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L 000	INITIAL COMMENTS An onsite state licensure complaint investigation survey was conducted from 07/15/25 through 07/16/25. Additional information was obtained offsite on 7/17/25. Therefore, the exit date was changed to 7/17/25. The following intakes were investigated NC00231743, NC00220826 and NC00202922. 1 of the 3 complaint allegations resulted in deficiency. Event ID# NUHF11.	L 000		
L 039	.2208(E) SAFETY 10A-13D.2208 (e) The facility shall ensure that: (1) the patients' environment remains as free of accident hazards as possible; and (2) each patient receives adequate supervision and assistance to prevent accidents. This Rule is not met as evidenced by: Type B Violation Based on observations, record review, and Medical Director and staff interviews, the facility failed to provide a safe transfer for Resident #1 using a mechanical lift when during a transfer from the bed to a care foam (tilt in space) chair, the lift tipped over and Resident #1 fell to the floor sustaining an acute non-displaced right tibia (shin bone) and fibula (bone located on the outside of the lower leg) fracture. This deficient practice occurred for 1 of 3 residents reviewed for	L 039		

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accidents.

The findings included:

The manufacturer's instruction manual for the mechanical lift provided by the facility read in part: The safety instructions noted that unbalanced lifting posed a risk of tipping and provided illustrated instructions to widen the legs of the lift for balance during transfers to and from a chair/toilet seat. The safety instructions also noted to maneuver the lift using the handles, and not to apply force to the lift arm or mast to maneuver the lift as it may cause a tilting hazard.

Resident #1 was admitted to the facility on 7/09/21 with diagnoses including dementia, repeated falls, and osteopenia (decrease in bone density).

The nursing assessment summary dated 6/10/25 revealed Resident #1 was severely cognitively impaired, was dependent on staff for all activities of daily living (ADL) and required the use of a mechanical lift for transfers.

The care guide dated 6/17/25 indicated Resident #1 required 2-person assistance and the use of a mechanical lift for all transfers.

An incident report dated 6/18/25 at 7:30 AM completed by the Nursing Supervisor revealed Nurse Aide #1 (NA) and NA #2 were using the mechanical lift to transfer Resident #1 from the bed to the care foam chair. NA #1 and NA #2 reported the lift feet got caught under the chair and when trying to release them, the lift tilted over, and Resident #1 fell to the floor. Resident #1 was assessed with no injuries noted and her vital signs were stable. The Medical Director and

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Resident Representative (RR) were notified of the incident.

An interview was conducted with NA #1 on 7/15/25 at 12:42 PM. NA #1 stated on 6/18/25 at approximately 7:30 AM NA #2 requested her assistance transferring Resident #1 out of bed using the mechanical lift. She indicated NA # 2 was operating the lift and she was helping position Resident #1 over the chair. NA #1 stated NA #2 was pushing the lift into position beside the chair and she went behind the chair to make sure Resident #1 was positioned correctly. NA #1 indicated the lift suddenly jerked forward, tipped over and Resident #1 fell to the floor. NA #1 stated it happened quickly, and she was focused on Resident #1 to get her centered over the chair, so she was unable to see the base of the lift. NA #1 indicated she thought the legs of the lift got caught under the chair and NA #2 pushed the lift forward to force it loose which caused the lift to tip over. She revealed they both tried to catch the lift and prevent Resident #1 from falling to the floor but were unsuccessful. NA #1 revealed Resident #1 landed on the floor and was in a reclined seated position with her legs bent. NA #1 indicated Resident #1did not hit her head, remained in the lift sling and the sling was still hooked to the lift. She stated she stayed with Resident #1 while NA #2 went to notify the Nursing Supervisor, and she was not exhibiting any signs of pain or distress.

During a phone interview with NA #2 on 7/16/25 at 12:14 PM she indicated she was assigned to Resident #1 on 6/18/25 and at approximately 7:30 AM she requested NA #1's assistance to transfer Resident #1 out of bed using the mechanical lift. NA #2 revealed she was operating the lift and NA #1 was making sure Resident #1 was positioned

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correctly over the chair. NA #2 stated NA #1 was standing behind the chair and guiding Resident #1 into position while she was pushing the lift closer to the chair. She stated when Resident #1 was centered over the chair she widened the base of the lift and started lowering Resident #1 into the chair. NA #2 indicated when lowering Resident #1 the lift suddenly started to tipping and they tried to prevent it from falling but were unsuccessful. She stated Resident #1 fell to the floor and landed on her bottom but remained in the lift sling and the sling remained attached to the lift. She revealed she went to notify the Nursing Supervisor while NA #1 stayed with Resident #1. NA #2 indicated she did not recall any other details related to the incident, that she operated the lift per the manufacturer's instructions and was unsure what caused the lift to tip over.

An interview with the Nursing Supervisor on 7/15/25 at 2:05 PM revealed she was Resident #1's assigned nurse on 6/18/25. She stated she was administering resident medications when NA #2 came into the hall and notified her that Resident #1 had fallen. The Nursing Supervisor revealed when she entered Resident #1's room she observed her on the floor in a reclined seated position with her legs bent. She indicated the mechanical lift was tipped over, but the lift sling was still attached to the lift and Resident #1 was still in the sling. She revealed NA #2 reported to her that the lift feet got caught on the legs of the chair when she was pushing it into position and when she attempted to reposition the lift it tipped over. The Nursing Supervisor stated she assessed Resident #1 and her vital signs were stable, she had no visible injuries and was not exhibiting any signs of pain or discomfort. She indicated she notified Resident #1's RR and the

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Medical Director of the incident and continued to monitor Resident #1 closely. She stated at approximately 11:00 AM Resident #1's private physical therapist was visiting and reported to her that Resident #1 had developed bruising and swelling to her right leg. The Nursing Supervisor indicated she immediately notified the Medical Director, and she ordered x-rays which were obtained in the facility. She stated the x-ray results revealed that Resident #1 had a non-displaced right tibia and fibula fracture. The Nursing Supervisor indicated the Medical Director arrived at the facility and assessed Resident #1 and then contacted the RR to discuss treatment options. She stated Resident #1's RR did not want her transferred to the hospital for further evaluation. The Nursing Supervisor revealed the Medical Director ordered a knee immobilizer and made a referral to palliative care. The Nursing Supervisor indicated that Resident #1 had orders for scheduled pain medication which were administered and effective. She stated Resident #1 had no changes in condition following the incident and remained at her baseline. The Nursing Supervisor revealed NA #2 reported to her that the lift feet got caught on the legs of the chair when she was pushing it into position and when attempting to reposition the lift it tipped over.

A nurse's note dated 6/18/25 at 11:06 AM written by the Nursing Supervisor indicated Resident #1 had developed swelling and bruising to her right lower leg. The Medical Director was notified and gave an order to obtain x-rays of Resident #1's right leg, right hip and pelvis.

The x-ray results dated 6/18/25 at 1:16 PM revealed Resident #1 had a non-displaced right tibia and fibula fracture, and diffuse osteopenia

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was noted in the right leg, hip and pelvis bones.

The Medical Director note dated 6/18/25 indicated Resident #1 had a fall during a transfer with the mechanical lift and x-rays obtained indicated a non-displaced right tibia and fibula fracture. Resident #1 was assessed to be at her baseline and was exhibiting no signs of pain or discomfort. A phone call to Resident #1's RR was made to discuss a treatment plan, and they did not want Resident #1 transferred to the hospital and their goal was to manage her pain and keep her comfortable at the facility. An orthopedic physician was consulted by phone and recommended a knee immobilizer, and a referral was made to palliative care for pain management. Pain medication orders that were in place were noted to be effective and a new order for ativan 0.5 milligrams to be administered every 6 hours as needed for anxiety.

An interview with the Medical Director on 7/15/25 at 2:54 PM revealed she was notified on 6/18/25 that Resident #1 fell during a transfer with the mechanical lift and a few hours after the incident she developed bruising and swelling to her right leg. The Medical Director indicated x-rays were obtained and Resident #1 was diagnosed with an acute non-displaced right tibia and fibula fracture. The Medical Director stated she assessed Resident #1, and she was exhibiting no signs of pain or discomfort. She revealed she discussed treatment options with Resident #1's RR and they did not want her transferred to the hospital, so she consulted with an orthopedic physician by phone. She indicated the orthopedic physician recommended a knee immobilizer and she also made a referral to palliative care for pain management. The Medical Director stated Resident #1 has remained at her baseline, her

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pain was managed and had no changes in condition following the incident.

An interview conducted with the Director of Nursing (DON) on 7/15/25 at 2:33 PM revealed she was notified on 6/18/25 that Resident #1 fell to the floor during a mechanical lift transfer. She stated NA #2 and NA #1 reported to her the legs of the lift got caught under the chair when NA #2 was pushing the lift into position and it just fell over. The DON revealed the exact cause of the lift tipping over was unclear, but the lift was inspected and in good working order which indicated NA #1 and NA #2 did not operate the lift per the manufacturer guidelines to ensure Resident #1 was transferred in a safe manner.

An interview was conducted with the Administrator on 7/15/25 at 4:48 PM. She stated she was notified on 6/18/25 that Resident #1 fell during a transfer with the mechanical lift. The Administrator revealed nursing staff should follow the manufacturer's instructions when using the mechanical lift as well as the facility's safe handling and mechanical lift procedure to ensure residents were transferred in a safe manner.

The Administrator was notified of the Type B violation on 7/15/25 at 5:34 PM.

The facility provided the following corrective action plan with a completion date of 6/26/25.

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

Problem: Resident #1 was being transferred by Nurse Aide (NA#1 & NA #2) from her bed to her care foam (tilt in space reclining) chair with the

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L 039	Continued From page 7 use of a mechanical lift when the mechanical lift tilted over during the transfer causing the resident to sustain a fall while in the lift resulting in an acute fracture on 6/18/25. a. Use of the mechanical lift involved in transferring Resident #1 was immediately ceased following the incident and removed from the unit to the DON office to prevent use and allow for inspection by the DON on 6/18/25. DON and Assistant Director of Nursing (ADON) inspected the mechanical lift on 6/18/25. b. Head-to-toe assessment of Resident #1 was completed by charge nurse immediately following the incident and then again by DON and ADON on 6/18/25 to assess potential injury. Responsible Party of Resident #1 was notified of the incident by charge nurse on 6/18/25. c. Attending Physician (Medical Director) and Administrator were notified via telephone of the incident on 6/18/25 by DON. d. Orders received on 6/18/25 for Resident #1 to have an x ray right hip, pelvis and right lower extremity (LE) due to swelling and discoloration noted on assessment following injury. Additional orders received from MD to monitor and manage Resident #1's risk of increased pain which included Morphine 2mg every 6 hours orally as needed and Ativan 0.5 mg every 6 hours as needed. e. 1:1 NA assigned to Resident #1 by facility to assist with monitoring for increased pain/discomfort on 6/18/25 continued through 6/21/25. 1:1 was staffed by Nursing Office Manager and verified each shift by Nurse Supervisor.	L 039		

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L 039	Continued From page 8 f. Resident #1's plan of care updated by DON on 6/19/25 following results of x ray to include a 2 person assist for all ADL's and a 3 person assist for transfers with the use of a mechanical lift to stabilize right lower extremity with movement. g. Physical Therapy (PT) consulted on 6/19/25 for Resident #1, right lower leg immobilizer ordered by PT. h. Immediate re-education of staff members involved (NA #1 & NA #2) in the incident on 6/18/25 on safe handling and mechanical lift procedures/protocol. Both NA #1 & NA #2 were suspended pending investigation. i. 24 Hour initial report for allegation of neglect self-reported by facility completed and faxed to Division of Health Service Regulation (DHSR) with confirmation of receipt on 6/19/25. DON and Administrator conducted a thorough investigation into the incident and 5 Day report was completed and faxed to DHSR on 6/24/25. j. Facility QIO (Quality Improvement Outside Consulting Organization) was notified of the incident by the Administrator and DON on 6/19/25 and POC reviewed. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. a. Mechanical Lift involved in the incident was inspected to ensure proper functioning per manufacturer guidelines by DON and ADON on 6/18/25 and additionally by maintenance department on 6/20/25. No issues or concerns with the function of the mechanical lift were	L 039		

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L 039	Continued From page 9 identified upon either inspection. b. Audit of all residents who utilize mechanical lifts completed by DON and ADON on 6/19/25 to ensure care plan and task record reflected appropriate instructions. Additionally, all nursing staff records were manually audited by DON and ADON to ensure they received training on the Safe Handling and Mechanical Lift policy and procedure. An additional audit of all residents in a tilt in space reclining wheelchair (i.e. care foam, Broda or Geri chair) who require a mechanical lift to transfer was completed by DON and ADON on 6/19/25 and review of operational practices was completed by DON, ADON and Administrator on 06/19/25. c. Immediate re-education of 100% of nursing team members by DON and/or ADON (NA's, LPN's and RN's) on Safe Handling and Mechanical Lift Policy and Procedure started on 6/19/25 and completed on 6/24/25. Nursing team members were not permitted to work until re-education and validation of lift re-training was completed by DON and/or ADON. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. a. Review of existing inspection and mechanical lift maintenance schedule to ensure ongoing safety completed on 6/25/25 by DON and Administrator. Monthly inspections of all lifts by maintenance staff members are ongoing. b. Safe Handling and Mechanical Lift Policy updated 6/19/25 by DON to include a return demonstration following training by a licensed nurse and/or therapist for all team members.	L 039		

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L 039	Continued From page 10 c. Safe Handling and Mechanical Lift Training Policy and Procedure reviewed by DON and Administrator on 6/19/25 and updated to include enhanced safety protocols including a time out procedure - which includes pausing before initiating transfer in the mechanical lift by all team members involved followed by a verbalized confirmation by all staff members that safety checks have been completed. Safety checks during the time out include verifying mechanical lift slings are secure, the base of the mechanical is stable and in appropriate position per manufacturers guidelines and resident is safe and secure in the transfer sling. All Nursing Staff were educated on this updated procedure by DON and ADON and education was completed on 6/24/25. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. a. Random audits of mechanical lift resident transfers across all shifts by DON & ADON began 6/24/25 at the following frequency: 10 transfers per week x 4 weeks to be completed on 8/22/25 followed by 5 transfers per week x 4 weeks to be completed on 9/19/25 and culminating in 2 transfers per week x 4 weeks until 10/17/25 for a total audit period of 3 months. Compliance audits to be submitted to the Administrator for review weekly. b. Beginning 6/24/25 DON and ADON auditing and assessing 100% of nursing new hires weekly to ensure adequate training and compliance on Safe Handling and Mechanical Lift Policy & Procedure has been provided and validated. Compliance audits submitted to the Administrator	L 039		

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L 039	Continued From page 11 for review weekly beginning 6/24/25 and will continue for a total audit period of 3 months. c. Findings of the above audits to be brought and reviewed in QAPI committee meetings beginning during Q2 2025 meeting (July 15, 2025, 8:00am) and continuing for a period of 1 year ending July 14th, 2026. d. Safe Handling & Mechanical Lift Policy training frequency updated on 6/19/25 to include annual re-training and competency validation of all nursing team members as part of annual compliance education. Date of completion: 06/26/25 The facility's corrective action plan was validated on 7/15/25 and 7/16/25. Interviews conducted with the DON and ADON indicated that education was provided to all nursing staff regarding the facility's Safe Handling & Mechanical Lift Policy 6/19/25 through 6/24/25. The ADON stated she conducted 10 observations a week of mechanical lift transfers and completed a skills check list for the staff observed. Interviews with NAs and Nurses indicated training was provided on the Safe Handling & Mechanical Lift Policy and they were observed by the ADON using the mechanical lift. During an interview with the Maintenance Manager and Maintenance Technician they revealed the facility's mechanical lifts were inspected monthly to ensure they were in proper working order and no concerns related to the lifts had been identified. An observation conducted of a resident transfer with the mechanical lift revealed the NAs were following the manufacturer's instructions as well as the facility's safe handling & mechanical lift policy and no concerns were identified. The facility's	L 039		

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L 039	Continued From page 12 corrective action plan completion date of 6/26/25 was validated.	L 039		