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	345408	A. BUILDING _____ B. WING _____	C 03/17/2023

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BRIAN CENTER SOUTHPOINT	6000 FAYETTEVILLE ROAD DURHAM, NC 27713

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F 000	INITIAL COMMENTS A compliant survey was conducted from 03/15/23 through 03/17/23 The following intakes were investigated NC00199459 and NC00198668, NC00198033. One of nine allegations resulted in deficiency. Intake NC00197305 resulted in immediate jeopardy. Past-noncompliance was identified at: CFR 483.12 at tag F689 at a scope and severity (J) The tags F 689 constituted Substandard Quality of Care. Non-noncompliance began on 1/17/23 . The facility came back in compliance effective 1/30/23. A partial extended survey was conducted.	F 000		
F 689 SS=J	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, observations, staff interview, family interview, resident and physician interview the facility failed to safely transfer a resident while using a mechanical lift for 1 of 3 sampled residents (Resident #6) reviewed for accidents. The result of the unsafe transfer was	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 04/05/2023

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.

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the resident fell from the lift and as a result of the fall Resident #6 experienced a hematoma to the left side of her forehead and pain to the left side of her body which the resident rated her pain as a 10 on a 0-10 scale to the nurse. Resident #6, who was on an anticoagulant, was transported and evaluated in the Emergency Department (ED) because there was a high likelihood of bleeding in the brain due to the injury.

The findings included:

Resident #6 was admitted to the facility on 12/23/2022 with diagnoses that included hemiplegia and hemiparesis affecting her left non-dominant side, muscle weakness, epilepsy, and Resident #6 was discharged from the facility on 1/24/2023.

Review of Resident #6's physician ordered dated 12/23/2022 included Eliquis (anticoagulant) 5 milligrams (mg) by mouth every 12 hours.

Care Area Assessment (CAA) for Resident #6 dated 1/4/2023 revealed Resident #6 required and received extensive to total assistance of 1-2 staff for mobility and activities of daily living. Resident #6 was unable to ambulate or maneuver a wheelchair and required a mechanical lift for transfers into the wheelchair. The CAA further revealed Resident #6 was cognitively intact and able to make her needs known.

The 5-day Minimum Data Set (MDS) assessment dated 1/5/2023 revealed Resident #6 was cognitively intact, was extensive assistance of 2+ staff with bed mobility, dressing. Required extensive assistance of one with toilet use and

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hygiene, total dependent on one staff for bathing, and totally dependent on 2+ staff for transfers. Surface to surface transfers she was not steady, only able to transfer with staff assistance and was impaired in range of motion on one side of both her upper and lower limbs.

A telephone interview with NA #1 on 3/15/2023 at 3:59 PM revealed on 1/17/2023 she recalled the incident in which she independently used a mechanical lift while transferring Resident #6 from her wheelchair to her bed. NA #1 stated she recalled Resident #6 being in her wheelchair on a red trimmed sling and identified the red trim sling as being a size small. Resident #6 required total assistance with the mechanical lift and a blue trimmed sling (large). NA #1 stated the reason she used the red trimmed sling (small) was because Resident #6 was adamant about getting back into bed and was actively sliding from her wheelchair. There was no one to assist who was visible on the hall and she proceeded to hook the sling up to the mechanical lift. While the resident was elevated, NA #1 indicated when turning the mechanical lift towards the bed Resident #6 fell to the floor by sliding out headfirst from the side of the sling. She stated she assumed the reason Resident #6 had fallen was because one of the loops on the sling had become detached from the mechanical lift. After Resident #6 had fallen, staff were present, and a nurse assessed Resident #6 for injury. NA #1 stated she knew the sling was the wrong size and she was to have another staff member present when operating a mechanical lift. The facility had provided her mechanical lift training prior to the incident and two staff were to be used when transferring a resident with a mechanical lift, which she had been told was policy.

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An incident report written by Nurse #1 was reviewed dated 1/17/2023 at 2:31 PM revealed Resident #6 experienced a fall during a mechanical lift transfer using a sling from the wheelchair to her bed. The incident report further revealed Resident #6 was oriented to person and situation. Resident #6's description of the incident was that she slid and fell. The action taken by the facility was that Resident #6 was evaluated by the Nurse Practitioner (NP) and orders were obtained to send the resident to the Emergency Department (ED) for further evaluation. The injuries observed at the time of the incident were described as pain/discomfort to her face and scalp. Resident #6's pain was rated at a 10 on a scale of 1 to 10. The incident report revealed the precipitating factors were use of mechanical lift and mechanical lift malfunction. The witness identified in the report was Nursing Assistant (NA) #1.

Review of nursing note dated 1/17/2023, Nurse #1 indicated Resident #6 experienced a fall during a mechanical lift transfer from the wheelchair to her bed. The Nurse Practitioner was on site to evaluate Resident #6, and orders were received to send resident to the ED for further evaluation, Resident #6 was noted to have a head injury (hematoma-collection of blood/fluid under the skin) and complaints of pain to the left side of her body. The nurse's note further indicated upon entering Resident #6's room she was noted laying on the left side of her body at the foot of her bed. Resident #6 had a closed hematoma noted to the left side of her head with no loss of consciousness.

On 3/15/2023 at 3:02 PM an interview was

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conducted with Nurse #1. She stated Resident #6 was residing on the hall she was assigned on 1/17/2023 and she was working at the time Resident #6 fell from the mechanical lift. Nurse #1 stated she did not witness the fall but recalled being notified by NA #1 that Resident #6 was on the floor. When Nurse #1 entered Resident #6's room Resident #6 was laying on her left side and an egg size hematoma was noted to the left side of her head. Nurse #1 revealed it appeared as though Resident #6 had fallen from the mechanical lift and there was only one staff present. Nurse #1 stated when she inquired as to why NA #1 did not get assistance for a two-person lift, NA #1 provided no response. The Director of Nursing (DON), Assistant Director of Nurse and Physician were notified of the fall and the improper transfer performed by NA #1.

Review of the Interdisciplinary Post Fall Review dated 1/17/2023 indicated there was a witnessed fall. The description of the fall stated Resident #6 fell during a mechanical lift transfer as stated by NA#1. The mechanical lift sling was too small, and Resident #6 slid out of the sling. As a result of the fall Resident #6 was sent to the ED for evaluation and neurological checks were initiated when Resident #6 returned to the facility. The intervention recommendations stated to utilize 2 persons for mechanical lift transfers.

Physician progress by the facilities Physician Assistant note dated 1/17/2023 revealed Resident #6 was seen due to a fall from a mechanical lift. Resident #6 landed on her left side on the floor and had a baseball size hematoma to her left forehead. Resident #6 reported having a lot of pain to the left side of her head. The progress note further revealed

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Resident #6 was sent to the ED for Computed tomography (CT) of the head (a noninvasive medical exam or procedure that uses specialized X-ray equipment to produce cross-sectional images).

Review of the Emergency Provider notes dated 1/17/2023 revealed that Resident #6 presented to the hospital following a fall. The summary stated Resident #6 had been transferred from a mechanical lift to her bed when she fell to the ground from approximately bed height. Resident #6 complained of right sided facial pain, denied loss of consciousness and any other neurological defects. Resident #6 was on an anticoagulant with apixaban (Eliquis) 5 mg. Further review of the report revealed Resident #6 received a (CT) scan of the brain and cervical spine both without contrast were negative for bleeding and fractures. Resident #6 was administered Tylenol at 8:57pm and Lyrica at 8:56pm on 1/17/2023 and was discharged back to the facility on 1/18/2023 at 2:18 AM.

On 3/16/2023 at 2:40 PM an interview was conducted with the physician. He stated he was made aware of the incident in which Resident #6 fell from the mechanical lift on 1/17/2023. Resident #6 was sent to the ED for a CT scan due to hitting her head and receiving an anticoagulant. A patient could suffer bleeding in the brain related to the injury and being on the anticoagulant medication which is why a CT scan was performed.

An interview with DON on 3/15/2023 at 5:05 PM revealed when using a mechanical lift there were to be two staff present per policy. On 1/17/2023 it was reported that Resident #6 had a fall from a

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mechanical lift that was being operated by one staff per person. During the investigation it was identified that NA #1 used the wrong size sling and operated the mechanical lift without getting assistance. It was further identified during the investigation that NA #1 did not obtain the correct size sling and should have located a blue sling (large) prior to transfer. As a result of Resident #6 fall from the mechanical lift she sustained a bump to the left side of her head and was sent to the ED. Resident #6 was also sent to the ED due to receiving to anticoagulant therapy, medication to help prevent blood clots, to rule out a subarachnoid hemorrhage, bleeding in the space between the brain and tissue covering the brain.

The Administrator was notified of the Immediate Jeopardy on 3/16/2023 at 1:00 PM. The facility provided a plan of correction on 3/17/2023 at 8:35 AM which alleged a date of compliance of 1/30/2023. The corrective action plan indicated.

The procedures for implementing the acceptable credible allegation for the specific alleged deficiency.
1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice

On 1/17/23at approximately 11am, Resident #6 was being transferred to a mechanical lift with 1 nurse aide (NA). Resident was getting prepared to go back to bed and she had a mechanical lift sling underneath her. NA was transferring residents from the wheelchair to the bed with the mechanical lift. She did not have another aide with her. Resident slipped from the lift pad and slipped to the floor and hit her head. Witnessed

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event. A visible head injury noted at the time and resident did complain of some head pain. The assigned nurse did enter the room right at the time of the incident and witnessed her fall as well. Nursing did an immediate assessment, Nurse Practitioner was notified immediately, and orders were given to transfer resident #6 for medical assessment and evaluation. Responsible party notified of incident. She was transported to the ER for evaluation of head pain and returned to the facility 1/18/23 at 8:30am - with no change in orders upon return. All diagnostic testing was completed, including advanced imaging with no acute fractures, bleeds or severe injuries noted. Employees involved with this incident was immediately removed from the building and removed off the schedule, pending this investigation and credible allegation investigation.

Resident #6 was previously assessed for transfers, and it has been determined her safest way to transfer out of bed was via a mechanical lift with a blue sling. Resident is not currently on Therapy caseload. Transfer evaluation completed with the most recent one with assessment date of 12/23/22, indicates total dependency in her transfer status with use of a blue sling. Resident #6 transfer status did not change after the 1/17/23 incident.

An incident report and SBAR (in-house assessment tool used to notify the physician) was completed on 1/17/23.

Resident #6 will be monitored closely for any changes in skin integrity, bruising, any increased pain, or swelling/redness to the head. Pain assessments will be completed per protocol to ensure proper pain monitoring and treatment.

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Any pain (if any related to this incident) will be evaluated daily by nursing and proper interventions put in place if indicated. Her transfer status did not change.

Root cause reveals that the 1 NA did not follow facility policy for transfers, and she did not ensure the mechanical sling was the rights size and properly placed under the resident while in her wheelchair. She did not operate the mechanical lift per the manufacturer's guidelines when lifting her with the remote device.

2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice

The Director of Nursing and Assistant Director of Nursing immediately audited 100% of all resident's current transfer assessments to ensure all residents were being transferred according to their most recent transfer assessments with correct sling size. Any discrepancies were corrected immediately to include new transfer assessment and correct sling size to be used. DON/ADON conducted a facility sweep to ensure all equipment needed for transfers were functioning properly. This was completed on 1/17/23.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
DON/ADON initiated education (verbal and written instruction) on 1/17/23 and completed on 1/19/23, with current licensed nurses and NAs to include contract agency staff. Education included Facility Policy on use of the mechanical lift

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emphasizing two (2) staff members required for all transfers with mechanical life, right pad/sling size and color of the sling to use, location of list of residents requiring Mechanical Lift Transfer, and competency validation. No staff shall work after 1/17/23 before receiving this education and competency (This includes contract agency staff). This education and competency have been included in the Facility Orientation program for new hires and contract agency staff.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed
DON/ADON/Designee will randomly audit 3 residents daily using the "Mechanical Lift/Sling Competency Audit Tool" for 12 weeks to ensure residents are being transferred appropriately with 2 staff members and correct pad size/color.
The interdisciplinary team (IDT) which included the NHA, DON, Medical Director, District Director of Clinical services, VPO, Unit Coordinator, and Rehab Manager met on 1/18/23 for an ad hoc Quality Assurance Performance Improvement Committee Meeting to conduct a root cause analysis of the events surrounding Resident's #6 incident regarding the transfer incident on 1/17/23. The IDT determined that resident # 6 has a prior history that requires Mechanical Lift transfers for all modes of out of bed status.

The results of these audits will be tracked and trended then forwarded to the Quality Assurance Performance Improvement Committee monthly x 3 months by the Director of Nursing for any concerns and recommendations.
Administrator and Director of Nursing is responsible for the completion of this POC.

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F 689	Continued From page 10 Date of Compliance: 1/30/23 The facility provided a plan of correction for the incident that happened on 1/17/23. The facility corrected the deficient practice on 1/30/23. The corrected action was as follows: As part of the validation process on 3/16/23 thru 3/17/23 the plan of correction reviewed including re-education of staff and observation of interventions put into place to ensure correct use of the slings and correct lift status. Resident #6 was not in the facility at the time of the investigation. Observations were made of other residents who required mechanical lifts and transfers were all conducted according to the Manufacturer's instructions. Interviews with staff revealed they were retrained to select the correct sling size. A review of the monitoring tools revealed that the facility completed the audits of residents who required mechanical lift transfers. The facility's alleged date of compliance for accidents was validated to be effective 1/30/2023.	F 689		