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F 000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted from 08/22/23 through 08/23/23. Event ID# WUFV11. The following intakes were investigated NC00205663, NC00200791, NC00198437 and NC00197867. 1 of the 4 complaint allegations resulted in deficiency. 1 of 1 FRI resulted in deficiency. Noncompliance began on 01/24/23. The facility came back in compliance effective 04/12/23.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, staff, and Physician Assistant (PA) interviews the facility failed to safely transfer a resident (Resident #3) from her bathroom to the recliner using the mechanical lift that resulted in the dislocation of the left shoulder which required treatment at a hospital. The facility also failed to safely transfer a resident (Resident #2) from her motorized wheelchair to the bed using the mechanical lift that resulted in a fracture to the right hip which required treatment at a hospital.	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 09/05/2023

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This was for 2 of 6 residents reviewed for supervision to prevent accidents.

Findings included:

1. Resident #3 was admitted to the facility on 03/07/22 with diagnosis that included osteoporosis, repeated falls, and pain to left arm.

A care plan dated 12/28/22 revealed in part; Resident #3 had a focus area to maintain current level of physical mobility and ability to perform any assist with her self-care. Interventions read in part staff to assist with all transfers and to transfer with the stand up mechanical lift on days she ' s not able to assist staff with standing.

The Minimum Data Set (MDS) quarterly assessment dated 01/13/23 revealed Resident #3 cognition was severely impaired she exhibited no behaviors. She required extensive assistance with the help of two people with toilet use and total assistance with the help of two people with transfers. No limitations to mobility of upper or lower extremities.

Resident #3 ' s incident report dated 01/24/23 at 6:40 PM that read in part that Resident #3 had a large area bruise on the left anterior thigh and complained of left shoulder pain. She was examined by the Physician Assistant (PA) which ordered an x-ray of her left shoulder. The x-ray revealed a dislocated left shoulder and Resident #3 was sent to the emergency room for further evaluation.

An interview with Physician Assistant (PA) was conducted on 08/23/23 at 10:32 AM. He indicated staff called him to the Resident #3 ' s room on

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01/24/23 due to a complaints of pain to her left shoulder. After assessing resident, he recommended Physical Therapy (PT) to assess her and to apply ice packs as needed. He further stated staff denied any injury or fall. PT recommended obtaining an x-ray for further evaluation which he ordered, and results revealed Resident #3 had a dislocated left shoulder. She was sent to the emergency room for further evaluation and treatment.

A phone interview with Nurse #1 was conducted on 08/23/23 at 12:10 PM. She confirmed she did work on 01/24/23 from 6 AM-6 PM and was Resident #3 ' s nurse. She indicated she was told by Nursing Assistant (NA) #2 that Resident #3 had complained of left shoulder pain prior to breakfast and requested pain medication. She stated upon entering Resident #3 ' s room, she was sitting up in her recliner. She then administered the pain medication and assessed her shoulder. She indicated that she could wiggle her fingers, move her wrist in a circle, bent her arm at the elbow, and shrugged her shoulders without complaints of pain, however she was unable to lift her arm up. Resident #3 was unable to give a reason for the pain to her left shoulder. Nurse #1 then notified the Physician Assistant (PA) that was in the facility at the time. She also indicated NA #2 did not report any type of injury or fall. Nurse #1 verified she worked with Resident #3 on 01/23/23 and she did not complain of shoulder pain nor did staff report pain to shoulder or a bruise to her left thigh area.

A phone interview with Nursing Assistant (NA) #3 was conducted on 08/23/23 at 12:10 PM. She stated she did work 6 AM-6 PM on 01/24/23 but she did not provide direct care to Resident #3.

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She indicated she did bring the resident her breakfast tray the morning of 01/24/23 and that she complained of left shoulder pain at that time. She further stated she notified the nurse of the residents ' complaints of pain. She also stated she did not assist NA #2 with any transfers with Resident #3 during her shift.

A phone interview with Nursing Assistant (NA) #4 was conducted on 08/23/23 at 1:12 PM. She stated she did work 6 AM-6 PM on 01/24/23 but she did not provide direct care to Resident #3. She further stated she did not assist NA #2 with any transfers with Resident #3 during her shift.

A phone interview with Nursing Assistant (NA) #5 was conducted on 08/23/23 at 1:21 PM. She stated she did work 6 AM-6 PM on 01/23/23 and she provided direct care to Resident #3. She indicated she did not see any skin discolorations, bruises, nor did Resident #3 complain of any new pain or discomfort during her shift.

A phone interview with Nurse #3 was conducted on 08/23/23 at 1:49 PM. She stated she did work 6 PM-6AM on 01/24/23 but she did not provide direct care to Resident #3. She indicated she assisted Nurse #4 with performing an assessment on the resident and instructed her to notify the Director of Nursing (DON) due to a large, bruised area to Resident #3 ' s left thigh area.

Nurse #4 was unavailable for interview. According to Nurse #4 ' s statement dated 01/24/23 during 6 PM-6AM shift she indicated she received report from Nurse #1 that Resident #3 had complained of left shoulder pain during her shift. She indicated that the Physician Assistant (PA) and

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Physical Therapy (PT) had evaluated Resident #3 and an x-ray had been ordered. She stated the Nursing Assistant (NA) notified her of a large bruised are to the residents left thigh area. She performed an assessment and noted the bruise/hematoma to her left thigh, resident denied pain at the time. X-ray results revealed Resident #3 had a dislocated left shoulder and was sent to the emergency room for evaluation and treatment.

An interview with the Director of Nursing (DON) was conducted on 08/23/23 at 2:12 PM. She stated she received a call from Nurse #4 on 01/24/23 informing her the x-ray results revealed a dislocated shoulder and she reported a bruised area to Resident #3 ' s left leg. She also stated that she was being sent to the emergency room for evaluation and treatment. She returned to work on the morning of 01/25/23 and performed an investigation of the dislocated shoulder and bruised leg. She indicated Nursing Assistant (NA) #2 was Resident #3 ' s direct care NA for 01/24/23 from 6 AM-6 PM. She had a phone interview with NA #2 which stated that when she went in to provide AM care to Resident #3, she had complained of shoulder pain. She indicated NA #2 then explained that during a transfer using the stand-up mechanical lift that the residents ' legs gave out and she lowered her to floor. She then stated NA #2 indicated a short girl with black hair assisted her in getting Resident #3 off the floor but was unable to provide a name. No employee ' s that worked on 01/24/23 matched the description that NA #2 gave. She verified NA #2 stated she did not have assistance by another staff member while utilizing the mechanical lift. The DON then stated that NA #2 had not reported the fall to the nurse and that her description of a

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staff member that assisted her with getting Resident #3 from the floor did not match anyone that had worked on 01/24/23. She further stated mechanical lifts require 2 person staff assistance. She indicated all nursing staff had received training on using the mechanical lift. She further stated NA #2 should have asked for assistance before transferring Resident #3 alone.

A phone interview with Nursing Assistant (NA) #2 was conducted on 08/23/23 at 2:45 PM. She stated she did work 6 AM-6 PM on 01/24/23 and she provided direct care to Resident #3. She also stated that when she went in to provide AM care to Resident #3, she had complained of left arm pain. She indicated that during a transfer using the stand-up mechanical lift the morning of 01/24/23 the residents ' legs gave out and she lowered her to floor, she did not have another staff member in the room with her during the transfer. NA #2 stated a short girl with black hair assisted her in getting Resident #3 off the floor, but she did not know the girl ' s name. She further stated Resident #3 had no difficulty holding the handles during the transfer and did not complain of pain. NA #2 indicated she did not observe any bruising to residents left thigh area when providing incontinence care but that she did not remove her pants, only enough to put the incontinence brief on.

2. Resident #2 was readmitted to the facility on 04/14/23 with diagnosis that included orthopedic aftercare after right hip fracture due to a fall, osteoarthritis, and spondylosis with myelopathy of the cervical region.

The Minimum Data Set (MDS) quarterly assessment dated 02/22/23 revealed Resident #2

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was cognitively intact. She required extensive assistance with the help of two people with bed mobility, transfers, and activities of daily living. Impaired mobility to both sides of upper and lower extremities and as having no falls.

A care plan dated 04/07/23 revealed in part; Resident #2 had a focus area of impaired functional status related to no functional use of her legs. Interventions included in part; to transfer with the total mechanical lift. She also had a focus area of at risk for falls related to no functional use of her legs. Interventions included in part; staff will assist me during transfers from surface to surface as needed.

Resident #2 ' s incident report dated 04/10/23 at 1:10 PM completed by Nurse #1 read in part that Resident #2 was being transferred to the emergency room for possible right hip fracture due to a fall. Resident complained of back pain and right hip pain, and her right leg was rotated outward.

Resident #2 ' s fall scene investigation report dated 04/13/23 read in part that she fell from the mechanical lift during a transfer from her electric wheelchair to the bed. The report included contributing factors observed at time of fall were staff/equipment error and that the mechanical lift pad caught the arm of her wheelchair. The report summary revealed staff member transferred resident using total lift without having a second clinical staff member present.

Discharge summary dated 04/14/23 read in part that Resident #2 presented to the emergency department related a mechanical lift fall with osteoporotic bone disease. The fall resulted in a

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right hip fracture that required a surgical right hip partial repair on 04/11/23.

Investigation report revealed Resident #2 had a fall from a mechanical lift during a transfer. The Physician Assistant (PA) was in facility at the time of the incident and assessed resident promptly. Emergency Medical Assistants (EMS) was called, and resident was transferred to the hospital and admitted for a right hip fracture. Nursing Assistant (NA) #1 was written up for failure to follow policy and training to have a second staff member present at the time of lifts. After a detailed fall investigation and witness statements, it was determined that there was no failure through inattentiveness, intentional or reckless behavior, or carelessness to provide resident services. All care staff immediately in serviced in safe operation of equipment and following established safety operating policy.

An interview with Nursing Assistants (NA) #1 was conducted on 08/22/23 at 2:41 PM. She indicated Resident #2 was in her electronic wheelchair and requested to be put in bed because she needed to use the bed pan. She stated Resident #2 required the use of a mechanical lift for all transfers and when she retrieved the lift, she did not see another staff member to assist her. She proceeded to Resident #2 ' s room and applied the lift pad to the mechanical lift, assuring the clasps were securely locked into place.

NA #1 then stated when she went to lift her up in the lift, she double checked that the clasps were in place and proceeded to raise her approximately two feet from her chair. She indicated she then went around to the back of the lift to turn it around to get to the bed when

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Resident #2 stated she was falling. She stated before she could get around the lift to assist, Resident #2 slid out of the lift pad landing on the floor in front of her wheelchair. NA #1 then went to get assistance from the nurse. NA #1 further stated that she does not know what could have happened and indicated the lift pad may have got caught on the wheelchair.

An interview with the Director of Nursing (DON) was conducted on 08/22/23 at 3:07 PM. She stated she was called to Resident #2 ' s room due to a fall from the mechanical lift. Upon entering the room, Resident #2 was on the floor and at that time denied pain or discomfort. She assisted Resident #2 onto her back, and she then complained of back pain. Resident #2 agreed to go to the emergency room for evaluation. She indicated she questioned Nursing Assistant (NA) #1 in reference to what had occurred, and she stated she did not know what could have happened that caused the fall with Resident #2. She indicated the lift pad may have got caught on the wheelchair handle. She stated she had NA #1 perform a reenactment of the incident and reeducated her regarding safe transfers and facility policy guidelines. She revealed that Resident #2 obtained a right hip fracture due to the fall from the mechanical lift.

An interview with Physician Assistant (PA) was conducted on 08/23/23 at 10:32 AM. He indicated staff called him to the Resident #2 ' s room on 04/10/23 due to a fall from the mechanical lift. Upon entering the room Resident #2 was lying on the floor with complaints of pain to the back of her head and right hip. He indicated Resident #2 was stable and comfortable while awaiting Emergency Medical Services (EMS). He further indicated

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staff should follow the facility protocol and the resident care plan when utilizing mechanical lifts to help prevent accidents and injuries.

An interview with Resident #2 was conducted on 08/23/23 at 10:54 AM. She indicated that she did remember the fall on 04/10/23 and that "it was just an accident". She indicated normally there were two staff members who assisted her with transfers using a mechanical lift. She recalled Nursing Assistant (NA) #1 transferred her from her wheelchair to the bed by herself. She stated during the transfer she told NA #1 that she felt like she was sliding out of the sling, but NA #1 was unable to get around the lift before she fell out. She further stated she doesn ' t know how she fell, maybe she was off center in the sling because she knew the clasps were fastened and locked into place. Resident #2 indicated the NA left the room to get help. She was sent to the emergency room for hitting her head, back pain and a possible fractured right hip. She revealed that she underwent a repair of the right hip due to a fracture she obtained during the fall.

An interview with the Director of Nursing (DON) was conducted on 08/23/23 at 2:12 PM. She stated the mechanical lift required 2 person staff assistance. The DON indicated the facility implemented a corrective action plan on 04/10/23 to prevent a reoccurrence. She indicated all nursing staff had

received training on 04/11/23 using the mechanical lift. She further stated Nursing Assistant (NA) #1 should have asked for assistance before transferring Resident #2 alone.

Corrective action for the involved resident dated

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04/11/23 read as follows: Resident #2 was assessed for potential injuries by the licensed nurse. Resident #2 was sent to the hospital for an evaluation and treatment. Employee providing care received disciplinary action.

Corrective action for other potentially affected residents dated 04/11/23 read as follows: Audit of all current residents was conducted by the Director of Nursing (DON) regarding transfer status. All current residents identified as being transferred using a mechanical lift were audited to make sure the transfer status was accurate in the chart and care plan by the Minimum Data Set (MDS) nurse.

Systemic Changes and Education initiated on 04/11/23 read as follows: All current nursing staff were educated by the Staff Development Coordinator (SDC) regarding the mechanical lift policy which requires two staff members be present for each transfer on 04/11/23. Any licensed or nursing staff that cannot be reached within the initial reeducation time frame will not take an assignment until they have received this reeducation. Agency licensed nurses or nursing staff and newly hired licensed nurses or nursing staff will have this education during their orientation.

Quality Assurance (QA) Plan initiated on 04/11/23 read as follows: The Director of Nursing (DON), Staff Development Coordinator (SDC) or Registered Nurse Supervisor will randomly audit a mechanical lift transfer 3 times per week for 3 months.

Reports would be presented to QA committee by the DON to ensure corrective action was

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appropriate. Compliance would be monitored, and ongoing auditing program would be reviewed at monthly QA meetings for the timeframe of the monitoring period or as it is amended by the committee. The April monthly QA meeting was attended by the Medical Director (MD), Administrator, DON, MDS Nurse, Social Worker (SW), medical records, Chief Executive Officer (CEO), Director of Rehab, and the Dietary Manager. The May monthly QA meeting was attended by the Medical Director (MD), Administrator, DON, SDC, MDS Nurse, Social Worker (SW), medical records, and Director of Rehab. The June monthly QA meeting was attended by the Medical Director (MD), Administrator, DON, SDC, MDS Nurse, Social Worker (SW), medical records, Chief Executive Officer (CEO), Director of Rehab, Dietary Manager, and Resident Care Coordinator.

The plan alleged compliance on 04/12/23.

Review of the facility plan of correction revealed evidence of 100% auditing of staff using correct transfer techniques for residents requiring a mechanical lift, evidence of 100% all staff interviewing and observation of utilizing mechanical lifts completed on 08/08/23. The facility provided evidence of 100% staff education on correct transfer techniques for residents requiring a mechanical lift completed on

04/12/23. The facility also provided evidence of a QA audits of observations for correct transfer techniques for residents requiring a mechanical lift completed on 08/08/23. Residents deemed alert and oriented revealed no current concerns related to staff using correct transfer techniques requiring a mechanical lift to include having two

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F 689	Continued From page 12 staff members present. Observations revealed two staff were transferring a resident with a mechanical lift as specified on the care plan. The facility ' s date of compliance was validated as 04/12/23. The facility ' s date of compliance was validated on 08/23/23.	F 689		