17/17 at 7:45 pm., NA #1 stated that Resident #1 had requested to go to bed on 08/03/17 and this required the use of the mechanical lift. The resident was cooperative with the procedure. She indicated that NA #2 was operating the lift and she was guiding the resident. She stated that the resident hit her leg against the armrest of her wheelchair. When asked if the resident was lifted high enough to achieve a smooth transfer, NA #1 did not provide an answer. She said she noticed that the resident was injured once she was in the bed.

In an interview on 10/18/17 at 6:35 a.m., NA #2 stated that NA #1 was operating the lift and he was guiding Resident #1. He stated that the resident hit her leg against the arm of the wheelchair. The NA stated that the resident didn't hit her leg hard but it was enough to cause an injury. He was not aware of any sharp edges on the resident's wheelchair.

On 10/19/17 at 10:09 a.m., an observation was conducted of NA #2 demonstrating how he transferred Resident #1. The NA was observed operating a mechanical lift to transfer a resident from the bed to her wheelchair. NA #3 assisted with the procedure. NA #2 demonstrated where the lift, wheelchair and bed were positioned on

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the day of Resident #1 injury. He showed how he had come from behind the wheelchair to the opposite side of the bed to guide the resident as the sling was lowered to bed. He stated that he felt the resident hit something as he was guiding her but couldn't tell what it was.

On 10/17/17 at 4:16 pm, an interview was conducted with Nurse #1. The nurse indicated the incident happened around 4:00 pm around the time she was starting her medication pass. The nurse said that NA #1 came to her to get her to assess the resident. NA #2 stayed in the room with the resident. The nurse's understanding was that the resident was being transferred from the wheelchair to the bed, and the resident "hit her leg on the wheelchair." The nurse said it must have been the armrest of the wheelchair, the bed side rail was lowered to accommodate the resident. The nurse said the layout of the room was such that the wheelchair was parallel to the bed and the mechanical lift was in front of the wheelchair. There was a lot of blood when she got to the room, more of it was fluid than blood. The left leg was open and bleeding, she dry dressed it. She could not give an estimate of the length or size of the wound. The nurse stated she called one of the nurse supervisors, and the supervisor notified the MD, and she phoned 911. The EMS arrived in maybe 10 minutes and the resident was sent to hospital emergency room. The nurse said the resident was sent to the hospital because of the extent of the injury.

In an interview on 10/17/17 at 5:16 p.m., Nurse #1 estimated the time of the incident as 4:00 p.m. NA #1 came to her and asked her to come to the room to assess Resident #1. NA #2, who was also assisting with resident transfer, had stayed in

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the room with the injured resident. She stated that the resident was familiar with the mechanical lift. She described the layout of the room with the wheelchair parallel to the bed and the lift positioning in front of the wheelchair. She was unable to provide an estimate of the length or size of the wound.

In an interview on 10/17/17 at 9:40 a.m., the Staff Development Coordinator (SDC) provided the Operator Instructions for the mechanical lift used for Resident #1. The mechanical lift had the capacity of 500, 600 or 1,000 lb. The manual revealed that the lift "was designed to be operated safely by one person. However, with some patients it is best to use two people." The SDC stated that facility policy was to use two staff members to operate a mechanical lift: one to operate the mechanical lift and the other to stand near the resident and guide the sling to assist in repositioning. She confirmed that the lift used was the correct device for Resident #1.

In an interview on 10/17/17 at 4:00 p.m., Nurse Supervisor #1 said she had come to the room of Resident #1 on 08/03/17 to assist the charge nurse in caring for the injury. She described the wound as a "skin tear" which needed evaluation for potential "stitches or staples." She indicated that the wound was not bleeding profusely but there was a lot of serous drainage and white tissue. She could not give an estimate of the length of the skin tear or the size of the wound. She notified the facility physician who gave the order for transfer. Resident #1 did have behavioral issues but was not yelling when she arrived to the room. She did not appear to be in pain.

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F 323	Continued From page 6 In an interview on 10/19/17 at 4:00 p.m., the director of nursing (DON) stated that she had reviewed the incident on the day it occurred because she was present in the building. She went to the room and spoke with the two nursing assistants involved in transferring Resident #1. She observed as the NAs demonstrated their technique in lifting the resident. The DON was satisfied that NA #1 and #2 had followed facility policy on using the mechanical lift. She concluded that the resident's leg had not cleared the wheelchair but this was not due to inattention or failure to properly guide the occupied sling. She did not document her investigation or conclusions.	F 323		