STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING _____ B. WING _____	C 09/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTHCARE CENTER	322 NUWAY CIRCLE LENOIR, NC 28645

(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 000	INITIAL COMMENTS An unannounced complaint survey was conducted on 09/05/19. There were three allegations investigated and one was substantiated. Event ID # XOWD11.	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, Physician and staff interviews, the facility failed to transfer a dependent resident using a mechanical lift with 2-person assist which resulted in the resident being lowered to the floor while still in the lift for 1 of 3 resident's reviewed for accidents (Resident #1). The findings included: Resident #1 was admitted to the facility on 03/22/16 with multiple diagnoses that included hypertension, diabetes mellitus, cerebrovascular accident and seizure disorder. Review of the quarterly Minimum Data Set (MDS) dated 07/01/19 assessed Resident #1 with severe cognitive impairment. Further review revealed Resident #1 required extensive to total staff assistance with most activities of daily living.	F 689	The nurse aide (NA) involved in incident was re-educated on lift usage and requirement of 2 staff members by the Staffing Coordinator. All NAs and nurses were re-educated on proper lift usage and skill check off including that all lifts require 2 staff by Director of Nursing and Restorative Aides by 9/26/2019. Upon hire nurses and NAs will be educated about proper lift use and that all lifts require 2 staff members beginning 9/26/2019. Administrative nurses (Director of Nursing, Staffing Coordinator, and RN Supervisor) will monitor random lift transfers of 2 resident three times weekly for 4 weeks then 4 residents weekly for 8 weeks beginning 9/30/2019. Findings of	10/3/19

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

Electronically Signed | 09/27/2019

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F 689	Continued From page 1 Resident #1 was dependent of two staff members for transfers. Review of Resident #1's care plan dated 02/12/19 and updated 04/11/19 revealed she had a focus area for impaired mobility. The goal was for Resident #1 to have no injury from falls through the next review date. Interventions included using a total lift for transfers. Review of an incident and accident form completed by Nurse #1 dated 08/17/19 read in part, "The nursing assistant (NA) reported to the nurse she had to lower Resident #1 to the floor with the mechanical lift". The incident report revealed the NA lowered the resident to the floor due to lack of experience and the NA had attempted to transfer the resident without assistance from other staff members. Nurse #1 completed an assessment of Resident #1's range of motion and neurological status which was documented as within normal limits. Review of a Physician progress note dated 08/19/19 revealed Resident #1 was evaluated on this date for a rash on her abdomen. The note indicated Resident #1 had an appointment to see a dermatologist. The documented revealed Resident #1 was in no acute distress or pain during the evaluation. Review of a chest x-ray dated 08/19/19 revealed Resident #1 was experiencing cough and congestion. The x-ray revealed an impression consistent with pneumonia. Review of a physician order dated 08/19/19 revealed Resident #1 was to receive the antibiotic, Levaquin 750 milligrams (mg) daily for	F 689	audits will be reported in QAPI by the Director of Nursing for trends and possible need for changes monthly. Completion date of 10/3/2019.	

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F 689	Continued From page 2	F 689		

a duration of 7 days.

Review of a nursing note dated 08/20/19 revealed Resident #1's oxygen saturation level was 85%. The nurse notified the Nurse Practitioner who gave orders for the medication Lasix 40mg to be given intramuscularly for one dose. A second note on this date revealed Resident #1's power of attorney was in the facility and requested the resident be sent to the emergency room for an evaluation.

Review of a transfer form dated 08/20/19 revealed Resident #1 was transferred to the hospital on this date for an evaluation due to cough, congestion and a diagnosis of pneumonia.

Review of the hospital discharge summary dated 08/26/19 revealed Resident #1 had presented to the emergency department on 08/21/19 due to worsening respiratory distress. Discharge diagnoses included sepsis, respiratory distress, intracranial bleed, left lower lobe pneumonia, and rib fractures. Review of the chest x-ray dated 08/21/19 revealed Resident #1 had several minimally displaced left rib fractures. A review of the computed tomography (CT scan) of the head completed on 08/21/19 revealed the resident had an acute 8-millimeter (mm) intracranial bleed (bleeding inside of the skull). The Neurologist was consulted and indicated the size of the lesion was too small for an aggressive procedure.

On 09/05/19 at 10:45 AM an interview was conducted with NA #1 during which she confirmed she cared for Resident #1 on 08/17/19. She stated the incident occurred prior to the 11:00 PM shift change and she was working on the hall with one other NA. The interview revealed

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F 689	Continued From page 3	F 689		

she could not find the NA she was working with and had decided to attempt to transfer Resident #1 using a mechanical lift alone without assistance from other staff members. NA#1 stated Resident #1 was sitting in her wheelchair when she attached her to the mechanical lift using a sling. She stated once the resident was in the air, she became jittery and anxious. The NA stated she then became nervous and decided to gently lower the resident to the floor on her bottom and go get another staff member to help her get the resident in bed. She stated once lowering the resident to the floor she removed the sling and placed a pillow under Resident #1's head. NA #1 stated the resident did not hit her head during this incident. She stated she left the resident on the floor and went to get help from Nurse #1. She stated she told Nurse #1 the resident was lying on the floor and also went to get help from a NA. She stated when she entered the room two nurses were in the room with the resident. The resident was stating "Get me off of this floor". The interview revealed four 4 staff members assisted the resident to the bed using a mechanical lift.

On 09/05/19 at 11:38 AM an interview was conducted with Nurse #1. Nurse #1 stated NA #1 came to her on August 17, 2019 and told her while she was putting Resident #1 to bed using a mechanical lift the resident became extremely anxious. She stated NA #1 explained to her she had lowered the resident to the floor using the mechanical lift. Nurse #1 explained NA #1 had used the mechanical lift alone to transfer the resident. The interview revealed once she had entered Resident #1's room she found the resident lying on the floor at the foot of Resident #1's roommates' bed with her feet under the edge

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F 689	Continued From page 4	F 689		

of the roommate's bed. Nurse #1 stated Resident #1 told her she did not hit her head during the transfer. Nurse #1 stated NA#1 was inexperienced and should have gotten assistance from another staff member prior to attempting to transfer Resident #1. The interview revealed she completed an assessment of Resident #1 following the incident and there were no injuries, redness or reports of pain noted.

On 09/05/19 at 3:35 PM an interview was conducted with the facility Physician. He stated he had evaluated Resident #1 on 08/19/19 for a skin rash. The interview revealed if Resident #1 was experiencing a change of condition he would have noticed it at that time. He stated there were other things besides a fall that could cause a brain bleed including a hemorrhagic stroke. The physician stated if a resident experienced a brain bleed caused from a fall, symptoms would appear within hours of the incident in which Resident #1 did not show. He stated regarding the rib fractures shown on the hospital x-ray Resident #1 had severe osteoporosis with brittle bones. The interview revealed rib fractures could have occurred on the day of being transferred to the hospital.

On 09/05/19 at 11:51 AM an interview was conducted with the Administrator. She stated during the incident on 08/17/19 NA #1 had attempted to transfer Resident #1 by herself. The interview revealed NA #1 had never used the mechanical lift on Resident #1 and her hall partner was on break. The Administrator stated NA #1 explained to her when she lifted the resident she started trembling. NA #1 lowered the resident to the floor, placing a pillow underneath her head and went to inform the nurse. She

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F 689	Continued From page 5 stated NA#1 was provided with education following the incident and an in-service was conducted for all staff members on use of the mechanical lift for staff members. The Administrator stated two staff members were required for resident transfers using the mechanical lift.	F 689		