STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 08/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328

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F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to safely transfer a resident with a sit to stand lift by failing to use the assistance of two persons, the correct sling size and leg strap which resulted in 1 of 1 resident (Resident #1) falling from a sit to stand lift during transfer and sustaining a hip fracture. The findings include: Resident #1 was originally admitted to the facility on 12/22/14 and was readmitted on 7/13/16 with diagnoses including Dementia without Behavior Disturbance, Osteoarthritis and Age related Osteoporosis without current pathological fracture and Hemiplegia and Hemiparesis. Review of a Quarterly Minimum Data Set (MDS) dated 7/20/16 revealed Resident #1's cognition was intact based on a Brief Interview for Mental Status (BIMS) of 15. In the area of activities of daily living, she required extensive to total assistance in most areas of activities of daily living except she required supervision during meals. Resident #1 required two person assistance with transfers. In the area of	F 323	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 323 Corrective Action for Resident Affected For resident # 1, on 08/04/16 the resident was sent to the hospital for evaluation for complaints of right hip pain post fall. Corrective Action for Resident Potentially Affected On 09/12/16, the Nurse Management team began completing a lift mobility assessment for all current residents to determine the type of transfer device and	9/16/16

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

Electronically Signed | 09/12/2016

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F 323	Continued From page 1 locomotion on and off the unit, Resident #1 required one person physical assistance. Review of Resident #1's care plan which was updated on 8/4/16 addressed the resident's increased risk for falls related to confusion, deconditioning and history of falls. The interventions did not address transfers. The care plan also addressed activities of daily living self-care performance deficit related to dementia, fatigue and pain. Review of the interventions revealed Resident #1 required total assistance with transfers, however the interventions did not mention Resident #1 required two person assistance with transfers. Review of a Staff Nursing note dated 8/4/16 at 12:26 PM, written by Staff Nurse # 1, read in part, "Nursing Assistant reports pt. (patient) fell on floor during transfer. Patient complains of pain to rt. (right) hip, right leg, ems (emergency medical services) called and in route for transport to hospital, report to charge nurse and supervisor, monitoring continued." Review of a Staff Nursing note dated 8/4/16 at 3:02 PM, written by Staff Nurse # 1, read in part, "Nursing Assistant reports pt.(patient) slide from lift, pt. noted in bed upon, assessment, transferred via ems (emergency medical services) for x-ray, report given to oncoming nurse." Review of a Staff Nursing Note dated 8/4/16 at 11:57 PM, written by Staff Nurse # 2, read in part, "Resident #1 admitted on 7/13/16. Currently the pain assessment revealed acute pain verbalized. New rt. (right) Hip fx. (fracture) hurts a whole lot. Additional Documentation: Resident returned to	F 323	sling size needed for each resident. This process was completed on 09/14/16. On 09/14/16, the MDS Coordinator began updating all residents who were identified as needing a lift for transfers. Included in the care plan and CNA task was the type of lift and sling size needed. This process was completed on 09/16/16. Systemic Changes On 09/12/16, education was initiated for all RN's, LPN's, Med Tech's, and CNA's FT, PT and PRN on the following topics: Where to locate a resident's transfer status, type of lift, sling size, securing the leg strap prior to transfer, and using 2 persons during a lift transfer. Any in-house staff member who did not receive in-service training by 09/16/16, will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training for all Nurses, Med Tech's and CNA's and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. On 9/12/16, the Nurse Consultant conducted education for Nurse Managers including information on communication of resident specific mechanical lift and sling size needs using the resident Care Plan, Kardex and Tasks. Quality Assurance The Director of Nursing will monitor this issue using the "Survey Quality Assurance Tool for Monitoring transfer devices. The	

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F 323	Continued From page 2 facility at 8:50 PM. New orders noted. Prn (as needed) pain-medication given." Review of the facility's fall incident report dated 8/4/16 at 2:30 PM, written by Staff Nurse #1 revealed Nursing Assistant (NA#1) reported that Resident #1 slid to the floor during transfer and the resident was in bed when the Staff Nurse entered the room. During Staff Nurse #1's assessment Resident #1 complained of pain to her right hip and right leg. Resident #1 was assessed for injuries, and no injuries were observed. Resident #1's level of pain was a 2 (on a scale of 0 to 10 with 0 no pain and 10 is the most pain that the patient experienced). The resident was alert and oriented to person. The doctor was notified and the doctor gave orders to send Resident #1 to the hospital emergency room. Review of the facility fall incident investigative report dated 8/15/16 revealed NA#1 was transferring Resident #1 using the "sit to stand lift," when during transfer, the lift sling began slipping up her torso. According to the report Nursing Assistant "1 tried to maneuver the wheelchair under Resident #1 but was unable to do so and was forced to assist Resident #1 to the floor. On 8/8/16, Nursing Assistant #1 demonstrated the lift procedure used at the time of incident. Through NA#1's demonstration it was determined that the cause of the incident was due to failure to use 2 staff member's assistance with the transfer by the lift, failure to use appropriate sling size and failure to secure leg strap. Review of a hospital emergency room report and radiology report dated 8/4/16, revealed Resident #1 was seen at the hospital emergency room for a fall, injury and severe pain to her right hip.	F 323	monitoring will include reviewing five transfers for correct lift, correct technique, and to review the care plan for correct device. This will be completed weekly x 4 weeks then monthly times 3 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	

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According to a radiology report Resident #1 had a prior right hip arthroplasty (surgical reconstruction or replacement of a joint) based on a 10/31/11 examination. The radiology report noted a trochanteric fracture right hip (upper part of the thigh bone).
During an interview on 8/23/16 at 10:08 AM, Nursing Assistant (NA#2) recalled when she went into Resident #1's room they already had the sling lift pad under Resident #1 to get her off the floor. She stated NA# 1 and NA#3 were in the room. NA#2 said she just hooked one of the sling hooks to the lift. She stated they said they had it under control after that. NA#2 said NA#1 & NA# 3 started lifting Resident # 1 from the floor using a full body lift. NA#2 commented she guessed they were going to put her back in the bed. She revealed Resident #1 was fine and she did not see her hurt or anything. NA# 2 said no one said what happened or anything. NA #2 stated she had worked with Resident #1 before, but it had been a while back. She recalled she used the sit to stand lift when she worked with Resident #1 and she controlled the sit to stand lift by herself. NA#2 stated she could not recall how long ago she worked with Resident #1.
During an interview on 8/23/16 at 10:22 AM, Staff Nurse #1 revealed NA#1 came to her and she was on the telephone talking to a doctor's office. She said NA#1 told her Resident #1 couldn't hold on to the lift and Resident #1 fell down. Staff Nurse # 1 revealed she told the aide to leave the resident there and to get a set of vitals and she would be there after she got off the phone. Staff Nurse #1 said it was an important call, it was a short call, a couple of minutes. She stated after the phone call she went to Resident #1's room and a Nurse Supervisor went with her to the room. Staff Nurse #1 stated the Nursing Assistant

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had other nursing assistants in the room when she got there. She stated she did not know all their names. She stated Resident #1 was on the bed. Staff Nurse # 1 said the Nursing Assistant did not tell her why she moved Resident #1 from the floor to her bed. She revealed she started the assessment, and the resident complained of pain. Staff Nurse # 1 stated she thought Resident # 1 got something for pain. She said everything happened so fast. Staff Nurse # 1 said initially Resident # 1 was not complaining of pain until after she touched her leg. She recalled Resident # 1 frowned up and barely wanted to admit she had pain. Staff Nurse #1 stated she kept checking Resident #1. Staff Nurse # 1 said she assessed Resident #1's right hip and right leg and Resident #1 grimaced a little, but she did not show extreme pain. She revealed Resident #1 did not want to go to the hospital. She stated she sent Resident #1 out to the hospital after the assessment and emergency medical services transported Resident #1 to the hospital.
During an interview on 8/23/16 at 10:34 AM, the Unit Manager stated when she got called to Resident #1's room, Resident #1 was lying in bed complaining of pain to her right hip. She stated she assisted the charge nurse with sending Resident #1 to the emergency room to have the right hip area assessed further. The Unit Manager reported that based on her observation with the resident, it was best for Resident #1 to go to the emergency room to have it checked further. She revealed they could not be sure if there was a problem without x-rays or scans. She stated she told Resident #1 that they were going to send her to the emergency room. The Unit Manager said Resident #1 was talking and was not crying or anything. She stated she called the doctor who gave an order to send Resident #1 to

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the hospital. The Unit Manager revealed she gave a report to emergency medical services that Resident #1 had a fall from a lift and she did not witness it. She also reported that Resident #1 used oxygen and was alert and oriented. The Unit Manager revealed after she gave the report, emergency medical services left with Resident #1. The Unit Manager stated she was surprised Resident #1 came back with a fracture because the resident did not initially complain of pain, except when she touched it.

During an interview on 8/24/16 at 11:09 AM, NA #3 stated she was called to help NA #1 assist Resident #1 from the floor and to put her in bed. She stated she did not know exactly what happened. NA# 3 stressed her main reason for being there was to get Resident #1 from the floor to the bed. She stated they used the full lift to transfer Resident #1 from the floor to the bed. NA# 3 said when she came in the room, Resident #1 was sitting on the floor, she was talking and she did not complain of pain.

During an interview on 8/24/16 at 11:28 AM, NA #1 revealed the day of the incident she was pulled from the 800 hall to the 300 hall with two other nursing assistants to work. She stated she received a verbal communication report about Resident #1's care. She revealed Resident #1 required the sit to stand lift for transfer. She stated during the morning she gave Resident #1's bath first and after her bath she transferred Resident #1 to her wheelchair using the sit to stand lift. NA# 1 stated when she did her last rounds at 2:00 PM Resident # 1 was in her wheelchair and she needed to be changed. She revealed she planned to transfer Resident #1 from her wheelchair to her bed to change her. NA #1 explained she hooked Resident #1's sling up to the lift and put a buckle around the resident's

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waist and lifted her up in the sling with the lift. NA #1 revealed that she tried to move the resident's wheelchair and oxygen out of the way because there was not enough room to maneuver the sit to stand lift. She revealed that she tried to direct the lift toward the resident's bed and she saw Resident #1 going down, slipping through the left side of the sling. She stated as she was trying to lower Resident #1 to her wheelchair, Resident #1 got to the edge of the wheelchair and she was still sliding and the wheelchair started moving. NA# 1 recalled when Resident #1's knees started to buckle, she pulled the lift out so she could straighten the resident's legs and when Resident # 1 finished sliding she was on the floor and the seat cushion from the wheelchair was pushed up against the night stand. NA #1 recalled that she got behind Resident #1 to try to support her back until someone else came to assist her. She stated Resident #1 did not bear weight on her legs, she said Resident #1's knees buckled and she did not hit the floor hard. NA#1 stressed that she called for assistance when Resident #1 slid to the floor. She stated she waited until Resident #1 was out of harm and she ran to the door and looked for help. NA#1 revealed Resident #1 said she was not hurting, but Resident #1 said she could not breathe right. NA#1 stated she shouted in the hall for the Nurse, but the nurse said she could not get there right away. NA#1 revealed two other Nursing Assistants came in to help her get the resident up from the floor. She revealed she thought the nurse asked the nursing assistants to come help her get Resident #1 off the floor. NA#1 stated the nursing assistants came in with a full lift and she recalled they used the pad from the full lift to lift Resident #1 up and put her in bed. NA #1 stated Staff Nurse #1 and the Unit Manager came and they checked Resident #1

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out. She stated they proceeded to change Resident #1 until emergency services arrived. NA#1 said NA#3 helped her change Resident #1 in bed. She revealed she did not know Resident #1 was supposed to have two staff to transfer her. She stated she could not recall who gave her the report on how to care for Resident #1.
During an observation on 8/24/16 at 4:25 PM, the Administrator and two Nursing Assistants NA #4 and NA# 5 demonstrated how residents should be transferred with a sit to stand lift. The two Nursing Assistants lifted the Administrator in the sit to stand lift. The Nursing Assistants revealed they looked at a chart with different colors noting the size of the slings, which was based on a resident's weight. The Nursing Assistants revealed they made sure they had the right size sling and going by the chart they used a medium sling to lift the Administrator. The medium sling pad was placed in the wheelchair. A velcro buckle from the sling was placed around the Administrator's waist. Velcro straps were also placed around the Administrator's legs. An apparatus from the lift was placed against the Administrators knees and legs for support. The sit to stand lift was locked into place. The Administrator held onto hand rails and NA#5 pressed the button on the lift and the lift caused the Administrator to go from a sitting position to a standing position. After the demonstration was over the Nursing Assistants removed the velcro buckles from the Administrator's waist and legs. The Nursing Assistants revealed they looked at the chart to determine what size sling to use and revealed staff could also ask the Nurse on the hall about the correct size of sling to use.
During an interview on 8/24/16 at 12:19 PM, the Administrator revealed he had NA#1 come in to demonstrate for them what happened during the

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F 323	Continued From page 8 transfer with the lift. He stated the Nurse Consultant was also present. The Administrator reported that NA#1 hooked him up in the sling to the lift. He stated he asked NA#1 what kind of sling she was using and she said she could eye ball it. The Administrator explained his arms were up as NA#1 stated Resident #1's arms were up while in the sling and she stated Resident #1 slipped through the sling and said she was going down. The Administrator stated NA#1 said it was like Resident #1 gave out. He stated he let his legs go too and he did not go anywhere. The Administrator revealed NA#1 was not able to show them how Resident #1 fell. He stated NA# 1 said she flagged a Nursing Assistant to help her get Resident #1 up from the floor. The Administrator revealed NA#1 did not give the nurse time to assess Resident #1 and she put the resident back in bed. He stated NA#1 could not recreate what happened. The Administrator suspected that NA#1 either did not hook up the resident properly in the sling or she did not use the right sling size.	F 323		