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	345363	A. BUILDING _____ B. WING _____	C 06/21/2022

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COMPASS HEALTHCARE AND REHAB HAWFIELDS, INC	2502 S NC 119 MEBANE, NC 27302

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F 000	INITIAL COMMENTS The surveyor entered the facility on 6/15/22 to conduct a complaint survey and exited on 6/16/22. Additional information was obtained on 6/17/22, 6/20/22, and 6/21/22. Therefore, the exit date was changed to 6/21/22. Two of thirteen allegations were substantiated. Event S9XT11. NC 188850; NC 189194; NC 189880; NC 190059	F 000		
F 689 SS=E	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 observation, record review, resident interview, staff interview, and mechanical lift representative interview the facility failed to assure staff were trained or followed through on training regarding mechanical lift transfers to prevent two residents from sustaining falls from mechanical lifts. The facility also failed to have evidence that mechanical lifts were checked for safety prior to a lift malfunctioning while a resident was being transferred in it. This was for two (Residents # 8 and # 10) of four sampled residents reviewed for falls. The findings included: 1. Resident # 8 was admitted to the facility on	F 689	F689 Free of accident hazards This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident.	7/15/22

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

Electronically Signed | 07/06/2022

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F 689	Continued From page 1 5/26/22. The resident had a history of cerebrovascular accident with right hemiplegia, osteoarthritis, history of right shoulder girdle dislocation, and history of right shoulder pain. The resident was advanced in age; being older than 90 years of age. Resident # 8's Minimum Data Set Assessment, dated 6/2/22, coded Resident # 8 as cognitively intact and as needing extensive assistance by two staff members with transfers. Resident # 8's care plan, dated 5/27/22, included the resident was at risk for falls due to her decreased mobility. Review of physical therapy documentation revealed Resident # 8 was evaluated on 5/26/22 by the therapy department to need a full body mechanical lift for transfers. On 5/29/22 at 9:41 PM, Nurse # 1 documented Resident # 1 was being transferred to the bed from the wheelchair with two Nurse Aides (NAs). Nurse # 1 further documented the resident slid off the bed and the NA's guided her to the floor without injuries. Further review of nursing notes revealed x-rays of the lumbar spine and the sacrum were completed on 5/31/22 and the results returned on 6/2/22 showing the resident had sustained no fractures. Seventeen days later, there was documentation Resident # 8 sustained another fall from a mechanical lift. On 6/15/22 at 9:20 PM Nurse # 2 documented the following. "VSS (vital signs stable) 97.4F-18-95% RA-11/82-83. Witnessed incident occurred by (NA # 1). She stated that the	F 689	1.a. Resident #8 no longer resides at facility as of 7/3/22. Resident #10 was assessed by physical therapy services to determine the most appropriate mechanical lift type and sling size to be used during transfers on 5/25/22 and again on 6/1/22. Resident #10 continued to work with therapy services during this time through 6/16/22. The therapy team conducted training for CNA and nursing staff on 5/31/22 regarding mechanical lift use. The care guide for resident #10, located in the resident room, has been updated to reflect the appropriate lift type and sling size. Staff have been educated on where to locate the assigned lift type, size and proper lift operation. b. All mechanical lifts have been inspected by the director of plant operations and found to be in working order according to manufacturer guidelines. 2.a. The director of nursing and the clinical team have conducted a facility wide audit of 100% of residents to ensure all are assigned the appropriate lift and sling pad size. No other residents have been identified as having been affected by the same deficient practice. b. The maintenance director has conducted a baseline inspection of all mechanical lifts to identify any issues or concerns as to their proper function. Any identified concerns have been resolved or lift has been removed from service. 3.a. Mechanical lift type and appropriate	

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F 689	Continued From page 2 resident slid out of the (full body) lift sling as she was trying to transfer her from wheelchair to bed. She assisted resident safely down to the floor. (Full body) Lift X 1 person assist to assist her back into the bed. She and the resident stated that she did not hit her head. Writer noted no bruising or open areas, +ROM (Range of Motion) of upper and lower extremities without pain. Denies hip pain, some mild to moderate c/o's (complaints) of back pain. Offered to call MD to obtain x-rays of her pelvis, lower back, and coccyx. She refused x-rays at this time." Nurse # 2 further documented he would refer Resident # 8 to therapy for a more effective transfer technique. Resident # 8 was interviewed on 6/16/22 at 12:50 PM and reported the following. She recalled falling from the mechanical lift two times. The first time she fell from the lift, her bottom and spine hurt the night after the accident. She did not recall the specific details of the first fall; only that she had fallen from the lift. During the second fall Resident # 8 reported that she came out of the sling and that the NA was a very good NA but she was by herself when it happened. Resident # 8 reported she was not hurt but she did have some bruises. She lifted her arm sleeves to show several purplish bruises on both arms. The rehabilitation director was interviewed on 6/16/22 and reported the following. The facility's procedures were as follows when a resident was admitted. If there were discharge orders from the hospital for the way a resident could be transferred, then those could be followed. Otherwise residents were to be a full body mechanical lift until evaluated by therapy staff. Once evaluated by therapy, then recommendations were made and given to the	F 689	sling size have been identified for all residents requiring mechanical lift use. As of 6/8/22, This information has been clearly posted in each resident room in the resident care guide, as well as in the CNA binder at each nurse's station. Each resident will be assessed quarterly and with a change in condition to determine appropriate lift type and sling size. Any identified changes will be updated in the CNA reference binder and on the care guide in the resident room. All licensed nurses and CNA staff members will be reeducated by Director of Nursing/designee on the proper identification of lift type and sling size, proper lift operation/function by 7/15/22. Education to include video training, manufacturer’s operation instructions, and return demonstration to ensure safe lift operation. Newly hired staff members and new agency staff will receive mechanical lift training prior to beginning their assignment. b. All mechanical lifts have been added to a preventative maintenance program to include a weekly inspection check per manufacturers recommendation. Also, the facility has hired Medical Equipment Services to begin quarterly preventative maintenance and calibration on all mechanical lifts. The first service is scheduled for July 12, 2022. 4. a. DON/Designee will review the staffing schedule and training record daily to verify each agency staff member who worked, received mechanical lift training prior to beginning their assignment. This	

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F 689	Continued From page 3 nursing staff. Resident # 8 had been evaluated on her admission date by the therapy staff to need a full body mechanical lift because she could not bear any weight. Nurse Aide (NA) # 4 had been the NA who was assisting to transfer Resident # 8 on the evening of 5/29/22 (which was the first incident) with the help of NA # 5. NA # 4 was interviewed on 6/17/22 at 4:15 PM and reported the following. On the evening of 5/29/22 she and NA # 5 had used the sit to stand mechanical lift and she had not known that she was to use the full body mechanical lift. They had been trying to get her from the wheelchair to the bed. Once on the side of the bed, Resident # 8 slipped to the floor and out of the sit to stand mechanical lift. Following the incident facility staff told her the instructions for transfers were on the back of the closet door. She had not known that prior to the incident. She did not recall having any inservice training about mechanical lift transfers since the incident. NA # 5 was interviewed on 6/17/22 at 4:45 PM and reported the following. She had helped care for Resident # 8 on the first day she was admitted and she had used the sit to stand lift. She only worked at the facility every 2 to 3 weeks and she was not familiar with their protocols. She knew the resident seemed alert and it seemed appropriate to use the sit to stand lift. NA # 5 felt Resident # 8 had done okay the first evening she used the sit to stand mechanical lift. On 5/29/22 she was assisting NA # 4 to transfer Resident # 8 with the sit to stand lift again. The resident started to say "Oh-oh" and stopped helping. She slid down to her bottom. At that time NA # 4 had been assigned to Resident #8 and NA # 5 thought NA # 4 knew which type of lift to use. NA # 5 stated she	F 689	audit will occur daily x 3 months. DON/designee will conduct 10 mechanical lift transfer observations per week x 4 weeks, then monthly x 2 months. b. Administrator/designee to audit the preventative maintenance (PM) records of the mechanical lifts to ensure the weekly PM checks are completed on each mechanical lift. This audit will occur weekly x 4 weeks, then monthly x 2 months. Audit results to be reported to monthly QAPI committee meeting until a pattern of compliance is established. 5. Completion date: 7/15/2022	

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had worked again last night (6/16/22) and found that Resident # 8 had fallen again from a mechanical lift. She did not know how that could have happened, but she did know that when she reported to work on 6/16/22 they had told her to use a full body sling and the full body mechanical lift.

Nurse # 2 was interviewed on 6/17/22 at 3:55 PM and reported the following about the 6/15/22 incident (which was the second incident). He had been passing medications when NA # 1 informed him that Resident # 8 had slid from the mechanical lift when she was transferring Resident # 8 from the wheelchair to the bed. NA # 1 had reported Resident # 8 was anxious and let go of the mechanical lift bars and slid through the sling. NA # 1 had reported to the nurse that she had stood behind Resident # 8 to guide her head so that it would not hit the floor as she fell to the floor. Nurse # 2 stated only NA # 1 was in the room and there was supposed to be two staff members. Resident # 8 complained of some back pain, but she refused to have x-rays done.

NA # 1 was interviewed on 6/17/22 at 9:27 AM and reported the following. She had been with Resident #8 on 6/15/22 when she slipped from the full body mechanical lift. There had been another NA with her, but she did not recall who it was. Resident # 8 panicked and let go of the mechanical lift bars. She then slipped through the lift pad. She was using a toileting sling and not a full body sling to transfer her from the wheelchair to the bed. As Resident # 8 was slipping she was no further off the floor than the seat of her wheelchair. She (NA # 1) got behind her to protect her head from hitting anything as she slid through and to the floor. NA # 1 reported she had

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never really been trained about the type of slings and that she used the one that was with the mechanical lift when she obtained the mechanical lift the evening of 6/15/22. NA # 1 reported she recalled there had been a piece of paper she had been asked to review about the mechanical lifts at some point, but that she was a visual learner.

NA # 2 was interviewed on 6/17/22 at 11:00 AM and reported the following. She had worked on the evening of 6/15/22 and she and NA # 3 were sitting at the desk when they saw NA # 1 go into Resident # 8's room alone. She had not gotten anyone to help with the transfer. They then saw her come out of the room calling for help. She (NA # 2) went to the room to help. When she arrived, she saw that it appeared NA # 1 had been using a larger lift sling than was needed for Resident # 8. It was so large that she (NA # 2) crisscrossed the leg straps so the hole would be smaller in order that Resident # 8 not slip back through again when they got Resident # 8 off the floor with the lift. She did not recall for sure but thought that the lift pad was blue. NA # 2 was interviewed regarding whether there had been problems or issues with the slings or the mechanical lifts. She reported that there were not enough slings for the mechanical lifts and at times the full body mechanical lift would get stuck when the controls were pushed. At times it would not stop and would keep going when a staff member tried to make it stop. At other times it would not go when they pressed the control for it to go. Also, the legs on the sit to stand mechanical lifts did not always work. NA # 2 was interviewed about training on the mechanical lifts and stated she had not received training since 5/29/22.

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A full body mechanical lift located on Resident #8's unit was observed on 6/16/22. There was a notation that it had been last inspected 12/26/19 and due in 12/2020.

The DON (Director of Nursing), Administrator, and Assistant Director of Nursing were interviewed on 6/16/22 at 4:30 PM. They reported the following. Following the incident of 5/29/22, they had audited all the residents to determine which type lift was needed. They then made a book and placed it at the desk to show which lift and color of sling were needed. They made sure that the instructions for the type of lift were on the backside of residents' closets' door also. According to the DON, the manufacturer's recommendations were that the lifts could be used with one person and therefore he did not feel as if NA # 1 had done anything wrong in transferring Resident # 8 by herself on 6/15/22. He had not had time to investigate to determine what all had gone wrong and how Resident # 8 slid through the sling to the floor on 6/15/22 since it had just happened the previous day. The ADON stated she had done some inservice training and had watched NAs do transfers following the incident of 5/29/22. She had not made records of inservice training or audits, but she had been checking transfers since the 5/29/22 incident to make sure transfers were done correctly. The DON thought Resident # 8's last fall might have something to do with using a toileting sling, which had an open area in the bottom of the sling, when compared to a full body sling.

During a follow up interview with the Administrator and DON on 6/21/22 at 11:10 AM these administrative staff members stated that prior to May they had also done training in April, 2022.

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The inservice training was presented. A review revealed on 4/12/22 that the ADON had instructed 39 staff members, who signed an education form, about mechanical lifts. Some of the information in the inservice training including that care guides were on back of residents' closet doors denoting which lift and pad to use; and that there needed to be two staff members present with any mechanical lift use. The name of NA # 1, who had reported she was a visual leaner and recalled she had only read a paper, was listed on the 4/12/22 inservice record. The names of NA # 4 and NA # 5 were not on the list.

A representative for the manufacturer of the mechanical lifts was interviewed on 6/17/22 at 4:30 PM and reported the following. If everything is used correctly then a resident cannot fall out of the mechanical lift. This would entail making sure the correct sling is used; the correct lift is used based on the resident's weight and abilities; and that the lift is used according to manufacturer's instructions. It does not make a difference if a resident does not hold onto the spreader bar. Even if the resident is not holding on, then they cannot fall through the sling if everything is correct. If the facility had multiple accidents involving mechanical lifts then it sounded as if a lot of it could be attributed to user error. The lifts should also not keep going when the operator wanted it to stop or get stuck if the operator wanted it to stop when used correctly and maintained correctly. The lifespan of a lift is 10 years. After that the parts do not work as well and the parts become obsolete. There are recommended maintenance specifications that the manufacturer technicians know to check for these things on a routine basis if the facility has a contract with them. Some facilities have contracts

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and others check their own equipment and are responsible for the proper functioning. Specifications for the lifts are in a manual. There is a certain amount of torque needed for different bolts of the mechanical lifts. According to the manufacture's representative, both maintenance of the lifts and the proper amount of training are key factors in preventing accidents with them.

According to the interview with the Administrator on 6/16/22 at 4:30 PM, the facility did not currently contract with the mechanical lift manufacturer for routine checks and maintenance.

Interview with the facility's maintenance director on 6/15/22 at 4:25 PM revealed he did not have a set schedule of checking the lifts but that he did do so when they were broken. At that point he would check the entire lift before putting it back into service. The maintenance director felt all the lifts had been checked at some point within the past year. During a follow up interview with the maintenance director, he stated he had downloaded the list of specifications and recommended checks from the lifts' manufacturer's website and started weekly checks on 6/17/22. He was aware of only one lift that had electrically malfunctioned and it had been taken out of service immediately after the incident.

Resident # 8's physician, who serves as the facility medical director, was interviewed on 6/21/22 at 2:40 PM and reported that Resident # 8 was checked after her incidents and did not seem to be experiencing any more pain than was her usual chronic pain. The physician felt as if the resident had not experienced any serious injury

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from her falls.

2. Resident # 10 was admitted to the facility on 12/11/19 with diagnoses of chronic kidney disease, vascular dementia, hypertension, anxiety, depression, diabetes, spondylolisthesis, and history of compression fracture.

Resident # 10's Minimum Data Set assessment, dated 3/3/22, coded Resident #10 as mildly cognitively impaired and as frequently incontinent. Resident # 10's Minimum Data Set assessment, dated 6/3/22, coded Resident # 10 as cognitively intact and as always incontinent.

Resident # 10's care plan, last updated on 6/15/22, included the information that Resident #10 was at risk for falls due to poor vision, weakness, and medication use. This had been originally added to the care plan on 9/23/20 and remained as an active part of the care plan.

On 5/25/22 at 6:00 AM Nurse #3 documented that Resident # 10 slid out of the sling while on the sit to stand mechanical lift and sat in her recliner chair. Nurse # 3 further documented Resident # 10 was complaining of left shoulder and upper arm pain and lower back pain. X-rays were ordered. On 5/25/22 at 6:21 AM, Nurse # 3 documented she administered Tylenol for Resident # 3 's pain and she tolerated it well. On 5/29/22 at 12:59 PM Nurse # 4 documented Resident # 10 remained sore on her left side and x-rays were obtained at 11:00 AM.

On 5/25/22 an intervention was added to the care plan which noted that the resident had sustained a fall and was having left arm/back pain. Physical therapy was to evaluate the appropriateness of

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the Sit to stand mechanical lift.

On 5/26/22 a progress note was entered into the record noting that the interdisciplinary team had met and the full body mechanical lift would be used at the time, and physical therapy would see the resident after the x-rays were complete.

On 5/30/22 at 2:50 PM Nurse # 4 documented Resident # 10 was very emotional that day and refused to be lifted in the full body mechanical lift. Nurse # 4 noted Resident # 10 was holding her urine and stool until she was incontinent and it was explained to her that she was not strong enough to use the sit to stand lift.

On 5/30/22 physical therapy noted they had worked with Resident # 10 again on the use of the sit to stand lift; and that she was refusing the full body mechanical lift. According to the therapy notes, it was discussed that a bedside toilet would be placed at the bedside so that the time in the sit to stand lift would be lessened and enable Resident # 10 to use it.

On 5/31/22 at 7:05 AM Nurse # 3 documented that Resident # 10 refused to use the full body Mechanical lift.

According to documentation, the facility physical therapist presented inservice training on 5/31/22 specific for Resident # 10 and transfers with the sit to stand mechanical lift. Ten staff members signed as attending.

On 6/5/22 at 10:44 PM, Nurse # 5 documented Resident # 10 had been lowered to the floor by a NA while using the Sit to stand lift and was without injuries.

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On 6/5/22 Resident # 10's care plan was updated to reflect that staff would be reeducated about the use of the sit to stand mechanical lift.

NA # 4 was the NA who had cared for Resident # 10 on 5/25/22 when she slipped out of the sit to stand lift. NA # 4 reported the following. NA # 4 was told that she had not secured Resident # 10 correctly in the sling somehow after the incident. NA # 4 was interviewed regarding if she had received training about the mechanical lifts and stated she may have when she was first hired but could not recall for certain. She had not received any training since the incident.

NA # 6 was interviewed on 6/17/22 at 1:31 PM and reported the following. During the end of May while caring for Resident # 10 she and another NA were using the full body mechanical lift with Resident # 10, and the lift kept going when they wanted it to stop. It got stuck in the bathroom door frame and would not come down with the resident in the lift. The NA did not know what had happened to the lift. NA # 6 reported she had not been to inservices about mechanical lift transfers since 5/29/22.

On 6/20/22 at 2:43 PM, it was confirmed with the Administrator that the day the resident got stuck in the lift was on 5/27/22, and the lift was taken out of service at that time. On 6/21/22 at 11:10 AM during a follow up interview with the Administrator and the DON, the DON and Administrator reported the lift was stuck in the doorframe so that they could not use the emergency release. It had kept going up while the resident was in the doorframe, and the doorframe blocked access to the emergency release control.

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	345363	A. BUILDING _____ B. WING _____	C 06/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASS HEALTHCARE AND REHAB HAWFIELDS, INC	2502 S NC 119 MEBANE, NC 27302

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Nurse # 4 was interviewed on 6/17/22 at 3:56 PM and reported Resident # 10 did not like the full body mechanical lift, and that being stuck in it when it malfunctioned may have contributed to this. She also thought that having no control while in it disturbed the resident and might also have contributed to her not wanting to use it.

The Rehabilitation Director was interviewed on 6/17/22 at 3:27 PM and reported the following. Resident # 10 was currently a sit to stand mechanical lift. Following the incident on 5/25/22, they had tried her in the full body mechanical lift but the incident of 5/27/22, during which she got stuck in it, scared her and she refused to use it. Therapy had then worked to get her a bedside toilet so that they could use the sit to stand lift and get her on the bedside toilet quicker when compared to using the lift to get her all the way in the bathroom. This enabled her to hold on to the sit to stand lift for the shorter time frame needed to get to the BST when compared to getting to the toilet. Thus Resident # 10 was once again made a sit to stand mechanical lift, and the therapist thought this was appropriate.

The nurse, who had worked on 6/5/22, was interviewed on 6/17/22 at 3:10 PM and reported the following. On that date (6/5/22) the NA had gotten the resident into the sit to stand lift. The resident turned loose and then they had to lower her to the floor.

Resident # 10 was interviewed on 6/21/22 at 10:15 AM. The resident could not recall the incident where the lift malfunctioned and kept going while she was in it. She stated she felt safe in the lifts.

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A representative for the manufacturer of the mechanical lifts was interviewed on 6/17/22 at 4:30 PM and reported the following. If everything is used correctly then a resident cannot fall out of the mechanical lift. This would entail making sure the correct sling is used; the correct lift is used based on the resident's weight and abilities; and that the lift is used according to manufacturer's instructions. If the facility had multiple accidents involving mechanical lifts then it sounded as if a lot of it could be attributed to user error. The lifts should also not keep going when the operator wanted it to stop or get stuck if the operator wanted it to stop when used correctly and maintained correctly. The lifespan of a lift is 10 years. After that the parts do not work as well and the parts become obsolete. There are recommended maintenance specifications and the manufacturer technicians know to check for these things on a routine basis if the facility has a contract with them. Some facilities have contracts and others check their own equipment and are responsible for the proper functioning. Specifications for the lifts are in a manual. There is a certain amount of torque needed for different bolts of the mechanical lifts. According to the manufacture's representative, both maintenance of the lifts and the proper amount of training are key factors in preventing accidents with them.

According to an interview with the Administrator on 6/16/22 at 4:30 PM, the facility did not currently contract with the mechanical lift manufacturer for routine checks and maintenance.

On 6/20/22 at 2:43 PM the Administrator provided information that the facility's mechanical lifts were

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approximately 15 years old.

Interview with the facility's maintenance director on 6/15/22 at 4:25 PM revealed he did not have a set schedule of checking the lifts but that he did do so when they were broken. At that point he would check the entire lift before putting it back into service. The maintenance director felt all the lifts had been checked at some point within the past year for safety. During a follow up interview with the maintenance director on 6/21/22 at 4:40 PM, he stated he had downloaded the list of specifications of the lifts from the manufacturer's website and started weekly checks on 6/17/22. He had never been able to identify the issue with the mechanical lift that got stuck in Resident # 10's doorframe on 5/27/22. It appeared to have been an electrical issue of some nature; which he felt could have happened with a new or older lift. Prior to the incident, he had not been made aware there had been any problems with the lift. The maintenance director felt as if the incident may have happened regardless of whether scheduled checks were being done because sometimes electrical problems occur with no prewarning.

Resident # 10's physician, who serves as the facility medical director, was interviewed on 6/21/22 at 2:40 PM and reported that Resident # 10 was checked after her incidents and did not seem to be experiencing any more pain than was her usual chronic pain. The physician felt as if the resident had not experienced any serious injury from her fall or when she was assisted to the floor. The physician also reported the resident was an anxious type of individual.