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F 000	INITIAL COMMENTS An unannounced complaint investigation was conducted on 01/03/24. Event ID #8R7E11. The following intake was investigated: NC00210657. 1 of 1 of the complaint allegation resulted in deficiency. Past non-compliance was identified at: CFR 483.25 at tag F689 at a scope and severity (G) Non-compliance began on 09/29/23. The facility came back in compliance effective 10/02/23.	F 000		
F 689 SS=G	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 observations, record review, and staff and resident interviews, the facility failed to provide a safe transfer when a resident (Resident #1) fell from a mechanical lift while being transferred by Nurse Aide #1 and Nurse Aide #2 and sustained a 10-centimeter laceration to the right ankle requiring 9 sutures, a contusion to the left wrist and left shoulder, and pain as a result of the fall for 1 of 3 residents observed for falls. Findings included:	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 01/18/2024

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Resident #1 was admitted to the facility on 06/08/23. Resident #1 had a diagnoses of congestive heart failure and hypoxia. The Minimum Data Set (MDS) quarterly assessment dated 09/21/23 revealed Resident #1 was cognitively intact and demonstrated no behaviors. Resident #1 required total dependence with two person physical assistance with transfers and did not receive anticoagulant (blood thinner) medication. Resident #1's weight was recorded as 199 pounds.

A review of Resident #1's care plan dated 09/21/23 revealed Resident #1 had a plan of care for activities of daily living/personal care with a goal that care would be completed with staff support as appropriate to maintain or achieve highest practical level of functioning. Interventions included, in part, two staff assistance required with extra-large mechanical lift and extra-large lift pad. A plan of care was also in place for at risk for falls with a goal that Resident #1 would be free of fall related injuries. Interventions included, in part, to observe and intervene for factors causing falls such as bowel and bladder needs, mobility, and transfers.

The MDS quarterly assessment dated 12/08/23 revealed Resident #1 was cognitively intact, demonstrated no behaviors and was coded as having one fall with injury (not major).

A review of a nursing progress note written by Nurse #1 on 09/29/23 at 7:21 PM revealed this nurse was called to the resident's room by the nursing assistant. Resident was noted lying on the floor next to the bathroom door with the mechanical lift pad under her. Resident was alert

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and talking and she stated she was having pain on her left side, which was the side she was laying on. There was blood around the resident's lower leg and it was noted that the resident had a laceration above the right ankle. A pressure dressing was applied to stop the bleeding. The resident was repositioned to make her more comfortable. The Nurse Practitioner ordered the resident to be sent to the hospital. Resident #1's responsible party and the Director of Nursing were notified.

Review of the Emergency Department (ED) visit dated 09/29/23 revealed, in part, Resident #1 presented with a laceration. The note indicated per Emergency Medical Services the resident was coming from a nursing home facility where staff were attempting to transfer her using a mechanical lift. The lift broke, resident fell and landed on her left side and sustained a laceration on the right lower leg. Resident was not on blood thinners and denied hitting her head. The Emergency Department Course and Medical Decision Making section revealed, in part, x-ray results were discussed with the resident and family and there were no signs of fractures. Resident was noted to have a 10 centimeter laceration to the right ankle, a contusion to the left wrist and left shoulder. Area to the right ankle was sterilely prepped and draped and anesthetized (numbed) with 1% lidocaine (a numbing medication) and 9 sutures were placed. The note indicated Resident #1 tolerated the procedure without any problems and was given pain medication and antibiotics. Resident was discharged back to the facility on 09/30/23 on antibiotics and instructions to keep the ankle area clean and dry and watch for any signs of infection and remove sutures in 10 days.

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A nursing progress note written on 09/30/23 at 3:44 AM by Nurse #2 revealed Resident #1 returned from hospital ED via emergency medical services' transport. She was alert and oriented. No complaints of pain and moved all extremities at baseline. Dressing was intact to right ankle laceration.

A follow up visit note from the Nurse Practitioner written on 10/01/23 revealed, in part, follow-up evaluation post fall of laceration to right ankle and pain. Resident reports she was sore on her left side from the mechanical lift fall and continued to have right knee pain and discomfort to right ankle laceration area. Will schedule hydrocodone-acetaminophen (narcotic pain reliever) 5-325 milligrams (mg) twice daily. Dressing was intact with no bleeding noted and she was followed by the wound nurse.

An investigation was initiated on 09/29/23. The summary written by the Administrator included Resident #1 had just finished dinner and requested to go to bed. Resident #1 was sitting in her wheelchair at the end of her bed facing the door at the time. Nurse aide (NA) #1 got the extra-large mechanical lift and the extra-large lift pad to transfer Resident #1. Before transferring Resident #1, NA #1 asked NA #2 to assist and spot her during the transfer. NA #1 hooked all the straps up and NA #2 used the remote control. NA #1 turned the resident slightly to guide her toward the bed. The NAs and Resident #1 heard a loud "pop" and Resident #1 began sliding out of the lift with her left shoulder going first toward the floor. NA #2 immediately called for the hall nurse. Nurse #1 entered the room and saw the resident laying on the floor on her left side and called a

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code green (a code to indicate a fall had occurred). The Unit Manager (UM) and Director of Nursing (DON) responded. The UM went to get the Nurse Practitioner (NP) to assess the resident immediately. Nurse #1 noted blood coming from the back of the resident's right leg above her ankle. The NP ordered a pressure dressing to be applied. Resident #1 had no complaints of pain. Resident #1 stated she did not hit her head. Range of motion of upper and lower extremities were within normal limits. The NP ordered Resident #1 to be sent out to the Emergency Department (ED) to address the laceration on her lower right leg. Resident #1 went to the ED and received 9 sutures. Resident #1 received x-rays at the ED and was negative for any fractures. Resident #1 was transferred back to the facility around 3:50 AM on 09/30/23 with a new order for Keflex (antibiotic) for infection prevention. Resident #1 did complain of pain/soreness on the morning of 09/30/23 and was given Hydrocodone. After review of the resident's record, interviews with Resident #1 and staff, and observations of return demonstration, it was determined the loop of the lift pad came out of the ring and resident slid out of the lift pad backwards. Resident #1 related she was able to catch herself with her left hand and lower herself to the floor. This action did cause a contusion of the left shoulder and wrist.

Review of a written statement by Nurse #1 written on 09/29/23 revealed "I was called to [Resident #1's] room by the nurse aide. When I arrived to the room, I observed the resident lying on the floor next to the bathroom door with the mechanical lift pad underneath her. Resident was observed to be alert and talking. She stated she was having pain on her left side. The side

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she was laying on. There was blood around the resident's lower leg and it was found that the resident had a laceration above the right ankle. A pressure dressing was applied to stop the bleeding. The resident was repositioned to make her more comfortable. The NP ordered the resident to be sent to the hospital The DON was notified and she notified the responsible party."

A phone interview was conducted with Nurse #1 on 01/03/24 at 1:21 PM. Nurse #1 reported he went to Resident #1's room and she was laying on the floor. He stated he assessed her and she was having pain on her left side. He added he applied pressure to her bleeding right ankle with towel. Nurse #1 stated after it happened there was a meeting to discuss the root cause. He stated he had understood that one of the straps to the lift pad had popped out of the ring that it would get secured too.

Review of a written statement by the Wound Treatment Nurse written on 09/29/23 revealed "I responded to the code green in the resident's room. Resident was supine [on her back] on the floor with nurse [#1] holding residents' right leg in his hands holding pressure to a laceration. No equipment or other items were near the resident. The NA stated that resident fell out of the mechanical lift when I asked how she fell. [Nurse #1] and I wrapped the wound with 4 X 4 pads and gauze. Resident was alert and responsive."

Review of a written statement by Nurse Aide (NA) #1 written on 09/29/23 revealed "I went in the room to spot [NA #2] with the transfer of [Resident #1]. We placed the straps on to the mechanical extra-large lift. We proceeded to lift her and I lifted her out of the wheelchair. I was

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instructed to lift her a little higher and the lift seemed to hesitate a little so then I gave [NA #2] the control to the lift to lift [Resident #1] higher and as we pulled her back to go to the bed, we all heard a snap and [Resident #1] was falling. My first instinct was to grab her/break the fall but it was absolutely an uncontrollable situation. She slipped out of the mechanical lift pad. I called the nurse and the nurse called EMS." An addendum to NA #1's statement written on 09/29/23 included: "I observed [Resident #1] in her room about 30 minutes prior to the fall awaiting to get back into bed. I was in the room for the fall as a spotter to assist [NA #2] with the transfer. Prior to the fall she had nonskid socks on with no clutter or wetness observed on the floor. During the fall we were using the mechanical extra-large lift on [Resident #1]."

A phone interview was conducted with NA #1 on 01/03/24 at 1:42 PM. NA #1 reported she had gone in to spot NA #2 with transferring Resident #1 from her wheelchair to the bed with the extra-large mechanical lift. NA #1 stated she and NA #2 secured the straps of the lift pad to the hooks on the mechanical lift. NA #1 stated she was standing beside Resident #1 spotting her and NA #2 proceeded to lift Resident #1 with the remote control. NA #1 stated she had asked NA #2 to lift Resident #1 a little higher from her wheelchair and the lift seemed to hesitate a little so NA #2 gave her the remote control. NA #1 stated NA #2 pulled the lift away from the wheelchair and began to roll her towards the bed. She stated at that time, she and NA #2 and the resident heard a snap and Resident #1 started falling out of the lift pad on her left side. NA #1 stated her first instinct was to grab Resident #1 to prevent her from falling but it was absolutely out

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of her control and Resident #1 slipped out of the lift pad. NA #1 stated she was certain the straps were secured to the rings on the mechanical lift and was not certain how the resident could have fallen out of the lift. NA #1 stated she had been educated on how to safely transfer a resident when she was first hired on 09/05/23. NA #1 stated she received additional education with return demonstrations after this happened with Resident #1.

Review of a written statement by NA #2 written on 09/29/23 revealed "Around 6: 00 PM [NA #1] came in to spot me with the transfer of [Resident #1] from her wheelchair to the bed with the mechanical lift. We placed the straps onto the lift. We proceeded to lift her and I was spotting her when she was being lifted from the wheelchair. I asked [NA #1) to go a little higher. The lift seemed to hesitate a little so [NA #1] gave me the remote control. [NA #1] pulled her back toward the bed. We all, including the resident, heard a snap and [Resident #1] was falling. Our first instinct was to grab her from falling but it was absolutely out of our control. [Resident #1] slipped out of the lift pad. [NA #1] called for the nurse and I called for a code green. Nonskid socks were on, the floor was free of clutter and dry. I was using the mechanical extra-large lift with resident and another aide when she fell."

A phone interview was conducted with NA #2 on 01/03/24 at 1:27 PM. NA #2 reported Resident #1 was in her wheelchair and she and NA #1 hooked her up to the extra-large mechanical lift and while she was going up NA #2 was right next to her and NA #1 was lifting her up slowly with the remote control and they heard a snap and noticed that one of the sides of the lift pad fell off and

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Resident #1 was dangling out of the lift pad. NA #2 stated Resident #1 was not very high up from her chair, and added, her buttocks was level with the wheelchair arm. NA #2 explained that the straps on the lift pad have upper support straps that support the back and lower support straps that supports the legs. NA #2 stated there were rings that she would hook the strap too and the strap hook would get secured in the ring. NA #1 stated somehow the top left strap of the lift pad had snapped off while Resident #1 was on the lift and she fell out onto her left side. NA #2 stated her legs were still secured, but she slipped out and fell to the floor. NA #2 stated she did not know how it happened and swore she had secured the hooks in the rings. NA #2 stated it all happened so fast, she did not know if it was the actual lift malfunctioning or the lift pad, but somehow the lift pad got loose. NA #2 believed the laceration to the right ankle may have been caused by hitting the bottom of the lift legs when Resident #1 went down. NA #2 stated both aides, the Unit Manager and the DON tried to figure out what happened. There was no disrepair noted to the extra-large mechanical lift or the extra-large lift pad, but the DON took that mechanical lift off the floor to be checked out. NA #2 added, Resident #1 was in the appropriate extra-large lift pad. She was assigned to a green pad with a black stripes. NA #2 stated she received her yearly education regarding safe resident handling on 06/09/23 and was again in serviced on 09/30/23 with a return demonstration.

An interview was conducted with Resident #1 on 01/03/24 at 11:40 AM. Resident #1 was alert and oriented and was lying in bed. She reported on 09/29/23 there were two aides in the room transferring her from the wheelchair with the

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mechanical lift to get her back to bed. Once she was in the mechanical lift and was raised up she heard a "snap or a pop" and she fell out to left side of the lift. She stated they used a green pad with black stripes which fit her and that was the pad they always used. She stated she did not fall straight down and that she actually fell out of the pad to her left side and put her left arm out to break the fall. She stated the mechanical lift did not fall, in fact, it did not even budge. She stated they quickly got the nurse and she had a wound to her right ankle but she was not certain how she got the wound which required 9 sutures and was bleeding. She stated she had never fallen from the mechanical lift before. She stated she did not have any pain to her ankle at that time, but her left side hurt and they put a pillow under my head for comfort. Resident reported she did not know what happened or how it happened. Resident #1 stated the two aides were not rushing while they were trying to transfer her.

An observation of a transfer with the extra-large mechanical lift on Resident #1 was done on 01/03/24 at 2:00 PM with NA #3 and the Unit Manager. NA #3 was observed placing the green pad with a black stripes labeled extra-large under Resident #1 while she was lying in bed. The lift pad showed no signs of poor condition. The Unit Manager and NA #3 rolled the mechanical lift which was numbered "0" to position over Resident #1. NA #3 crissed crossed the lower straps and secured each hook noted on the end of the strap to a ring on the mechanical lift. NA #3 then raised the right strap by the Resident's shoulder and secured the hook on the end of the strap to a ring on the mechanical lift and repeated the same way with the left strap. The hooks were noted to lock in place and the rings were noted to

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only be moved inward toward the mechanical lift frame. Once the hook was in the ring, the ring would not move outward - away from the mechanical lift frame. Resident #1 was noted to fit in the lift pad securely. The Unit Manager used the remote control to raise Resident #1 and once she was above the bed, she moved the lift away from the bed and toward the secured wheelchair next to the bed while NA #3 guided Resident #1 with her hands holding on to the resident and the lift pad. The UM and NA #3 positioned Resident #1 over the wheelchair and the UM began to slowly lower her in the wheelchair while NA #3 guided the resident into position. Once seated, the hooks were unhooked from the rings on all four corners.

An interview was conducted with the Assistant Maintenance Director on 01/03/24 at 2:00 PM. The Assistance Maintenance Director stated he did lift inspections to all lifts monthly which included cleaning the hair out of the wheels, checking the wheels for any damage, ensuring the guards (protective case) were on all the wheels, checked the remote to ensure it was in working order and the up and down buttons were working, making sure the battery was charging, and making sure all the rings that the straps were hooked on to were intact and not loose on all 4 points of the lift. The Assistant Maintenance Director stated he kept a log to ensure all the lifts were inspected and each of the 10 mechanical lifts were numbered. He stated after this event happened with Resident #1, the lift and the lift pad were immediately removed the floor so that he could inspect them. The Assistant Maintenance Director reported he inspected mechanical lift numbered "0" which was brand new in July 2023 and he could not find anything

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wrong with it. There was nothing noted to be in disrepair. The Assistant Maintenance Director stated he placed weighted materials on the lift pad, and secured the straps to the rings as though a resident was in the lift pad. He stated he raised the lift pad all the way up with the remote control and the straps remained secured in the rings. During this interview, the number 0 mechanical lift was inspected with the Assistant Maintenance Director and there was no disrepair to the mechanical lift noted. The rings that the mechanical lift straps clip into were noted to go inward and were not able to fold outwardly. The Assistant Maintenance Director stated the only way the strap would come out is if it was not securely clipped in.

A maintenance log from June 2023 to September 2023 revealed monthly inspections of each numbered mechanical lift were being done. The dates the inspections were done were: 06/08/23, 07/25/23 (indicating lift number "0" was new), 08/07/23, 09/25/23, 10/02/23, 11/08/23 and 12/14/23.

An interview as conducted with the Administrator on 01/03/24 at 3:13 PM. She stated she was in the facility when Resident #1 fell from the mechanical lift. She stated she, the Unit Manager and the DON went to Resident #1's room immediately to see what had happened. She added, she immediately took the mechanical lift out of service and had the Assistant Maintenance Director do a full inspection. She stated at that time he had also checked all the other mechanical lifts to be sure they were in working order. The Administrator stated after reenacting the event the only conclusion they could come up with was that the lift pad hook was not fully

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(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
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secured in the ring. The Administrator added, the ring would not pull out and would only push in with the force of putting the strap inside. She stated the mechanical lift was brand new in July and there were no signs of disrepair to the mechanical lift or the lift pad. The Administrator stated she brought both NAs into the room and had them show her how they hooked up Resident #1 and the process they went through. She stated, based off the reenactment it looked like they did everything correctly which was why we thought the actual strap did not get secured in the ring. The Administrator stated the lift pad went with Resident #1 when she was sent to the hospital and it was never returned back, but stated she looked over the lift pad and there were no rips or knots noted in the pad. The Administrator stated she initiated a plan of correction immediately to include education on safe handling and movement and return demonstrations. The Administrator stated we closed it out in December but continue to do random competency checks utilizing the questionnaire and return demonstration.

The facility provided the following corrective action plan:

F689 Failure to provide supervision to prevent accidents:

1. The facility identified how correction action will be accomplished for those residents to have been affected by the deficient practice:

Resident #1 sustained a fall from a mechanical lift on 09/29/23. Resident was immediately assessed by Nurse #1, the Nurse Practitioner, and the Wound Treatment Nurse. Resident #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345119	A. BUILDING _____ B. WING _____	C 01/03/2024

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was noted to have a laceration to her right ankle and a pressure dressing was ordered and applied. Resident #1 was sent to the Emergency Department for further evaluation. Resident #1 returned to facility with 9 sutures to her right ankle and was started on an antibiotic for infection prevention and pain medicine for pain control. The mechanical lift used for the transfer and all the other mechanical lifts were removed from the floor and immediately inspected by the Assistant Maintenance Director. Nurse Aide #1 and Nurse Aide #2 were provided additional in servicing regarding safe resident handling and provided a return demonstration for understanding on 09/30/23.

2. The facility identified other residents having the potential to be affected by the same deficient practice:

Review of documentation to ensure there were no mechanical lift accidents in the past 30 days. An audit was completed of all mechanical lifts and lift pads. There were no issues identified. An audit of all falls were conducted. There were no falls related to mechanical lifts. Care plans were updated for all residents to include independent residents, stand by assist residents and one or two person assist residents for all transfers indicating the use of a mechanical lift, the type of mechanical lift and size of the lift pad. A 100 % skin assessment audit on non-alert and oriented residents was completed. A resident questionnaire was utilized for the alert and oriented residents regarding using a lift during transfers and if there had been any concerns. No concerns were noted. This was completed on 09/30/23.

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3. The facility implemented systemic changes to ensure that the deficient practice will not recur:

The Administrator and Director of Nursing conducted in services on safe resident handling and movement with return demonstration for all nursing staff. The in services and demonstration would be completed by 09/30/23. After 09/30/23, nursing staff who did not receive in services and provide return demonstration will have this completed prior to the start of their shift. Additional education was provided by the DON on 09/30/23 regarding mechanical lifts safe handling to include always ensure the mechanical lifts are in proper working order and the lift pad was intact before using the mechanical lift, make sure the straps were secured in the ring, always use the proper size lift pad, and refer to the care plan before transferring a resident. A staff questionnaire was provided to all staff to ensure understanding. All nursing staff were in serviced as of 10/02/23.

4. The facility plans to monitor its performance to make sure that solutions are sustained:

Weekly monitoring for 4 weeks and then monthly for 1 month was conducted for observations of mechanical lift use to include the resident name, date, type of lift, if the care guide was reviewed prior to transfer, if the transfer was done properly and if there was reeducation needed.

The Administrator and the Director of Nursing would review the transfer audit tools weekly for 4 weeks then monthly for 1 month for completion and to ensure that any areas of concern were addressed. The Administrator and DON will forward the results of the transfer audit tools to

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the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 2 months. The QAPI committee will meet monthly for 2 months to review the transfer audit tools to determine trends and or issues that may need further interventions put into place and to determine the need for additional monitoring (NOV/DEC).

Validation of the corrective action was completed on 01/03/24. This included staff interviews with nurses, nurse aides, and medication aides. Return demonstration of a mechanical lift transfer with nursing staff. Observation of all the current mechanical lifts and lift pads to ensure no disrepair. Review of other residents' medical records who required a mechanical lift for transfers to ensure there were no falls with injury with the lift. Care plans were reviewed to ensure they were updated to reflect residents' care. A review of the signature sign in sheets to affirm all nursing staff received education regarding utilizing mechanical lifts safely.

The facility's alleged compliance date of 10/02/23 was validated.