STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0383	A. BUILDING: _____ B. WING _____	C 09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAN E. & MARY LOUISE STEWART H	1500 SAWMILL ROAD RALEIGH, NC 27615

(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) COMPLETE DATE
L 000	INITIAL COMMENTS A complaint investigation was conducted on 09/06/2023. Event ID# YRDV11. The following intakes were investigated NC00206548 and NC00206245. 2 of the 2 complaint allegations resulted in deficiency. Past non-compliance was identified for a Type B Violation at 10A NCAC 13D at .2208(e) SAFETY Non-compliance began on 08/15/23. The facility came back into compliance effective 08/18/23.	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 staff interviews, Nurse Practitioner interview, observation, and record review, the facility failed to safely transfer a resident from bed to wheelchair using a sit to stand lift (mechanical lift) for 1 (Resident #1) of 3 residents reviewed for	L 039		8/18/23

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accidents. On 08/15/23 during transfer with assist of 1 with a sit to stand lift by Nursing Assistant (NA) #1, Resident #1's left lower leg had contact with the bed. Resident #1 sustained a laceration to left lower leg which measured 14 centimeters (cm) in length. The resident was sent to the Emergency Department for treatment and required 15 sutures. There was a large area of skin tear with skin missing and full closure was not possible.

The findings included:

A review of the manufacturer's sit and stand patient lift and transfer instructions indicated the following procedures:
- or the lift with leg straps, lift one leg to position the sling under the thigh. Repeat for the other leg.
- Attach the underarm and leg straps, if using, securely to the lift using the attached points legs straps- short and log.

Review of the facility's policy titled "mechanical lift," dated June 2020 specified the following:
- Two staff members should be present during transfers with lift.
- One staff member is responsible for operating the equipment, other staff member stays with the resident for safety.

Resident #1 was admitted on 09/09/2022 with cumulative diagnoses of osteoarthritis and dementia.

The Annual Functional Assessment dated 07/18/2023 indicated Resident #1 had severely impaired cognitively skills for decision making, required extensive assistance with transfer with 2 people.

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L 039	Continued From page 2 Resident #1's care plan revised on 08/29/2023 indicated Resident #1 had a focus of falls, risk for related to confusion aging, poor safety awareness and impaired mobility. Review of the nurse note dated 08/15/2023 revealed that the Certified Nurse Aide (CNA) #1 called a nurse in the room indicating there was a problem and she wanted the nurse to see. The nurse went in the room, and observed a big flap wound laceration on the resident's left shin. The CNA #1 was asked what happened. CNA #1 stated she was transferring the resident from bed to the wheelchair, by using sit-to stand transferring lift. The nurse notified the unit supervisor, and the wound was cleaned, covered with an abdominal pad and a bandage. The resident was sent out to the emergency room. Review of the History and Physical dated 08/15/2023 revealed the resident was at the Emergency Room (ER) with a concern for 14 cm laceration to the left lower leg sustained reportedly in the process of being moved by a lift. On the evaluation the resident appeared with normal vital signs with exception of elevated blood pressure 211/87 (normal range 120/80). The resident appeared to be in significant discomfort until local anesthetic took effect. Plan was for fully updating Tdap (combinations of three vaccines that protect against tetanus, diphtheria, and pertussis) and be possible closure of the wound. There was a large area of skin tear with skin missing and full closure was not possible. Most inferior (lower) aspect will need to be left open to heal by secondary intent (healing takes place when the wound edges cannot be approximated and the wound needs to heal from the bottom). The plan was to refer the resident to wound care for further management.	L 039		

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L 039	Continued From page 3 Review of the ED (Emergency Department) discharge instruction dated 08/15/2023 revealed the resident was seen at the emergency department for a large laceration to left lateral leg. The resident received 15 simple sutures which were absorbable and did not need to be formally removed. There was a large wound that was unable to be closed which will have to heal by secondary intent. Review of the nurse note dated 08/16/2023 revealed ED discharge instructions were reviewed by the Nurse Practitioner (NP) in the clinic, received order to cleanse wound with normal saline, apply xeroform (yellow dressing), non-adherent pad and secure with bandage and paper tape every day. The resident's wound was assessed, sutures were in place and intact, length of the skin tear was approximately 14 cm. Wound was cleansed with normal saline, xeroform and dry dressing applied. There were no signs of infection. Per ED instructions, sutures were absorbable and did not need to be formally removed. Since Review of CNA #1's statement dated 08/16/2023 revealed she did not know what happened to the resident during the transfer. CNA #1 indicated she saw the "sit and stand" sign beside the resident's bed and knew the resident was on a lift. She went to get the sit and stand lift to transfer the resident from bed to wheelchair for supper. The CNA #1 indicated she did not know what the resident cut her leg on. She indicated the resident did not yell or cry out. She just saw the blood and knew there was a problem. She called the nurse. The CNA #1 indicated she did not apply safety straps on the resident's legs.	L 039		

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L 039	Continued From page 4 During the interview on 09/06/2023 at 2:27 PM, CNA #1 indicated on 08/15/2023, she noticed blood on the floor after she completed transferring Resident#1 from bed to wheelchair. She indicated that she used sit to stand lift to transfer the resident from bed to wheelchair. CNA #1 indicated she transferred the resident alone without the assistance of another staff and she did not apply the leg straps to secure the resident leg on the lift. CNA #1 indicated she notified the nurse about the blood and the nurse came to the resident's room to assess the resident's leg. CNA #1 indicated she was not aware that she needed to have 2 persons to assist with the sit to stand lift and, she was not aware that she needed to secure the resident's legs using the straps on the sit to stand lift. CNA #1 indicated after the incident; she was in-serviced that she required 2 persons for transfer when using the sit to stand lift. She also indicated that she was required to secure the resident's legs on sit to stand lift using the leg straps. Review of the Nurse Supervisor statement dated 08/16/2023 revealed that he was called to Resident #1's room. Upon arriving to the resident's room he saw the resident sitting in wheelchair and the blood was observed to the resident's left lower leg, on the sit to stand lift and on the floor in front of the bed. The Nurse Supervisor indicated Resident #1 was unable to state what happened. He reported that the resident was not complaining of pain and was not in distress. Nurse Supervisor also stated that pressure was applied on the affected area and bleeding stopped. EMS (Emergency Medical Services) was called. Steri-strips (a skin closure device in the treatment of lacerations and surgical incisions) and a dressing were applied to the wound. CNA #1 indicated to the Nurse	L 039		

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Supervisor that she was transferring resident could not tell what she hurt her leg on.

During the interview on 09/06/2023 at 3:01PM, Nurse Supervisor indicated he was called to Resident #1's room by CNA #1. He observed the resident sitting on the wheelchair and blood on the floor. He observed blood to the resident's lower leg and applied pressure and the bleeding stopped. He called the EMS and notified the family and physician about the incident. He indicated CNA #1 was alone in the room during the transfer using sit and stand. He indicated the 2-person assist was expected when using a sit and stand.

Review of the CNA #2's statement dated 08/16/2023 indicated that she went to the room after Resident#1 incident to help. The resident was in bed and nurse supervisor was treating resident. She observed sit to stand in room and skin was on lower purple pad and blood on floor of sit to stand and on carpet in front of bed. The resident was observed to be quiet, not crying and not saying anything.

Review of the Nurse #1's statement dated 08/16/2023 revealed that she was in another room pushing the resident in wheelchair down the hall to supper. CNA #1 came running out of Resident #1's room stating something has happened and something was wrong. Nurse #1 went to Resident#1's room and observed the resident sitting in her wheelchair facing the bed. Blood was on the floor next to bed. Sit and stand in room with blood at the base. He observed the resident was calm, not crying, unable to say what had happened.

Nurse #1 was not available for an interview.

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L 039	Continued From page 6 The incident report completed by Director of Nursing (DON) dated 08/17/2023 revealed Resident #1 was transferred from bed to wheelchair with sit to stand lift with CNA #1 on 08/15/2023. Resident#1 sustained a 14 cm laceration on left lower leg from leg contacting bed during transfer. The investigation of the incident dated 08/17/2023 revealed CNA #1 was the only staff member during the transfer of Resident #1 from bed to wheelchair and that the safety belt was not used for the legs on sit to stand lift. The resident sustained a 14 cm laceration on left lower leg from leg contacting bed during transfer. The doctor was notified, and resident was transferred to the Emergency room and received 15 sutures. The resident returned to the facility on 08/15/2023. Wheelchair, bed and sit to stand lift were taken out of operation and inspected by maintenance department. Resident #1's wound on 09/06/2023 at 12:10PM revealed a scar with dissolving sutures at the top of the involved area. The nurse applied wet to dry dressing to the wound bed. During the interview with Nurse #2 she indicated the wound was healing well. Observation conducted on 09/06/2023 at 12:35 PM, CNA #1 and CNA#2 using sit and stand secured Resident #1's legs using a straps and secured straps on the resident's back. The NA's safely transferred Resident #1 from bed to wheelchair. During the interview on 09/06/2023 at 12:40 PM, CNA #1 and CNA #2 both indicated they were in-serviced to use 2 persons when using sit and	L 039		

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stand to safely transfer a resident. In addition, they were in serviced to use legs straps to secure the residents legs on sit to stand lift before transferring a resident.

During the interview on 09/06/2023 at 12:53 PM, the Rehab Director indicated that a sit and stand assessment was completed on Resident #1 after the incident on 08/15/2023. She indicated that the resident was safe using the sit and stand. The recommendation was for the staff to continue using the sit and stand safely.

During the interview on 09/06/2023 at 2:58PM, the Nurse Practitioner (NP) indicated that she assessed the resident's wound after the resident was readmitted back on 08/15/2023. She indicated that the resident's wound sutured at the hospital but could not be closed all the way. She indicated that there was swelling observed, and antibiotics was administered. She indicated the wound was healing well.

During the interview on 09/06/2023 at 3:01 PM, the DON indicated Resident #1's incident was investigated, and it was revealed that CNA #1 did a return demonstration on 08/16/2023 safety. The DON indicated that CNA #1 acknowledged that she did not have safety straps attached to the legs. The DON indicated CNA #1 and all the other staff were reeducated on using the safety straps on the resident's legs when using sit to stand lift and always to have 2 people for assistance. The DON also indicated that the sit to stand lift, the resident's bed and the wheelchair were pulled out of service for inspection and all of the items were found in good condition. She further indicated that the Occupational Therapist reassessed the resident for the sit and stand lift and they indicated it was safe for Resident #1 to continue

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using sit and stand lift. The DON also indicated the resident's wound was healing and the nurse continues with dressing the wound.

During the interview on 09/06/2023 at 3:06 PM, the Administrator indicated that the CNA #1 on 08/15/2023 during a transfer of Resident #1 failed to strap the resident's legs when transferring Resident#1 and did not have 2 people to assist. The Administrator indicated that the CNA #1 was in serviced in reference to using safety straps to secure the residents legs before transferring a resident and the use of 2 persons assist.

Plan of Correction
1) Resident Affected:
It was identified that resident, was transferred from bed to wheelchair with sit to stand lift with CNA #1, present on 8/15/23. Resident sustained a 14cm laceration on left lower leg from leg contacting bed during transfer. Medical Director was notified, and resident was transferred to the hospital and received 15 sutures. Resident returned to the facility on 8/15/23. Wheelchair, bed and sit to stand lift were taken out of operation and inspected by Maintenance. Referral for therapy services was completed on 8/16/23. NP completed visit with resident on 8/17/23. Therapy evaluation was completed on 8/17/23.

CNA #1 stated that she was the only staff member during the transfer and that the safety belt was not used for the legs. Employee received education on proper usage of mechanical lift with return demonstration completed by Director of Nursing on 8/16/23.

2) Residents with Potential to Be Affected:
All residents that use a mechanical lift have the

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L 039	Continued From page 9 potential to be affected. 3) Systemic Change: Beginning 8/16/23 all certified and licensed employees were educated on proper usage of mechanical lifts with return demonstration completion by Staff Development Coordinator or designee. Certified and licensed employees that have not been educated by 8/17/23 will not be allowed to work until education has been completed by the Staff Development Coordinator or designee. On 8/17/23, education will be added to new employee orientation on proper usage of mechanical lifts with return demonstration completion by Staff Development Coordinator or designee. 4) Monitoring: The Director of Nursing or designee will audit by interviewing 10 certified or licensed employees to determine how many certified or licensed employees are to be present when utilizing a mechanical lift for a resident transfer and should verification straps and belts be secure and in place before a transfer is completed. This audit will be completed 5x per week for 2 weeks, then weekly for 2 weeks, then monthly for 2 months. The Director of Nursing or designee will audit by completing observations of 5 resident transfers using mechanical lift to ensure proper usage of mechanical lift. This audit will be completed 5x per week for 2 weeks, then weekly for 2 weeks, then monthly for 2 months. Data obtained during the auditing process will be analyzed for patterns and trends and reported to	L 039		

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L 039	Continued From page 10 Quality Assurance Performance Improvement (QAPI) by the Director of Nursing or designee monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Compliance Date: 8/18/23 Onsite validation was completed on 09/06/2023 through staff interviews, observation, and record review. The review of the in-service training revealed the staff were educated on 08/16/2023 until 08/17/2023 on proper usage of mechanical lifts and, staff were educated on using 2 persons when using the mechanical lift. Staff were interviewed to validate in-services completed on education provided to ensure that they had knowledge of proper use of mechanical lift and use of 2 persons when using a mechanical lift. No issues were identified. Observation was conducted on 09/06/2023 of 2 (CNA #1 and CNA#2) staff completing a transfer using a mechanical lift. The staff properly positioned Resident#1 and used the straps correctly on the resident's leg. A review was completed of the mechanical lift education audit questionnaire related to number of staff required when using a mechanical lift and how to use straps and belts before transfer of the resident. No issues were identified. The validation process verified the facility's date of compliance of 08/18/2023.	L 039		