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	345097	A. BUILDING _____ B. WING _____	06/10/2021

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JESSE HELMS NURSING CENTER	1411 DOVE STREET MONROE, NC 28111

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E 000	Initial Comments An unannounced Recertification survey was conducted on 6/7/2021 through 6/10/2021. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #259511.	E 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, observation and staff interviews the facility failed to transfer a resident using a mechanical lift and adequate supervision to prevent two falls with injury for 1 of 2 residents, Resident #17, reviewed for supervision to prevent accidents. Findings included: Resident #17 admitted to the facility on 11/15/2019 with diagnoses of osteoarthritis and anxiety. A care plan for fall risk that was initiated on 11/22/2019 and updated on 2/17/2021 indicated Resident #17 required a sit to stand lift mechanical lift for transfers and required assistance of two staff members.	F 689	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F689 - Based on record review, observation and staff interviews the facility failed to transfer a resident using a mechanical lift and adequate supervision to prevent two falls without injury for 1 of 2 residents, Resident #17, reviewed for supervision to prevent accidents.	7/2/21

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

Electronically Signed | 07/02/2021

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F 689	Continued From page 1 A Quarterly Minimum Data Set (MDS) Assessment dated 4/12/2021 revealed Resident #17 was cognitively intact and required extensive assistance of two staff members for transfers and had falls since the last assessment. During an interview with Resident #17 on 6/9/2021 at 10:23 am she stated she fell recently and hit her face on the floor. Resident #17 stated she fell because the Nurse Aide instructed her to reach across to another chair and pull herself up. Resident #17 stated she did not remember exactly when the fall occurred, but it was within the past three months. Review of the Nursing Fall Assessments for Resident #17 revealed she had 3 falls since 4/1/2021: Review of a Nursing Fall Assessment dated 4/7/2021 written by Nurse # 1 stated Resident #17 fell on 4/7/2021 while being transferred from the bed to the wheelchair by Nurse Aide #1. The report stated Resident #17 fell to the floor during the transfer and landed face down and sustained a knot above her right eye. The assessment stated the Physician was on site and was aware of the fall. Nurse #1 assessed the resident and documented Resident #17 denied a headache, and a neurological check was normal. During an interview with Nurse Aide #1 on 5/9/2021 at 11:52 am she stated on 4/7/2021 she was transferring Resident #17 from the bed to the wheelchair without the sit to stand mechanical lift when she got weak and fell to the floor on her face. Nurse Aide #1 stated she did not have another staff member helping her and Resident #17 should have two staff members to assist with	F 689	On 6/24/21, therapy reevaluated Resident #17 sit to stand fall intervention to determine if changes were needed. Outcome of the reevaluation determined to continue utilizing the sit to stand lift with 2 person assist while providing verbal cues for safety, correct feet placement and correct hand placement. On 6/28/21, therapy scheduled to reevaluate 100% of residents that utilize sit to stand lift to ensure safe transfers. On 6/24/21, the lift manufacturer representative provided a presentation and demonstration to nurses and nurse aide on proper use and safety features of the sit to stand lift. Beginning on 6/24/21, Director of Nursing and Nurse Manager will train all nursing staff on safe transfers utilizing the sit to stand lift. Any staff members who do not receive the training by 7/2/2021 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation. Beginning 6/21/21, the Nurse Manager will validate that the resident profile, iPOC (electronic care plan system), and orders match the therapy recommendations. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must	

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F 689	Continued From page 2 her transfers and she should be transferred using a sit to stand mechanical lift. Nurse Aide #1 stated she was not able to find anyone to help her and did the transfer herself without the sit to stand mechanical lift, but she should have waited on someone to assist her. Nurse Aide #1 stated Resident #17 had a bruise under her eye due to the fall but did not complain of pain. An interview was conducted on 6/9/2021 at 10:05 am with Nurse #1 and she stated Resident #17 was her patient when the fall occurred on 4/7/2021. Nurse #1, which is also a Unit Manager, stated Resident #17 required a sit to stand mechanical lift to transfer and staff should have another staff member in the room when they transfer her with the sit to stand mechanical lift. Nurse #1 stated Nurse Aide # 1 should have asked someone to assist her before transferring Resident #17 and should have used the sit to stand mechanical lift. Resident #17's Care Plan was reviewed, and an intervention was found for neurological checks and a physician's referral for a fall on 4/7/2021. A Nursing Fall Assessment dated 4/11/2021 written by Nurse #1 stated Resident #17 fell during a transfer using a sit to stand lift. The assessment further stated Resident #17 sustained a bruise to her anterior left arm and left lower anterior leg. Nurse #1 documented she assessed Resident #17 and her neurological assessment was normal. Resident #17's Care Plan was reviewed, and an intervention dated 4/11/21 was found for neurological checks and cold compresses to a bruise to her left arm.	F 689	develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system of the facility. Beginning 6/21/21, Nurse Manager or designee will conduct weekly audit of lift transfers based on therapy recommendations 3 times a week x 1 month, 2 times a week x 1 month, then 1 time a week x 1 month. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI quarterly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

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F 689	Continued From page 3	F 689		

During an interview with Nurse #3 on 6/10/2021 at 7:51 am she stated Nurse Aide #3 was with Resident #17 when she fell on 4/11/2021. She stated Nurse Aide #3 told her she tried to get Resident #17 up with the sit to stand mechanical lift, but her legs buckled, and she went down to the floor. Nurse #3 stated when she entered the room the belt that goes around the resident's waist on the sit to stand mechanical lift was not hooked to the lift as it should have been. Nurse #3 stated Nurse Aide #3 was the only staff member in the room when Resident #17 fell on 4/11/2021. Nurse #1 also stated Nurse Aide #3 should have had another staff member in the room when she transferred Resident #17. Nurse #3 stated Resident #17 had a bruise to her left anterior lower leg. She also stated Resident #17 did not complain of pain. Nurse #3 indicated Nurse #1, the Unit Manager, did an education with Nurse Aide #3 because she should have another staff member with her when using the sit to stand mechanical lift.

An interview was conducted with Nurse Aide #3 on 6/10/2021 at 8:52 am and she stated she had cared for Resident #17 when she fell on 4/11/2021. Nurse Aide #3 stated Resident #17 was sitting on the edge of the bed and she put the belt to the sit to stand mechanical lift around her waist and pulled it snug. She stated she was lifting her up when Resident #17 got weak and she started sliding down and the lift belt slid up under her arms. Nurse Aide #3 stated she lowered Resident #17 to the floor and removed the lift belt, and she was not injured, and she did not complain of pain. Nurse Aide #3 stated Resident #17 was a two person assist and she should have two staff members with her when

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F 689	Continued From page 4	F 689		

she transferred her. Nurse Aide #3 stated she looked for someone to help her, but everyone was busy.

A Nursing to Therapy Referral dated 4/11/2021 stated Resident #17 was currently using a sit to stand lift and had two falls during the last week and requested therapy evaluate Resident #17 for balance and mobility. The Nursing to Therapy Referral also stated Resident #17 may need a total mechanical lift.

A Physical Therapy Evaluation and Plan of Care dated 4/28/2021 stated the reason for the referral was Resident #17 had two recent falls. The Physical Therapy Evaluation and Plan of care further stated nursing felt Resident #17 was weak in both lower extremities and had difficulty performing sit to stand mechanical lift transfers.

The Administrator was interviewed on 6/10/2021 at 2:40 pm and he stated the staff involved with Resident #17's falls had been educated on how to use the sit to stand mechanical lift and had Annual Competency Assessments on 5/18/2021 but the facility had not started a plan of correction for the falls.

During an interview with the Director of Nursing on 6/10/2021 at 3:38 pm she stated the fall that occurred on 4/7/2021 should not have happened and it was not proper technique since Resident #17 should be transferred using a sit to stand mechanical lift. The Director of Nursing further stated Resident #17 did not need two people when the staff are using the sit to stand mechanical lift and she was safe to use a hand bar to pull up from a chair. The Director of Nursing stated the sit to stand mechanical lift is

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F 689	Continued From page 5 safe to use with one staff member per the manufacturer's directions	F 689		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and staff interviews, the facility failed to discard expired nutritional supplement drinks in 1 of 2 coolers observed and failed to dry before stacking meal trays for use for 1 of 3 kitchen observations. Findings included: 1. The kitchen was observed on 6/7/2021 at 9:15 AM. A cooler designated as the resident drink cooler was observed to have 6 cartons of a clear nutritional supplement with an expiration	F 812	"F812 - Based on record reviews, observations, and staff interviews, the facility failed to discard expired nutritional supplement drinks in 1 of 2 coolers observed and failed to dry before stacking meal trays for use for 1 of 3 kitchen observations. On 6/7/21, the 6 cartons of Ensure Clear were discarded. On 6/23/21, 120 trays were ordered to increase the tray inventory.	7/2/21

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F 812	Continued From page 6 date of 6/1/2021. The dietary supervisor (DS) was interviewed at the time of the observation and reported the coolers were checked daily by the dietary aide (DA) for expired items and the expired supplements should have been discarded. The DA was interviewed on 6/7/2021 at 9:46 AM. The DA reported she had worked 6/6/2021 and had checked the resident drink cooler, but she must have missed the nutritional supplement. The patient service manager (PSM) was interviewed on 6/9/2021 at 10:50 AM. The PSM reported the coolers should be checked daily by a DA and all expired food and drinks should be discarded if expired. The PSM reported no residents were currently taking the clear nutritional supplement and thought the clear nutritional supplement was overlooked by the DA during the daily checks. The Administrator was interviewed on 6/10/2021 at 12:35 PM. The Administrator reported the kitchen staff were expected to monitor and rotate the food and drinks in the coolers, discard food and drinks close to their expiration, and he did not know why the clear nutritional supplements were missed. The Administrator reported he expected all expired items were removed from the kitchen before their expiration date. 2. The Certified Dietary Manager (CDM) was observed preparing resident trays to serve lunch on 6/7/2021 at 12:14 PM. The food trays were noted to be stacked and the surfaces of the trays were wet. The CDM was using a cloth dishtowel to dry the surface of the trays prior to setting up the tray for the meal. The CDM was interviewed	F 812	No current patient/resident had orders for Ensure Clear. On 6/7/21 and 6/9/21, the Food and Nutrition Patient Safety Manager re-educated staff to check expiration dates individually as trays are made. Also, to check weekly in the refrigerator for expiration dates. Any staff members who do not receive the training by 7/2/21 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation. On 6/7/21 and 6/9/21 staff reeducated to air dry food trays prior to setting up the tray for a meal. Any staff members who do not receive the training by 7/2/21 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation. Beginning 6/7/21, new practice for Food and Nutrition Manager to remove non ordered supplements from facility and return to hospital. Increased inventory of trays and allows all trays to be properly air dried prior to being placed in use for meal services. Beginning 6/21/21, Administrator or designee will conduct weekly audit of expired items once a week x 3 months. Beginning 6/21/21, Administrator or designee will conduct weekly audit of trays being air dried prior to setting up the tray	

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F 812	Continued From page 7 at the time of the observation and she reported the trays were wet because the main kitchen was running behind. The CDM stated it was appropriate to dry the trays with a dishcloth. A follow-up interview was conducted with the CDM on 6/9/2021 at 10:50 AM. The CDM explained the main kitchen had gotten behind and the food trays had been washed but did not have enough time to air dry before lunch. The CDM reported the trays should have been air dried and a dish towel should not have been used because it could allow for the spread of bacteria. The Administrator was interviewed on 6/10/2021 at 12:35 PM. The Administrator reported he expected all food service items to be dry before stacking.	F 812	for a meal once a week x 3 months. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Senior Director of Food and Nutrition on a weekly basis and with QAPI quarterly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		7/2/21

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F 880	Continued From page 8 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 9 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and staff interviews, the facility failed to place soiled linen and a soiled incontinence brief into a trash bag at the point of collection and transported the unbagged linen and brief out into the hallway for 1 of 1 staff observed (NA #4). Findings included: The facility policy "Linen Services" dated 9/90 and revised 7/18 was reviewed. The policy stated, in part: "Soiled linen will be handled and transported in a manner to prevent contamination and transmission of pathogenic organisms." Nursing assistant (NA) #4 was observed entering room 611 at 10:08 AM on 6/9/2021. NA #4 was observed exiting the room at 10:12 AM with a yellow stained bed sheet and a soiled incontinent brief. The bed sheet and the incontinence brief were not in a trash bag. Fecal matter was noted to be on the brief. NA #4 disposed of the soiled brief in the trash bin that was in the hallway. NA #4 was interviewed on 6/9/2021 at 10:12 AM. NA #4 reported there were no trash bags in room 611 and she had forgotten to take trash bags into the room. NA #4 reported the soiled linen and soiled brief should have been placed into trash	F 880	F880 Based on record reviews, observations and staff interviews, the facility failed to place soiled linen and a soiled incontinence brief into a trash bag at the point of collection and transported the unbagged linen and brief out into the hallway for 1 of 1 staff observed (NA #4). On 6/9/21, NA #4 was reeducated by the Infection Preventionist on safe handling of linen. Beginning 6/15/21, all staff reeducated by the Infection Preventionist on COVID safe behaviors including safe handling of linen based on current CDC guidelines. Any staff members who do not receive the training by 7/2/21 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation. On 7/1/21 the facility conducted a Root Cause Analysis (RCA) with the assistance of Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee and	

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F 880	Continued From page 10 bags in the room to be taken out into the hall. The Director of Nursing (DON) was interviewed on 6/9/2021 at 3:38 PM. The DON reported that soiled linen and trash with biohazard fluids or solids were to be bagged in a trash bag in the resident ' s room for transport out into the hallway to the trash and linen bins. The DON reported she did not know why NA #4 did not bag the linen or brief at the point of collection. The Administrator was interviewed on 6/10/2021 at 12:37 PM. The Administrator reported NA #4 should not have taken the soiled linen or brief out into the hallway without bagging in the resident ' s room. The Administrator reported it was his expectation staff properly bagged linen and soiled briefs before leaving a resident ' s room, and if they did not have a trash bag available, to ask another staff member to retrieve trash bags.	F 880	Governing Body and developed the intervention plan Beginning 6/21/21, Charge Nurse or designee will conduct weekly audit and observe for compliance with handling soiled linen, 3 times a week x 1 month, 2 times a week x 1 month, then 1 time a week x 1 month. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI quarterly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	