| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345301 | A. BUILDING _____ B. WING _____ | C 02/02/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHITE OAK MANOR - BURLINGTON | 323 BALDWIN ROAD PO BOX 3427 BURLINGTON, NC 27217 |

| (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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| F 323 SS=G | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, record review, and observation the facility failed to safely transfer 1 of 3 residents (Resident #2) with the mechanical lift which resulted in a large open deep tissue wound that required surgical debridement with a wound drain to promote healing.<br><br>Findings included:<br><br>A video [titled the name of the facility] provided by the facility on safe mechanical lift transfers during staff orientation revealed; the section of the video presented by the manufacture included the ideal way to retrieve a resident off the floor was to have the resident ' s head at the mast and for the care giver to protect the resident ' s extremities from any injury.<br><br>Resident #2 had multiple admissions to the facility since 2011 with diagnosis of chronic pain syndrome, difficulty in walking and muscle weakness-general. She had a history of a right side knee replacement and right foot/ankle congenital deformity.<br><br>The annual Minimum Data Set dated 12/3/2014 | F 323 | F 323: White Oak Manor - Burlington ensures that the residents environment remains as free of accidents hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents.<br><br>Resident #2 was re-assessed for use of the mechanical lift on 2/5/15 by Todd Moody, RN, Restorative Nurse.<br><br>The mechanical lift for Resident #2 is the "Total Lift" and will be used with placing the resident's legs to one side and guiding their legs by staff to ensure safe transfer.<br><br>Resident #2's lift status is communicated to the staff via the CNA care guide under "Special Instructions". (This is in the electronic medical record on the kiosk.)<br><br>Other residents who use the lift are lifted per manufacturer recommendations and facility policy. | 3/2/15 |

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

Electronically Signed | 02/25/2015

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| F 323 | Continued From page 1<br>revealed Resident #2 was moderately cognitively intact. Resident #2 was able to recall the correct year, month and day of week. She required extensive assist with two persons physical assistance for transfers; and required limited assistance with one person physical assistance with toilet use. Resident #2 was independent with locomotion on the unit.<br><br>A 12/17/2014 care plan identified Resident # 2 as being at risk for falls due to history of falls. The care plan specified " Requires extensive to total assistance with all ADL ' s (activities of daily living) and requires mechanical lift for transfer (sit to stand with transfer). " One person assistants required during all transfer.<br><br>An incident report on 1/28/2015 at 7:45 PM included: Resident #2 usually requested assistance with toileting but did not. She slipped and fell when independently transferring herself from commode to wheelchair. During a mechanical lift transfer by staff Resident #2 ' s right lower leg, outer aspect, scraped over a latch and tore her skin. Resident #2 ' s injuries were an above the right knee V-shaped 2cm (centimeter) x 2cm laceration (skin tear) and a right lower leg, outer aspect, large open deep tissue wound. Resident #2 was sent to the emergency room for an evaluation.<br><br>A statement from Nurse Assistant # 1 dated 1/28/2015 at 7:45 PM included Resident #2 yelled for help. Resident #2 was on bathroom floor on her back. Nurse Assistant #1 called for Nurse #3 and Nursing Assistant #2 to assist in getting Resident#2 off the floor. Nurse Assistant #1 got the total [mechanical] lift. Once Resident#2 was lifted off floor Resident#2 ' s leg was bleeding and | F 323 | Initially, the "Get a Lift-WOM (White Oak Manor) Burlington" lift video was reviewed by the Todd Moody, RN, Restorative Nurse. The nursing staff were retrained on how to transfer a resident from the floor per the manufacturer's recommendations, i.e. with the Resident's head at the mast of the lift to reduce the risk of the resident's extremities being injured. The training was conducted by Todd Moody, RN, Restorative Nurse and was completed by 2/13/15.<br><br>On 2/9/15 WOM-Burlington received new lifts from a new manufacturer. The staff training on using the new lifts was conducted by the lift company and included the lift procedure when a resident is on the floor. The training on the new lift included a<br>video and return demonstration and was completed on 2/19/15.<br><br>Newly hired nursing staff receive the lift training and return demonstration during their specific job orientation with the SDC (Staff Development Coordinator).<br><br>The lift training is part of the annual training for nursing staff.<br><br>Nursing Administration (Director of Nursing (DON), SDC, Restorative Nurse, Safety Nurse, Unit Coordinators and Shift Supervisors will conduct staff observations when using the mechanical lift is per manufacturer recommendation and facility policy, a total of at least 10 observations per week for 4 weeks, then | |

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| F 323 | Continued From page 2<br>skin was torn. " Nurse called EMS (emergency medical services). "<br><br>A statement from Nurse Assistant #2 dated 1/28/2015 (no time given) included " I [Nurse Assistant #2] was at the head of the resident [Resident #2] holding the lift pad and looking down at her and talking to her trying to comfort her when all of a sudden the resident [Resident #2] started to yell and I [Nurse Assistant #2] looked up to see the resident ' s leg to have a hole in it then the Nurse [Nurse #3] wrapped a towel around the wound and lifted the resident [Resident #2] up with the total lift and got her to her room then I [Nurse Assistant #2] exited the room because there were nurses in the room taking care of the resident. "<br><br>A record review of a progress note written by Nurse # 3 on 1/28/2015 at 7:45 PM for Resident #2 included Nurse #3 was called to Resident #2 ' s bathroom and observed Resident #2 lying on her back. Resident #2 reported she went to the bathroom unassisted and fell trying to get in the wheelchair. Nurse #3 reported a small superficial skin tear above the right knee. Resident #3 was rolled onto a bed sheet and pulled out of bathroom into a larger open space. Resident#3 was rolled onto a lift pad and while she was being lifted Resident #3 said " Oh, my leg. " Nurse #3 documented:<br>Outer aspect of the lower right leg examined and noted to have a large open, deep tissue wound. Small amount of bleeding noted. Leg wrapped with towel. Staff x 3 continued to lift resident into bed without further incident.<br>Nurse #3 included the family notified the facility to report Resident#2 was going to surgery to have the wound surgically repaired. | F 323 | 10 observations monthly for 2 months, then random observation each month for 6 months.<br><br>Concerns / issues observed during the lift observations are discussed during the morning QI (Quality Improvement) meeting Monday - Friday for 4 weeks, then monthly for 2 months and then as concerns arise thereafter. The QI committee will make recommendations during the QI meetings when indicated.<br><br>The DON is responsible for ongoing compliance to F 323.<br><br>Compliance Date: 03/02/15 | |

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| F 323 | Continued From page 3<br><br>On 2/1/2015 and on 2/2/2015 at 11:27 AM the Director of Nursing (DON) reported the policy was for staff to proceed with a total lift transfer [mechanical lift] after a fall.<br><br>On 2/1/2015 at 12:00 PM an interview with Resident #2 revealed she recalled the fall in the bathroom. She was in the bathroom attempting to transfer her self and knew she was not supposed to. When she was transferring herself she lost her balance and fell to the ground. Resident #2 did not know how she was injured. She did reveal that she shouted " ouch " when she was being lifted off the floor with the mechanical lift.<br><br>On 2/2/2015 in the AM an interview with Nurse Assistant #2 revealed he was coming out of the break room and was called for assistance by Nurse assistant #1 to lift a resident off the floor with a mechanical lift. He reported he was at Resident #2 ' s head during the lift and Nursing Assistant #1 was at Resident #2 ' s feet and the controls during the lift. He did not see what happened.<br><br>On 2/2/2015 at 10:30 AM and interview with Nursing Assistant #1 revealed she was making her rounds and heard Resident #2 yell for help. Nursing Assistant #1 found Resident #2 lying on the bathroom floor. Nursing Assistant #1 reported she " looked over " Resident #2 and did not see any injury. Nurse Assistant #1 went out of the room and retrieved Nurse #3 and Nurse Assistant #2. Nurse #3 did her assessment. The staff members put a sheet under Resident #2 and pulled her out of the bathroom and into a room. Nurse Assistant #1 brought the lift in and rolled Resident #2 on to the lift pad. Nurse Assistant #1 | F 323 | | |

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| F 323 | Continued From page 4 | F 323 | | |

held the feet at the mast, Nurse Assistant #2 was at Resident #2 ' s head, and Nurse #3 was in the middle. Nurse Assistant #1 reported she put Resident #2 ' s legs together in the lift pad for support because Resident #2 had injuries to her right leg.
Nurse Assistant #1 worked the controls for the mechanical lift and reported there was no problem with the control function on the mechanical lift. Nurse Assistant #1 revealed when she was lifting Resident #2 with the mechanical lift, Resident #2 said " ouch " and Nurse Assistant #1 stopped the lifting control. Nurse Assistant #1 reported she did not see Resident #2 ' s leg [right] hit anything. Nurse #3 looked at Resident #2 ' s leg and said " get a towel " . The three staff members put Resident #2 in the bed and Nurse #3 called EMS.

A record review of hospital records date of admission was 1/28/2015 revealed Resident #2 presented with a complex traumatic laceration following an injury obtained during transfer. The laceration was too large to be closed in the emergency room. Resident #2 was taken to the operating room for a partial closure and debridement of the wound. A JP drain (used to promote wound healing) was left in place. Resident #2 was placed on antibiotics.

On 2/2/2015 at 10:40 an interview with Nurse #3 revealed during her first assessment of Resident #2 there was no blood just a small skin tear above the right knee. There were three staff members to lift Resident #2 with the mechanical lift. Resident #2 hit her leg on a latch on the base of the lift during the lift. Nurse #3 reported Resident #2 said " oh my leg " then Nurse #3 assessed a wound on the right lower leg. Nurse

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| F 323 | Continued From page 5<br>#3 reported she knew Resident #2 ' s leg caught on the latch because Nurse #3 identified there was flesh and blood on the latch. Nurse #3 showed the surveyor the latch [identified as the locking handle on the base of the lift mast in the manufacture guide for the mechanical lift]. Nurse #3 revealed when she assessed Resident #2 in the bathroom the wound was not there. Nurse #3 reported that Resident #2 ' s injury could have been prevented by having a forth staff member assist in Resident #2 ' s transfer with the mechanical lift.<br><br>On 2/1/2015 and 2/2/2015 at 12:16 PM an Interview with Nurse #1 who was the restorative coordinator revealed he was in-servicing staff on the proper technique for mechanical lift and he and the DON were working on QI (quality improvement) for the best way to transfer Resident #3. Nurse #1 was observed on 2/1/2014 at 10:50 AM performing an audit of staff members using a mechanical lift. He provided instruction to the staff members. Nurse #1 was asked where his knowledge of the proper way to transfer a resident with a mechanical lift came from. Nurse #1 revealed his instructions were from his own knowledge and there was no facility procedure he followed for the education provided in the staff in-service. Nurse #1 reported he had not watched the manufacture video instructions since his facility orientation in November of 2010 and he had not read the manufacture instruction for the mechanical lift. Nurse #1 was unaware of the manufacture instructions for the ideal way to lift a resident off the floor was to have the resident ' s head at the mast.<br><br>On 2/2/2015 at 1:24 PM an interview with the DON revealed her expectation was for the staff | F 323 | | |

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| F 323 | Continued From page 6<br>member/individual who provided the in-service was to know the process [how to use the mechanical lift and educate on safety to prevent the same injury] and in-service accordingly.<br><br>On 2/2/2015 at 1:25 PM the Administrator agreed with the DON ' s expectation. | F 323 | | |