

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NH0383</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/01/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>DAN E. &amp; MARY LOUISE STEWART H</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1500 SAWMILL ROAD</b> <b>RALEIGH, NC 27615</b>
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L 000	<p><b>INITIAL COMMENTS</b></p> <p>The survey team entered the facility on 7/28/25 to conduct a state licensure complaint investigation survey and exited on 7/29/25. Additional information was obtained on 7/30/25, 7/31/25 and 8/1/25. Therefore, the exit date was changed to 8/1/25. Event ID#Q1YS11. The following intake was investigated: NC00232670.</p> <p>1 of 1 complaint allegation resulted in a deficiency.</p> <p>The deficiency resulted in a Past Corrected Type A2 violation at 10 NCAC 13D .2208(e). The violation began on 6/8/25 and was found in compliance on 6/12/25.</p>	L 000		
L 039	<p><b>.2208(E) SAFETY</b></p> <p>10A-13D.2208 (e) The facility shall ensure that:</p> <p>(1) the patients' environment remains as free of accident hazards as possible; and</p> <p>(2) each patient receives adequate supervision and assistance to prevent accidents.</p> <p>This Rule is not met as evidenced by: Based on record reviews, observations, and interviews with staff, Nurse Practitioner, Physician, Family Member #1, and the Responsible Party (RP), the facility failed to safely</p>	L 039		6/12/25

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Division of Health Service Regulation

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L 039	<p>Continued From page 1</p> <p>transfer a resident from bed to wheelchair using a total mechanical lift. On 6/8/25 at 7:20 AM, Nurse Aide #1 and Nurse Aide #2 failed to check the securement of the clip attachments to the lift per manufacturer's instructions prior to transferring the resident and resulted in Resident #1's falling backwards out of the lift sling and hitting her head on the floor. Resident #1 was assessed by a nurse who observed three skin tears to her left elbow and a cut to the top right side of the head with bright red blood. The Resident was administered Ticagrelor (a platelet inhibitor which is prescribed to prevent blood clots and may cause serious or life threatening bleeding) twice a day. Resident #1 was sent to emergency department (ED) for an evaluation where a computerized tomography (CT) scan (detailed imaging test) of the head noted a large scalp hematoma (an abnormal pooling of blood in the body under the skin that results from a broken or ruptured blood vessel) on the right side of the skull. The ED Physician noted a 2 centimeter bruise on the left anterior chest wall (towards the front of the body) and crepitus (sensation or noise when you move a joint, such as clicking, cracking or popping) and tenderness of the right lateral chest wall (to the side of the body). In addition, several small skin tears were observed on the right lower extremity and on her right wrist. A CT scan of the chest/abdomen/pelvis revealed no pneumothorax, obvious rib fractures or acute fracture of the right shoulder. Resident #1 was administered acetaminophen and Fentanyl (powerful synthetic opioid) for pain in ED and returned to the facility the same day. The deficient practice affected 1 of 3 sampled residents reviewed for accidents (Resident #1). Failure to secure a resident in the total mechanical lift prior to transfer resulted in a past corrected Type A2 violation meaning there was</p>	L 039		

Division of Health Service Regulation

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L 039	<p>Continued From page 2</p> <p>substantial risk that death or serious physical harm could occur.</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on 11/21/18 with diagnoses that included Alzheimer's disease, Parkinson's disease, failure to thrive, communication deficit, and dementia.</p> <p>Resident #1's St Louis University Mental Status exam (SLUM) that assessed Resident #1's cognition dated 1/30/24 revealed Resident #1's cognition was severely impaired for daily decision making.</p> <p>The Morse fall scale assessment was completed on 4/3/25. Resident #1 was high risk for falls.</p> <p>Review of the Physician orders revealed an order dated 2/6/25 for Ticagrelor (platelet inhibitor) 90 milligrams (mg) 1 tablet twice a day and stop date of 7/22/25.</p> <p>Resident #1's care plan dated 1/20/25 included a focus area for falls risk related to a fall due to weakness, confusion, no safety awareness and inability to ambulate. Resident #1 will not sustain any injury from a fall that required the attention of a physician. The interventions included two-person assistance during the use of the mechanical lift.</p> <p>A review of the manufacturer's [total mechanical lift] patient lift and transfer instructions dated 9/2022 indicated the following procedures.</p> <ul style="list-style-type: none"> <li>- always refer to the label on the sling being used to make sure of its actual safe and working. A label is placed on the spreader bar for a quick color-to-size reference.</li> </ul>	L 039		

Division of Health Service Regulation

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L 039	<p>Continued From page 3</p> <p>- always check that the attachment is locked in place by verifying the markings on the attachment that show that there is proper alignment, and verifying that the locking clip is fully engaged, this ensuring that the attachment is securely fastened. An unsecured spreader bar may lead to a patient fall.</p> <p>-apply the leg clips of the sling onto the lugs so that they become positioned vertically.</p> <p>-always check that all the sling attachment clips are fully in position before and during the lifting cycle, and in tension as the patient's weight is gradually taken up.</p> <p>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. Staff should check the sling and attachments prior to the transfer.</p> <p>The incident report completed by the Nursing Supervisor on 6/8/25 at 7:20 AM revealed Resident #1 received three small skin tears to her left elbow with purple bruising. Resident #1 also had a cut to the top of her head with hematoma. At 7:20 AM, the charge nurse was approached by Nurse Aide #1 who stated that Resident #1 had fallen out of the total mechanical lift. Nurse Aide #1 stated that the resident hit her head and was placed back in the chair. Upon entrance, Resident #1 was seated in the wheelchair with her head positioned on the right side. Nursing Supervisor was called stat into the room. The Nursing Supervisor was given a report of the fall. Resident #1 was able to respond verbally to direct questions and when asked if she was in pain. The resident shook her head yes but could not give a</p>	L 039		

Division of Health Service Regulation

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L 039	<p>Continued From page 4</p> <p>definitive location or pain scale. The resident had facial grimacing and moaning. The blood pressure was 163/78 (normal range 120/80), pulse 70 (normal range 60 to 100), respiration 18 (normal range 12 to 20), non-labored, oxygen saturation 92% and temperature 97.5. The resident was able to squeeze the nurse's hand slightly with her left hand but when instructed to squeeze it with her right hand she could not do so. The resident has three skin tears to her left elbow; the area was cleansed. There was a cut to the top right side of the head with bright red blood, cleansed with normal saline, swelling noted, cold compress applied to the area. The area continued to bleed but later stopped. At 7:25 AM the responsible party was notified by the Nursing Supervisor and agreed to send Resident #1 to the emergency room for evaluation. The Physician was notified at 10:30 AM. At around 7:38 AM fire rescue x 2 (two personnel) and 7:39 AM emergency medical service (EMS) arrived and was provided with an update of resident condition and the resident was transferred to the hospital at 7:45 AM.</p> <p>Nurse Aide #1's written statement dated 6/8/25 revealed Nurse Aide #1 was getting Resident #1 up for breakfast and had her hooked up to the mechanical lift with a new sling. "I went and asked Nurse Aide #2 to spot (assist) me which he agreed. Resident #1 was lifted from the bed without a problem; the sling was secure and no hanging straps. Nurse Aide #1 stated Resident #1 was positioned over the wheelchair to be seated and when the button was pressed the strap at the bottom of the sling popped off. Resident #1 hit the floor on her head. She was out the leg of sling of the mechanical lift." Nurse Aide #1 and Nurse Aide #2 used the sling to pick her back up and put her in the wheelchair. Nurse Aide #1 went to</p>	L 039		

Division of Health Service Regulation

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L 039	<p>Continued From page 5</p> <p>get the charge nurse to report the incident.</p> <p>An observation and interview were conducted on 7/29/25 at 1:00 PM with Nurse Aide #1 who operated the mechanical lift at the time of Resident #1's fall from the total mechanical lift on 6/8/25. Nurse Aide #1 with the assistance of Nurse Aide #3 did a return demonstration of a total lift transfer with another resident. Nurse Aide #1 stated Resident #1 was in bed with a sling in place, the mechanical lift clips were attached to the frame of the lift on all four sides. Nurse Aide #1 was observed locking all four black clips on the sling attachments that slid onto to the metal lug part of the mechanical lift and checked behind himself to ensure the clips were in place from the sling to the lift. Nurse Aide #1 stated the straps/clips were attached to the lift while Resident #1 was in bed before he raised the resident in position to be transferred to the wheelchair. Prior to the transfer he got assistance from Nurse Aide #2. Nurse Aide #1 pointed to all four points of the lift where the clips of the sling would be attached to the frame lug (fixed metal post on the mechanical lift arm). Nurse Aide #1 demonstrated the use of the remote control, Nurse Aide #1 indicated as he operated the control Resident #1 was positioned over the wheelchair in a normal seated position while in the sling. Nurse Aide #1 demonstrated as Resident #1 was being lowered to the wheelchair, the attachment clip and sling slipped from the lug of the lift frame near the residents' legs. Resident #1 fell backward from the sling hitting her head on the floor. Nurse Aide #1 stated everything happened so fast, that he and Nurse Aide #2 picked Resident #1 from the floor using the sling to support the resident and placed Resident #1 back in the wheelchair as a sudden reaction. Nurse Aide #1 stated he immediately went to get</p>	L 039		

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L 039	<p>Continued From page 6</p> <p>the charge nurse to inform her of the incident and Nurse Aide #2 remained in the room with the resident. Nurse Aide #1 stated he had been trained on the use of mechanical lifts prior to the incident on 6/8/25.</p> <p>Nurse Aide #2's written statement dated 6/8/25 revealed Nurse Aide #2 was asked to assist Nurse Aide #1 with the transfer of Resident #1 to the wheelchair when something wrong happened. The [total mechanical lift] was used to get the resident up when one of the supports was out, the resident fell and hit her head. Nurse Aide #2 stated he spoke with the nurse in charge and told her what happened.</p> <p>A telephone interview was conducted on 7/28/25 at 11:55 AM with the Nurse Aide #2 who assisted Nurse Aide #1 with transferring Resident #1 on 6/8/25. Nurse Aide #2 stated he was asked by NA #1 to assist with the use of the total mechanical lift lift to transfer Resident #1 from bed to the wheelchair. When he arrived at the room the resident was in bed and NA #1 had already hooked up the sling to the lift. He stated he did not notice anything wrong with the sling attachment or the actual lift. He stated based on his training and his observation; everything was secure. Nurse Aide #2 stated he did not recheck the attachments of the sling on the lift. Nurse Aide #2 stated he was standing behind the wheelchair to secure the chair when NA #1 began to operate the lift toward the chair. Nurse Aide #2 indicated when the leg part of sling came off the lift Resident #1's legs came out of the sling and the resident fell backward hitting her head on the floor. NA #2 stated he did not see anything wrong with the actual lift other than the sling sliding off the hooks from between Resident #1's legs. Nurse Aide #2 stated Resident#1 fell so fast that</p>	L 039		

Division of Health Service Regulation

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L 039	<p>Continued From page 7</p> <p>neither one of them could stop the resident from falling. Nurse Aide #2 stated the two of them used the sling to lift the resident back into the chair and Nurse Aide #1 immediately went to get the charge nurse.</p> <p>An interview was conducted on 7/28/25 at 1:19 PM with the Charge Nurse who stated on 6/8/25 Nurse Aide #1 reported that Resident #1 fell from the total mechanical lift, so she immediately went to the room and the resident was already in the wheelchair. Resident #1 was very calm and confused. Resident #1 was unable to state what happened due to her dementia and confusion. She stated the resident had some bleeding to the back of the head on the right side and a few skin tears on her elbows. Resident #1 stated she was in pain but was unable to specify the exact location. The Charge Nurse reported there were no other visible injuries. The Charge Nurse stated following her assessment she immediately notified the Nurse Supervisor of the incident. The Nurse Supervisor assessed the resident as well and contacted the Director of Nursing and the family. The Charge Nurse stated when she asked both nurse aides what happened, both replied the sling came off the mechanical lift and the resident fell on the floor and hit her head. The Charge Nurse indicated when she asked the nurse aides why the resident was moved from the floor there was no response. She stated all staff have been trained not to move a resident before they were seen by a nurse.</p> <p>An interview was conducted on 7/28/25 at 1:55 PM with the Nursing Supervisor who stated she was called into Resident #1's room on 6/8/25 by the Charge Nurse who stated Nurse Aide #1 reported that Resident #1 fell from the mechanical lift and hit her head on the floor. The</p>	L 039		

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L 039	<p>Continued From page 8</p> <p>Nurse Supervisor stated when she arrived at the room Resident #1 was seated in her wheelchair leaning to the right side with blood coming from the back of her head. She reported Resident #1 was confused and disoriented and unable to state what happened or a specific area where she was in pain. The Nurse Supervisor indicated Resident #1's vital signs were stable and there were no other visible injuries. Nurse Supervisor stated the Director of Nursing was notified immediately of the incident and the Nurse Supervisor notified the RP. The Nurse Supervisor stated she informed the responsible party that Resident #1 had fallen from the total mechanical lift and needed to be transferred to the hospital for further evaluation and the responsible party agreed with the decision for transfer. She indicated the Director of Nursing was also in direct communication with the physician while she made the arrangements for the transfer. The Nursing Supervisor indicated once she completed the transfer process, she interviewed the nurse aides and obtained written statements about the fall. She reported Nurse Aide #1 stated he had prepared the resident for transfer while the resident was in bed, by attaching the clip attachments to total mechanical lift. Nurse Aide #1 stated he asked for assistance from Nurse Aide #2 before the transfer was made. Nurse Aide #1 stated the lift sling was secured and all clips were in place before he began to operate the lift. Nurse Aide #1 stated as he began to operate the lift the sling from the leg area came off the lift and the resident fell from the sling onto the floor hitting her head. Nurse Aide #2 confirmed that he saw the sling and clips were attached to the lift and the sling had come off the lift and the resident fell to the floor. The Nurse Supervisor indicated all staff have been trained to have two people in the room while using any mechanical lifts. She stated at the time she was</p>	L 039		

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L 039	<p>Continued From page 9</p> <p>unaware that the nurse aides had moved the resident from the floor before the nurse could assess the resident. She stated when she arrived the resident was already in the wheelchair and the charge nurse had already started the initial assessment.</p> <p>Physician order dated 6/8/25 specified for Resident #1 to be transferred to hospital for further evaluation.</p> <p>Review of the emergency department (ED) history and physical dated 6/8/25 revealed Resident #1 was transferred to the ED from a skilled nursing facility after a fall from a mechanical lift. The ED Physician documented, "By report, the patient fell 3 feet directly onto her head." Vital signs on arrival were temperature 97.5, pulse 85, respirations 20, blood pressure 178/93 and oxygen saturation was 97%. Resident #1 was awake, answered questions somewhat appropriately, followed commands and was oriented x 2. Resident #1 reported she hurt all over. A 4 cm (centimeter) scalp contusion (any injury that causes blood to collect under the skin) with an overlying abrasion (superficial scrape) was noted on the right side of her skull. The ED Physician noted a 2 centimeter bruise on the left anterior chest wall and crepitus and tenderness of the right lateral chest wall. In addition, several small skin tears were observed on the right lower extremity and on her right wrist. Resident #1's was difficult to evaluate given underlying dementia but did endorse pain to palpation. It was noted her Glasgow Coma Scale (GCS) was 14 which was baseline for Resident #1. (The GCS is an assessment tool used to evaluate a person's level of consciousness after a head or brain injury. The range of 13-15 is typically classified as a mild traumatic brain injury or concussion.) The</p>	L 039		

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L 039	<p>Continued From page 10</p> <p>following imaging test was done; CT of the chest/abdomen/pelvis revealed no pneumothorax, obvious rib fractures, or acute fracture of the right shoulder. The CT of head, spine revealed no acute intracranial hemorrhage or mass effect, and a large scalp hematoma on the right side of the skull. The computed tomography angiography scan (CTA) of the head and neck revealed no evidence of traumatic vascular injury (damage to blood vessels) of the head/neck. Medications administered included acetaminophen and Fentanyl (powerful synthetic opioid). There was no medication dosage or pain scales included in the hospital record. Resident #1 was discharged back to the facility on 6/8/25.</p> <p>Nursing note dated 6/8/25 revealed at 2:30 PM the resident returned to facility via stretcher, accompanied by 2 emergency medical team (EMT) attendants. Awake. verbally responding to questions. Transferred to bed. Head of bed (HOB) up at 45 degrees. Head wrapped with bandage with abdominal pad (ABD) in place to area of hematoma, bandage left in place. The resident was able to lift right and left arms upon command. Bilateral palm grips weak- Clear speech. Noted upper left thigh wrapped: removed: resident has large open skin tear, scant blood from dressing: new dressing applied. Skin tears to left arm cleansed with new dressing applied and wrapped. Large, dark purple bruise to posterior knee. Multiple bruises to upper arms.</p> <p>Nurse Practitioner note dated 6/9/25 read in part: revealed a follow-up visit status post fall, scalp hematoma and T5 wedge compression fracture. Resident #1 was seen on 6/8/25 at the hospital due to a fall from a mechanical lift. Resident #1 sustained a scalp laceration. She was noted with right should pain and right sided weakness after</p>	L 039		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NH0383</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/01/2025</b>
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L 039	<p>Continued From page 11</p> <p>the event. However, her Glasgow Coma Scale (GCS) Resident #1's GCS improved from 11-14 upon arrival to the hospital. She had computed tomography angiography (CTA) and CT scan which were negative for acute hemorrhage or vascular injury. She does have severe stenosis on her proximal left subclavian artery and a large right posterior vertex scalp hematoma. A pressure dressing was applied but removed today with a small amount of oozing. Upon arrival at bedside Resident #1 did not have any oozing from her hematoma site. Resident #1 lying in bed in no acute distress, denied headaches, vision changes, dizziness, numbness, tingling chest pains, shortness of breath, abdominal pain, nausea, constipation diarrhea or chills. Resident#1 did have 1 episode of vomiting after taking medication, however, the resident had no repeat episodes. The resident has dementia and is a poor historian. She does not recall the fall.</p> <p>On 6/10/25 the Nurse Practitioner (NP) ordered physical therapy post fall.</p> <p>An interview was conducted on 7/28/25 at 4:01 PM with the Nurse Practitioner (NP) who saw the resident on 6/9/25. She stated Resident #1 was unable to recall the fall and did not express that she was in any major pain. There was no drainage to the hematoma on her scalp. The NP stated Resident #1 had multiple medical comorbidities that included osteoporosis, osteoarthritis, advance dementia, Parkinson's disease, weight loss that continued to contribute to the decline of Resident #1's general health. The NP noted Resident #1 had only one episode of vomiting on the morning of 6/9/25 and did not require any additional interventions. The Nurse Practitioner (NP) who stated she was unaware at the time of the incident that Resident #1 had been</p>	L 039		

Division of Health Service Regulation

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L 039	<p>Continued From page 12</p> <p>moved by the nurse aides prior to a nursing assessment. She further stated the expectation was for staff to notify nursing before a resident was moved from any position and/or had a change of condition to allow a nurse to assess the resident.</p> <p>A telephone interview was conducted on 7/28/25 at 2:24 PM with Resident #1's Responsible Party (RP) who stated he received a call on 6/8/25 from the Nurse Supervisor that Resident #1 had fallen from the mechanical lift and hit her head and needed to be transferred to the hospital for further evaluation. Based on what he was told he agreed to the transfer.</p> <p>A telephone interview was conducted on 7/28/25 at 10:40 AM, with the Family Member #1 who stated Resident #1 was bed bound for about a year or more due to advanced dementia, Parkinson's disease, osteoporosis and osteoarthritis Family Member #1 indicated Resident #1 had experienced a decline in health in the past year which resulted in a decrease in mental status and activities of daily living. Family Member #1 reported that the facility called Resident #1's Responsible Person (RP) on 6/8/25 and reported that Resident #1 had fallen from the total mechanical lift, hit her head on the floor and was being sent to the emergency room. Family Member #1 visited the facility to find out the actual cause of the fall and it was reported that a metal tab over the lug/bolt where the sling was to be secured was not properly secured when the nurse aides raised Resident #1 from the bed to the wheelchair with the mechanical lift. Resident #1 sustained multiple injuries because of the fall which included a laceration to the elbow and head. Family Member #1 reported a care plan meeting was held to discuss the actual cause of</p>	L 039		

Division of Health Service Regulation

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L 039	<p>Continued From page 13</p> <p>the fall and future interventions. Family Member #1 indicated the concern was why the staff did not use the mechanical lift properly. During the meeting the family was informed that all staff were re-educated on the proper use of the mechanical lift, safety inspections were conducted on the slings and all the lifts used in the facility.</p> <p>An interview was conducted on 7/29/25 at 10:18 AM with the Social Worker who stated Family Member #1 attended the care plan meeting and was informed of the fall investigation findings and the interventions that were implemented to protect all residents. He stated he informed the RP of a care plan meeting discussion as well and the RP did not express any new concerns with the investigation.</p> <p>An interview was conducted on 7/28/25 at 4:30 PM, with the Director of Nursing (DON) who stated she received a call from the Nurse Supervisor on 6/8/25 around 7:30 AM about the Resident #1's fall from the mechanical lift. She notified the physician of the fall and instructed the Nurse Supervisor to send the resident to the hospital and to notify the family of the fall. The DON reported the mechanical lift used to transfer Resident #1 on 6/8/25 only had two slings and she asked both NA #1 and NA #2 what happened and what sling was used during the incident. The aides showed her the sling that was used on the mechanical lift, and she did a physical inspection of the sling and inspected the condition of the lift for any damages as part of her investigation. The sling was intact, and the lift was functioning properly. The sling and lift were not used until the inspections were completed on 6/8/25. She followed-up with reviews of the mechanical lift policy and manufactures instructions and return</p>	L 039		

Division of Health Service Regulation

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L 039	<p>Continued From page 14</p> <p>demonstration training for all aides and nursing,</p> <p>A telephone interview was conducted on 7/31/25 at 4:10 PM with the Director of Nursing (DON), who stated the information about the resident being transferred by Nurse Aide #1 and Nurse Aide #2 from the floor back to the wheelchair before the nurse completed the assessment was revealed during investigation through interviews with the staff. She indicated she did not have this information at the time of the initial call to notify the physician. The DON stated current and newly hired staff would be re-educated on the fall policy to ensure staff were aware of the procedures for reporting and notifying the nurse of any falls, visible injuries and change of condition prior to moving a resident.</p> <p>An interview was conducted on 7/28/25 at 4:35 PM with the Administrator indicated the investigation revealed NA #1 and NA #2 failed to attach the sling clip attachment to the lift in accordance with the manufacturer's instruction before transferring Resident #1 on 6/8/25. During the investigation both aides were required to perform a return demonstration of how the resident was prepared for the transfer and how the sling was secured to the mechanical lift. The Administrator indicated that all identified residents that use a total mechanical lift should have two people when doing transfer with a mechanical lift per the policy and manufacturer's instructions. She stated the management team reviewed the facility's mechanical lift policy and the manufacturer's instructions which provided specific illustrations and instructions on how the sling for the total mechanical lift was to be used to ensure the instructions matched. The Administrator further stated the nurses and nurse aides were re-educated on the proper use of the</p>	L 039		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NH0383</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/01/2025</b>
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L 039	<p>Continued From page 15</p> <p>lift and were required to perform a return demonstration. The staff were observed to ensure they were able to use the lift correctly and that everyone using the lift checked the clips before the resident was lifted for transfer.</p> <p>A telephone interview was conducted on 7/31/25 at 4:15 with the Administrator who stated the investigation revealed Nurse Aide #1 and Nurse Aide #2 moved Resident #1 before the nurse was able to complete her assessment. She indicated all staff have been educated and in-service on the importance of notifying the nurse of a fall, change of condition before moving the resident.</p> <p>An interview was conducted on 7/29/25 at 9:55AM with the Physician who stated the resident had been at the facility for 6 years and had experienced on-going/gradual decline due to osteoporosis, osteoarthritis, advance dementia and Parkinson disease. The resident had been experiencing weight loss, and decline of mobility and overall function which had impacted on her general strength resulting in on-going weakness. He stated the Director of Nursing had contacted him and informed him of the events of the fall from the mechanical lift and it was suspected that staff did not secure the sling properly to the lift. He reported he reviewed the medical records from the hospital which indicated the resident was treated for a head/scalp laceration, x-rays and CT scans of the head/neck were negative for fractures, acute hemorrhage and vascular injury. The Physician stated the fall and injuries were acknowledged and the facility took immediate action to send Resident #1 to the hospital. The facility also implemented safety measures and education for current staff and newly hired staff to ensure a fall does not occur with the use of a mechanical lift. The Physician acknowledged the</p>	L 039		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NH0383</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/01/2025</b>
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L 039	<p>Continued From page 16</p> <p>fall could have resulted in serious injury and/or death.</p> <p>A telephone interview was conducted on 7/31/25 at 4:55 PM with the Physician who stated he was unaware Resident #1 was moved before a nurse was able to complete the assessment. He further stated the nurse aides should inform the nurse prior to moving the resident to ensure a thorough and complete assessment was done. The nurse would then notify the supervisor, director of nursing and the physician of any notable changes during the assessment period.</p> <p>The Administrator was notified of the Type A2 violation on 7/29/25 at 3:36 PM.</p> <p>The facility provided the following Corrective Action Plan:</p> <p>1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>On Sunday 6-8-2025, Resident #1, who was on ticagrelor (antiplatelet medication) and was alert with confusion, had a fall while being transferred from a bed to a wheelchair with a mechanical sling lift by Nursing Assistant (NA) #1 and NA #2. The resident #1 fell to the floor, hit her head and shoulder, with no apparent injury other than a bump to the back of her head. The resident was assessed by the Nursing Supervisor and floor nurse #1. The Medical Director was notified and Emergency Medical Services (EMS) arrived and transported Resident #1 to hospital for an evaluation.</p> <p>Report received from hospital to Nursing Supervisor. Computed Tomography Scan (CT</p>	L 039		

Division of Health Service Regulation

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L 039	<p>Continued From page 17</p> <p>scan) of Resident #1's head was negative for a head bleed but resident #1 did sustain a scalp contusion (cut) from the resident sliding out of the mechanical lift sling and contacting the floor with her head. The contusion to the back of the head did not require any sutures or interventions. It was also noted, resident #1 had a compression wedge fracture to her Thoracic 5 vertebrae (T5) (a bone in the middle part of the spinal column) of an undetermined age. Discharge instructions included keeping the head of bed less than 45 degrees and to follow up with the neurosurgical clinic in 2 weeks to reassess the compression fracture to T5. No intervention was necessary at that time and treatment was conservative with pain control with acetaminophen 650 milligrams every 6 hours scheduled. Resident #1 returned to the facility the same day via Emergency Medical Services (EMS). On 6-8-2025. Staff were informed of positioning order to keep head of bed less than 45 degrees. Floor Nurse #1 assessed the resident upon return from emergency room. Neuro-checks were initiated.</p> <p>The Nurse Practitioner completed a follow up emergency room visit assessment with resident #1 on 6-9-2025. Per provider note, the resident was lying in bed with no acute distress. The dressing to Resident #1's head was removed as there was no further drainage noted. Resident #1 denied headaches, vision changes, dizziness, numbness, tingling chest pain, shortness of breath, abdominal pain, nausea. Resident #1 had dementia and was a poor historian. The resident did not recall the fall. Resident #1 was in no distress during nurse practitioner assessment; however, the provider chose to add an as needed low dose pain medication for availability to maintain resident's comfort, if needed, in between the scheduled acetaminophen every 6 hours</p>	L 039		

Division of Health Service Regulation

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L 039	<p>Continued From page 18</p> <p>order.</p> <p>Referral for physical and occupation therapy services was completed for positioning on 6-10-2025. The Therapy Director reviewed recommendations with the neurosurgeon office via phone call for best safety methods for transfers and recommendations for positioning to maintain comfort for resident #1. The Therapy Director evaluated resident #1 focusing on transfers for positioning and comfort. The Therapy Director completed education with staff for positioning and log rolling during care. The care plan was reviewed by the Director of Nursing and care plan coordinator and updated on 6-11-25 to include pain management, transfer status, head of bed to be kept less than 45 degrees and addition of physical and occupational therapy services.</p> <p>When the Nursing Supervisor interviewed NAs #1 and #2 immediately following the incident on 6-8-2025, both staff members acknowledged the failure to follow facility policy in not checking the sling clips were fully secured to the arm of the lift. The Nursing Supervisor provided verbal re-education with both NAs on mechanical lifts prior to them continuing to work. The sling and mechanical lift utilized in the transfer of Resident #1 in the fall were taken out of operation by Nursing Supervisor and were inspected by the Director of Nursing on 6-9-2025.</p> <p>On 6-10-2025 the Director of Nursing interviewed NA #1 and a return demonstration of the mechanical lift and transfer was completed by NA #1 utilizing a staff member in the lift. NA #1 was able to properly complete a return demonstration and correctly secured lift sling clips (plastic pear-shaped eyelet) to the lift lug (a fixed metal</p>	L 039		

Division of Health Service Regulation

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L 039	<p>Continued From page 19</p> <p>post on the lift arm). NA #1 verbalized correct steps while demonstrating proper safety use of mechanical lift; however, he acknowledged he already had resident #1 lying in bed and positioned on the sling and clips were attached to the lift and sling clips attached to the lift lugs prior to NA #2 entering resident #1 room for completion of transfer. The DON interviewed the Nursing Supervisor regarding the incident involving the fall for Resident #1. The DON met with NA #2 for an interview and return demonstration on a staff member completed. NA #2 was able to properly complete the return demonstration both physically and verbally and correctly secured all lift sling clips to the mechanical lift lug NA #2 verbalized while demonstrating proper safety use of lift; however, NA #2 acknowledged that during the incident on 6-8-2025, NA #2 did not verify that all clips were firmly secure to the mechanical lift lug before initiating transfer for resident #1. NA #1 and #2 stated Resident #1 was lifted with the mechanical lift and sling following facility policy and procedure with 2 staff members present.</p> <p>NAs #1 and #2 failed to adhere to the manufacturer's instructions to verify that all four clips on the sling were fully secured to the lift arm lugs prior to initiating the lift. Resident #1 was lifted out of the bed without issue, but once resident #1 was being moved from a horizontal position to a 90-degree position to be lowered into the wheelchair, the clips on the sling supporting the resident's legs on the sling gave way from the mechanical lift lug and resident #1 slid out of sling onto the floor.</p> <p>Training files reviewed to verify that NA #1 and NA #2 had both completed their annual training on mechanical lift policy/procedure following the</p>	L 039		

Division of Health Service Regulation

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L 039	<p>Continued From page 20</p> <p>manufacture guidelines with return demonstrations by both NAs #1 8-17-2023 and 10-10-2024 and NA #2 in 8-17-2023 and 11-7-2024. Both employees received re-education on proper usage of mechanical lift and securing all four clips on the sling to all four lugs on the mechanical lift with return demonstration completed by Director of Nursing on 6-9-2025 and 6-11-2025. Re-education was provided immediately by Nursing Supervisor at the time of the incident and NA #1 and NA #2 returned to work. Additional re-education provided to NAs #1 and #2 by DON on the Mechanical Lift policy to include two staff members are required to be present for all mechanical lifts. One staff member is responsible for operating the equipment and the other staff member stays with the resident and ensures that all straps, belts, and clips are secured to all four lugs.</p> <p>2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All mechanical lifts and all residents who use a mechanical lift have the potential to be affected. Seven residents were care planned to use mechanical lifts, and 9 residents were care planned to use sit to stand lifts for their transfer statuses. These 16 residents were identified by the Assistant Director of Nursing (ADON) as those that could potentially be affected by the same deficiency through review of care plans by the Director of Nursing, care plan coordinator, and therapy department review of mechanical monthly lift audits, with admissions and with change in condition.</p> <p>3. Address what measures will be put into place or systemic changes made to ensure that the</p>	L 039		

Division of Health Service Regulation

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L 039	<p>Continued From page 21</p> <p>deficient practice will not recur.</p> <p>The facility had a total of 5 Sit to Stand lifts and 3 mechanical lifts. All 8 mechanical lifts at the facility were consistent with using the same branded mechanical lift and sit to stand manufacturer as the facility standard to ensure 100% of nurses and NAs were trained on hire on day one of orientation and annually with skills check offs per manufacture recommendations. Standards of Nursing Practice-Mechanical Lift Policy was reviewed on 6-9-2025 by DON, ADON and Staff Development Coordinator (SDC) to ensure it was consistent with the manufacturer recommendations. Policy includes securing clips to the lugs of the mechanical lift.</p> <p>Corrective action included determining the 5 Whys Root Cause Analysis, reviewing facility mechanical lift policy, interviewing Nursing supervisor, floor nurse, NAs #1 and 2, and resident #1 to investigate incident.</p> <p>5 Whys Root Cause Analysis: 6-9-2025: Problem: Resident fell during transfer with a mechanical lift.</p> <p>1. Why? Because one of the sling clips was not fully secured to the lift arm lug (a fixed metal projection on the lift arm), causing the resident to fall when the sling gave way.</p> <p>2. Why? Because NAs #1 and #2 involved with the incident did not verify that all sling clips were securely attached to the mechanical lift arm lugs before initiating the lift.</p> <p>3. Why? NA #1 had Resident #1 lying in bed on an appropriately sized sling and clips were attached to the lift lugs When CNA #2 entered resident #1 room to assist with transfer, NA #2 did not re-verify that the clips of the sling were</p>	L 039		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NH0383</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/01/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>DAN E. &amp; MARY LOUISE STEWART H</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1500 SAWMILL ROAD</b> <b>RALEIGH, NC 27615</b>
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L 039	<p>Continued From page 22</p> <p>securely attached to the mechanical lift arm lugs prior to beginning transfer.</p> <p>4. Why? Failure to follow policy by NA #1 who assumed the clips were securely in place on the lugs on the mechanical lift arm, instead of pulling the clip down until it clicked into place and by NA #2 who did not remember to double check that all clips were securely in place on the lugs on the mechanical lift arm prior to beginning lift.</p> <p>5. Why? Because there was a failure to adhere to the manufacturer's instructions requiring verification of all sling attachments before lifting.</p> <p>Root Cause: Policy was in place, Training per manufacturer's instructions had been provided, but NAs #1 and #2 did not adhere to instructions to verify that all sling clips were fully secured to the mechanical lift lugs as outlined in the manufacture's guidelines per annual training and education received. NA #1 put all the clips on the lug of the mechanical arm and assumed the clips were securely in place on the lugs on the mechanical lift arm instead of pulling the clip down until it clicked into place on the lug and NA #2 assumed that NA #1 had already ensured that all clips were secured in place and did not recheck and verify that all four clips were secured to the four lugs prior to beginning the lift.</p> <p>Reeducation of 100% of all nurses and NAs in facility to verify return demonstration to verify responsibility of both staff members during mechanical lift transfers to ensure all straps, belts, and clips are secured and fully engaged and in place on lugs of the mechanical lift and sling by SDC, DON, ADON, and Nursing Supervisors starting on 6-9-2025- 6-10-2025. Any part-time or per diem staff that were not present on the 6-9-2025 or 6-10-2025 were reeducated by</p>	L 039		

Division of Health Service Regulation

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L 039	<p>Continued From page 23</p> <p>the Nursing Supervisor on their shift prior to assuming their assignment.</p> <p>Standards of Nursing Practice-Mechanical Lift Policy was reviewed DON and ADON on 6-9-2025 to ensure that it was consistent with the manufacturer recommendations. The policy included expectation of ensuring that all sling clips and/or belts are secure and in place and ensuring that sling clips are secured to the lugs on the lift machine.</p> <p>All certified nursing assistants and all licensed nurses on all shifts were reeducated in person on proper usage of mechanical lifts and sit to stand lifts including verifying that straps/belts/clips are secure and in place before a transfer is completed with return demonstration completed by Staff Development Coordinator, DON and ADON on 6-9-2025 and 6-10-2025. Each employee was required to demonstrate verbally and physically the steps to operate both the sit to stand and the mechanical sling lifts prior to being signed off on the procedure and permitted to work. The training was provided at the beginning of each shift and staff were not permitted to work until the employee was checked off with a return demonstration. A written policy and procedure were also presented to each NA and nurse to read, understand, and endorse that education was provided and understood. Opportunity was given for questions and all questions answered. Aides and licensed employees that had not been educated by 6-10-2025 were not permitted to work until education was completed by the Staff Development Coordinator (SDC) or Nursing Supervisor. For those staff members that work per diem, the SDC and Nursing Supervisor completed one on one training prior to the employee being permitted to work. An attendance log of all certified nursing assistants and all</p>	L 039		

Division of Health Service Regulation

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L 039	<p>Continued From page 24</p> <p>licensed nurses on all shifts was used to ensure that 100% of all staff completed the required reeducation on mechanical lifts and sit to stand lifts prior to being permitted to work. Staff in the facility therapy department did not require in-service training due to that department not utilizing resident lift equipment.</p> <p>Per facility policy, upon hire and on day one of orientation and before working hands on with residents, all certified or licensed employees were required to complete education on proper usage of mechanical lifts and sit to stand lifts, including verifying that straps/belts/clips are secure and in place per manufacturer's instructions before a transfer is completed with return demonstration observed and checked off by Staff Development Coordinator or Nursing Supervisors. It is noted that the facility does not utilize any agency staff. Both the mechanical lift and the sling were returned to service on 6-9-2025 after being inspected and cleared by the Director of Nursing on 6-9-2025.</p> <p>4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.</p> <p>Observations of transfers with mechanical lifts were completed by DON, ADON and Staff Developing Coordinator on 6-9-2025 and 6-10-2025 for all residents who use lifts to audit safety procedures and to ensure that all staff were correctly transferring all residents utilizing mechanical lifts by following the manufacturer's instructions. policy, procedure and previous and ongoing training.</p> <p>On 6-11-2025, the Director of Nursing, SDC or Nursing Supervisor will complete ongoing by</p>	L 039		

Division of Health Service Regulation

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L 039	<p>Continued From page 25</p> <p>interviewing 10 certified employees to determine how many certified or licensed employees are to be present when utilizing a mechanical lift for a resident transfer and that the second staff member present is required to verify by physically checking that all straps/belts/clips are secure to the lugs on the mechanical lift 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 x 2 months. The Director of Nursing, SDC or Nursing Supervisor will complete audits by completing observations of 5 resident transfers using a mechanical lift to ensure proper usage of mechanical lift. This audit will be completed 5x/week for 2 weeks, then weekly for 2 weeks, then monthly for 2 months. The Director of Nursing, or ADON will complete audit lifts monthly to ensure they are in good repair and function properly. Any lift found to have issues will be removed immediately and serviced by maintenance or a mechanical lift technician prior to returning to service.</p> <p>On 6-11-2025, Quality Assurance Performance Improvement (QAPI) team members held a meeting to review Plan of Correction including deficiency identified, education required, ensure 100% participation, and ongoing monitoring schedule. QAPI meetings will continue monthly and as needed to monitor Plan of Correction. Data obtained during the auditing process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing or SDC 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.</p> <p>The facility's alleged date of compliance is 6/12/2025.</p>	L 039		

Division of Health Service Regulation

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L 039	<p>Continued From page 26</p> <p>Alleged date of Type A2 violation removal: 6/12/25.</p> <p>The facility's corrective action plan was validated on 7/29/25 during staff interviews and return demonstration with the nurse aides and nursing of the mechanical lift and transfer were completed by utilizing residents that were identified for transfer using the mechanical lift. There was a list of residents at the nursing station that identified the type of lift to be used for each resident. All staff including NA#1 were able to properly complete a return demonstration and correctly secured lift sling clips (plastic pear-shaped eyelet) to the lift lug (a fixed metal post on the lift arm). Staff were able to verbalize the correct steps while demonstrating proper use of a mechanical lift and requirements to have two staff present prior to using the lift. Both mechanical lift slings were observed for any damage and there were none. The safety procedures and safety checklist for return demonstration, equipment checks were reviewed from 6/10/25 through 7/29/25 was completed by the nurse supervisor and reviewed director of nursing. Additionally, audit and monitoring tools included the completion of skin assessment and body audits to assess any skin condition changes, notification of injury to physician and RP. Attestations were signed by trained staff for the verbal education that was provided. Staff indicated they were trained prior to working in the facility for their next shifts. Newly hired staff after 6/10/25 received an in-service on mechanical lifts and transfer during orientation and this was verified by the facility trainers and orientation form.</p> <p>The Type A2 violation removal and corrective</p>	L 039		

Division of Health Service Regulation

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L 039	Continued From page 27  action compliance date of 6/12/25 was validated.	L 039		