STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345514	A. BUILDING _____ B. WING _____	C 02/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF NASH	1210 EASTERN AVENUE NASHVILLE, NC 27856

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F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with residents, staff and the primary care physician (PCP) and record review the facility failed to provide a safe transfer for 1 of 3 residents (Resident #1) reviewed for a fall. Failing to provide a safe transfer resulted in Resident #1 sustaining a fracture of his pelvis and fractured ribs. Findings included:	F 323	F 323 1. How was corrective action accomplished for the resident found affected by deficient practice On Thursday, 2/9/2017, Resident #1 was being transferred to the toilet by NA# 1 at approximately 7:25p when he fell from of the sit to stand lift. NA#1 immediately	2/17/17

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

Electronically Signed | 03/10/2017

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F 323	Continued From page 1 Resident #1 was admitted to the facility on 11/27/15 with diagnoses that included abnormal posture, cancer, depression, hypertension, congestive heart failure, generalized muscle weakness, hemiplegia and hemiparesis affecting non-dominant side and osteoarthritis. The most recent fall risk evaluation, dated 5/27/16 indicated Resident #1 was at high risk of falls. Review of a 9/4/16 Restorative Functional Assessment indicated that while the resident did not ambulate, he required assistance to maintain balance, had left side weakness, was chair bound and had joint limitations in his left shoulder, wrist, hip, knee and ankle. A 10/24/16 nurse's note that was identified as a late entry for 10/21/16 indicated Resident #1 required a total lift with green sling for transfers related to inability to hold sit to stand mechanical lift with both hands and the resident's leg came off the lift even when strapped at the base. Nursing notes dated 11/16/16 at 12:22 PM indicated Resident #1 had been reassessed for transfer status. Documentation indicated staff would use the total lift, with the blue sling and the assistance of 1 staff for transfers. Monthly nursing notes dated 11/30/16 at 7:55 AM indicated Resident #1 was a one person physical assist with transfers. It was noted that staff used the total lift for transfers. The most recent Minimum Data Set (MDS), a quarterly dated 12/1/16 identified Resident #1 as alert and oriented with no behaviors. The resident was coded on the MDS as requiring	F 323	went to get Nurse#1 for assistance. Nurse #1 assessed the resident. The resident complained of lower back pain. He was removed from the floor using a full lift and put into his bed. At this point the resident complained of pain with inspiration and pain in his leg. Nurse#1 went to get the Director of Nursing. At approximately 7:30pm, Director of Nursing, went to speak to Resident#1. She asked him what had happened. He stated I just let go and declined to answer further questions. At approximately 7:35pm, Resident#1 PCP was notified by Nurse#1 and an order to send Resident#1 to the emergency room for evaluation was given. At approximately 7:40pm, Resident#1 spouse was notified of the incident and that the resident was being sent to the hospital. At approximately 7:38pm, Director of Nursing notified Administrator about the incident. At approximately 7:50pm, the ambulance arrived and took Resident#1 to the hospital. Statements were obtained from NA#1 and Nurse#1 by Director of Nursing. NA#1 was immediately reeducated concerning lift use. 2. How was corrective action accomplished for residents having the potential to be affected by the same deficient practice On 2/10/2017 at approximately 1:45 pm,	

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F 323	Continued From page 2 extensive assistance with bed mobility, transfer, dressing, toilet use and personal hygiene. Transfer was coded as 2+ person physical assist. Functional limitation in range of motion was coded as impairment on one side of upper and lower extremities. The MDS indicated the resident had experienced no falls since the previous assessment. The 12/4/16 Restorative Functional Assessment indicated the resident was alert and oriented, understood others and always followed directions. He was unable to ambulate and balance required assistance to maintain. The resident was documented as requiring the assistance of two staff members for transfers and was chair bound due to left sided weakness. Joint limitations remained in the left shoulder, wrist, ankle and foot. The assessment indicated the resident easily fatigued and had no weight bearing. Poor hand/eye coordination was also identified. The care plan reviewed on 12/14/16 indicated Resident #1 was at risk of falls due to a history of falls, use of psychotropic medication and left sided weakness. Interventions to protect the resident included assessing previous falls to determine pattern/trend, assist with mobility as needed, bed in low position, call bell in reach, environment free of clutter, mechanical lift per routine using a blue lift pad, medication review, non-skid foot wear when out of bed, not to be left alone when toileting and therapy referral as indicated. Monthly nursing notes dated 12/30/16 at 7:55 AM indicated Resident #1 was alert and oriented x 3, pleasant and cooperative. He required physical assistance of one with transfers. The note	F 323	Director of Nursing and Administrator called the Regional Director of Clinical Services to discuss the incident. After the call, all sit to stand lifts (4) were taken out of service by Administrator, He obtained the Arjo Sara 3000 instructions for use manual and inspected the sit to stand lifts with this as the guideline. There was no malfunction of the equipment found during this inspection. All slings used for the sit to stand lifts were also inspected. There was no damage or defect noted in any of the lift slings. The lifts were then put back into service after inspection. At approximately 3:00pm, present 1st shift and oncoming 2nd shift nursing staff were reeducated concerning the following information. The reeducation was provided by Director of Nursing at the huddle. There was a huddle at the beginning of each shift from this point forward. These education huddles were led by either Director of Nursing, Assisted Director of Nursing or RN Supervisor The reeducation included: " Understanding signage for transfer status that is located on each resident□s door " The transfer status for each assigned resident " All lift transfers require 2 people " All staff have the ability to question any lift status. At approximately 9:39pm, Regional Director of Clinical Services called Director of Nursing to inform her that all sit to stand lifts need to be taken out of service and placed behind a locked door	

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F 323	Continued From page 3 indicated the resident was working with therapy on strengthening and transfers. He was identified with left sided weakness per baseline. Review of a nursing note written on 2/9/17 at 7:34 PM indicated the nurse had been called to the room by the nursing assistant (NA) #1. The NA told the nurse the resident had fallen out of the sit to stand lift. The resident was found lying on the bathroom floor. The nurse documented Resident #1 stated his back hurt. The nurse documented the NA stated the resident was on the sit to stand lift and took his arm out of the sling causing him to fall. The nurse documented Resident #1 agreed with the circumstances of the fall. When Resident #1 was placed back in bed, he stated it was painful to take a deep breath and complained of left hip pain. The PCP and RP were notified and Resident #1 was sent to the hospital. Emergency room (ER) documentation, dated 2/9/17, indicated Resident #1 told the ER physician he had been dropped on the toilet from a lift. The physician noted the resident had a fracture of his left hip and fractures of the left 7th and 8th ribs. Notes indicated Resident #1 was in severe pain requiring Morphine for pain control. On 2/13/17 at 7:12 PM, Resident #2, who was the room-mate of Resident #1 was interviewed. The resident stated Resident #1 had a stroke and could not use his left arm and leg; adding a sit to stand lift was used for Resident #1's transfers. On 2/9/17, Resident #2 added NA #1 came into the room to transfer the resident to the bathroom. When he was placed in the bathroom, the NA left the room. Resident #2 stated he heard "an awful sound" and then heard Resident #1 yelling for help. Resident #2 stated he opened the	F 323	where staff had no access. Additionally Director of Nursing was directed that no sit to stand lift will be used until the resident was reassessed for current lift need. Additionally, no staff will utilize the sit to stand lift until they have competency verification for use of the lift. At approximately 9:50pm, Nurse#1, secured all sit to stand lifts in the building. At this point there was no further risk to any resident in the building related to this issue. A total lift was then used for any resident requiring mechanical transferring. Throughout the weekend, education of the staff continued and care plans were updated as needed. 3. Measures put into place to ensure deficient practice will not occur. On Monday, 2/13/2017, the transfer indicator signage located on the doors of each resident and the resident transfer assessment were compared to verify that the signage accurately reflected the appropriate transfer status for each resident by the Director of Rehab and the Nursing Supervisor. On Monday, 2/13/2017, reevaluation of resident lift status began. Reevaluation of all residents previously using the sit to stand lift were completed on Thursday, 2/16/2017, by the Director of Rehabilitation and/or the Occupational Therapist. The door signage was validated at the time of each reassessment. During the week of	

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F 323	Continued From page 4 bathroom door and saw Resident #1 had fallen; adding he appeared to be tangled in the belts on the lift. He stated the NA returned to the room and told him he needed to get out of the way. Then the nurse and eventually the Director of Nursing (DON) came into the room. Resident #2 stated he had not been interviewed about what he had seen and heard. When he tried to tell administration, he was told the incident was none of his concern. Nurse #1 was interviewed on 2/14/17 at 11:34 AM. She stated she was Resident #1's primary 7:00 AM to 3:00 PM nurse. The nurse stated with Resident #1 having diarrhea for at least 3 weeks during January he was weak and pale. Nurse #1 stated Resident #1 had left sided weakness and a sit to stand mechanical lift was used for transferring the resident from bed to chair. NA #1 was interviewed on 2/14/17 on 1:27 PM. The NA stated she worked on different halls and while she primarily worked first shift, she at times, would stay over and work second shift. The NA stated information about resident transfer status could be found on the door by the resident's name. She explained the coding and added Resident #1 was transferred with a sit to stand lift using a green sling with the assistance of 2 staff. The NA added Resident #1 was heavy and because of that, he required 2 staff members to assist with his transfer. The NA acknowledged on 2/9/17 she had transferred Resident #1 by herself. She added she had asked NA#2 who was on break to assist with the transfer. NA #2 advised NA #1 to wait and she would assist when her break was completed. Rather than wait for NA #2 to assist, NA #1 stated she transferred Resident #1 alone because he was ready to go to	F 323	2/13/17, the care plans and kardex of these residents were reviewed by Regional Director of MDS for accuracy. On Wednesday, 2/15/2017, staff competency verification for sit to stand lift use began. This verification was completed for every nursing staff member prior to their taking their next assignment. These competency were verified by Director of Nursing, Assistant Director of Nursing, Nursing Supervisor, Director of Rehabilitation, or Occupational Therapist. 4. The facility will perform the following in order to ensure that solutions are effective and sustained. The following audits will be conducted beginning 2/17/2017 to ensure the effectiveness of the plan of correction. 5 sit to stand lift transfers will be observed daily by Director of Nursing or designee of various nursing staff for 7 days, 5 days a week for one week, 3 days a week for 3 weeks, and then weekly for 4 weeks. The transfer indicator signage on the doors will be audited weekly for accuracy for 10 weeks by the Director of Rehabilitation or designee. The Director of Nursing and the Director of Rehabilitation will report the results of the monitoring to the monthly QAPI meeting for review and recommendations for the duration of the monitoring period.	

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the bathroom and he had fallen. The NA stated she had not asked Nurse #2 to help her transfer the resident because she was busy passing medication. Other than NA #2, NA #1 acknowledged she had not requested any other staff member assistance and had not told Resident #1 it was unsafe and requested that he wait until NA #2 could help. The NA then stated she thought she had noticed the coding for Resident #1 indicated he was to be transferred with 1 staff assisting and did not know he was a 2 person assist until the Director of Nursing (DON) told her after the fall. NA #1 stated the incident occurred around 7:30 PM. She added Resident #1 was sitting in his wheelchair. She had pushed the sit to stand lift in front of him and secured him with the straps around his legs, his waist and under his arms. When the resident was secured, she had lifted him and was headed for the bathroom. NA #1 added most of the lift was in the bathroom and she had almost arrived to the toilet when the resident's left hand dropped from the handle and then he let go with his right hand and fell. NA #1 stated Resident #1 landed on the bathroom floor on his left side. The NA stated she unclipped the straps and moved the lift. She then went to get Nurse #2. She acknowledged Resident #2, the room-mate, was in the room at the time. At the time of the fall, Resident #1 complained of hip pain and stated his back felt tight. NA #1 added after the fall, she had to do a return demonstration of how she had lifted the resident for the DON, Administrator and the corporate nurse. NA #1 stated she knew the resident had been sick, but had been told by other NAs that he was improving. She acknowledged Resident #1 was alert and oriented.

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The Restorative NA (RNA) was interviewed on 2/14/17 at 2:23 PM. The RNA stated she was familiar with Resident #1 since she provided range of motion to his legs and assisted with splinting his left arm. She added the resident was unable to bear weight and used a sit to stand for transfer. The RNA stated as long as Resident #1 was strapped in properly, there was no issue with using the sit to stand lift. The RNA stated she had worked with Resident #1 during his recent illness and had found him to be weak and unable to move as much.

On 2/14/17 at 1:58 PM, the Administrator was interviewed. He stated to the best of his knowledge, Resident #1's fall occurred when NA #1 was assisting him to the bathroom using the sit to stand lift. The NA had told him she had looked at the signage on the door and thought the resident's transfer status was with the sit to stand with 1 staff assisting. The Administrator added Resident #1 actually had been assessed as requiring 2 staff to assist and NA #1 had read the directions incorrectly. NA #1 had reported Resident #1's left hand shot up and then he let go with his right hand. He slid to the floor and landed on his left side. The NA then notified Nurse #2 who assessed the resident. The RP and the PCP were notified and Resident #1 was transferred to the hospital. The following day, the signage on the doors was reviewed to see if there were any issues. The staff found the signage had a very small 2 that had slipped down and had been blocked. He stated as NA #1 glanced at the signage, she went into the room thinking Resident #1 only required 1 person to assist with transfer. The Administrator stated Resident #1 had been acutely sick leading up to the fall and had been out on 2/9/17 for a family visit. He

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added fatigue may have played a part in the resident's fall.

On 2/14/17 at 2:46 PM, NA #1 demonstrated how she had transferred Resident #1 using the sit to stand lift with the Administrator playing the part of Resident #1 during the lift. The NA stated Resident #1 was able to lift his feet, including his left foot, and place them on the foot of the sit to stand lift. The NA confirmed she had used a green pad as indicated by the dot on the door. The NA stated the resident's wheelchair was setting between the bed and the bathroom door facing the hallway. NA #1 then placed the pad/sling around the Administrators waist and buckled the waist pad. Another strap was placed behind his back and under his arm and clipped to the handle bar. The NA added when she had buckled the two buckles to the waist belt on Resident #1, she had only heard one click which indicated only one of the buckles had been securely fastened, but did not stop to check and make sure both buckles were secure. The NA stated Resident #1's left hand was placed on the left handle of the lift. Since he was unable to grab the handle, she had placed his thumb under the handle. The NA added Resident #1 was able to grip the right handle bar of the lift. NA #1 then took the Administrator's arm and raised it approximately 6-8 inches high and over the bar of the left, resting by his side. After the resident's left arm drop, the NA stated Resident #1 let go of the right handle bar which led Resident #1 to slide downward. As he slid downward, the waist buckles came undone causing Resident #1 to fall, landing in the bathroom floor on his left side.

The Facility's Rehabilitation Manager (RM) was interviewed on 2/14/17 at 3:18 PM. She stated Resident #1 had been referred to therapy for

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evaluation of transfer safety on 1/6/17. The RM stated the resident was able to bear weight and was able to raise his arm as described by the NA during her previous demonstration. The RM stated Resident #1 had progressed during therapy and had been upgraded from total mechanical lift to the sit to stand lift.

NA #2 was interviewed via telephone on 2/14/17 at 3:25 PM. She stated Resident #1 was alert and oriented and required assistance with transfer and bed mobility. She stated the resident had left sided weakness and could only lift his left arm if he did so with his right hand. She stated on 2/9/17, prior to the resident's fall, NA #1 had not asked her to help transfer Resident #1. The NA stated she was unaware of Resident #1's fall until NA #1 went to get her to help transfer the resident to bed. NA #1 reported to her that Resident #1's left arm slipped and he let go with his right hand. NA #2 stated Resident #1 reported to her the same story when asked.
On 2/14/17 at 4:30 PM, Nurse #2 was interviewed. Nurse #2 stated she was the primary second shift nurse for Resident #1 and had been the nurse on duty on 2/9/17 when the resident fell. The nurse stated during January 2017, Resident #1 had diarrhea for approximately 3 weeks which left him physically weak and depressed. He was more lethargic and stated he was weak and tired. She added that typically Resident #1 would be up in his wheelchair, but for 3 weeks during his illness, he stayed mostly in bed. Nurse #2 stated Resident #1 was unable to independently or voluntarily move his left arm and was only able to move his left arm if he used his right hand to move the arm. She stated if his left foot fell off the wheelchair foot rest, he either used his right leg or hand to place his left foot

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back or would call staff to help him place his left foot back on the foot rest. The nurse gave another example and stated when she put lotion on the resident's foot, she would have to lift his foot from the bed because he was unable to do so independently. On the night of 2/9/17, Nurse #2 stated NA #1 came to get her from the nurse's station and told her Resident #1 had fallen out of the lift. The nurse stated she remembered entering the resident's room at 7:30 PM and remembered asking NA #1 if she had securely fastened the resident in the lift. The NA had replied yes. The nurse stated when she arrived in Resident #1's room, she observed him sitting on the bathroom floor with his left side propped against the toilet and maintaining position with right hand. Nurse #2 stated she asked the resident specifically if he had been secured in the lift and he replied yes. When she asked what happened, he replied "that stupid arm of mine (left) slipped out and I let go with the right and fell out of the sling". The nurse stated when she asked the NA about the waist straps being tight, the NA replied they were, but NA #1 had not mentioned she was unsure if the buckles had been secured. Nurse #2 stated when she arrived in the bathroom, the NA had already undone all the straps. The nurse added the room-mate was aware of what had happened as was NA #2. The nurse stated NA #1 had not asked her for assistance with the transfer. Nurse #2 stated if NA #1 had not been sure the waist buckles were secure, she would have expected the NA to stop and make sure the buckles were securely fastened before lifting Resident #1.

The DON was interviewed 2/15/17 at 8:43 AM. The DON stated the NAs assigned to residents were to look at the color on the resident's door

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and the code to determine what sling and mechanical lift plus the number of staff needed to lift a resident. She stated Resident #1 had been assessed as requiring 2 staff members to transfer him with the use of a sit to stand lift. The DON added she was in the facility when the resident fell. Nurse #2 had motioned to her to come and on arriving in Resident #1's room, he had already been placed back to bed. The DON added she asked NA #1 what happened and had been told the resident let go of the lift and fell. The DON stated this story was confirmed by Resident #1. She added when she tried to talk with Resident #1 to get more information, he stated, "I just let go and I don't want to talk about it". She stated she did not pursue with more questions due to the resident's pain status. The DON stated the room-mate was in the room during the fall and was alert and oriented. She acknowledged Resident #2 had not been interviewed and concluded since his interview was not included the investigation would not be considered complete. During the investigation and re-enactment, the DON stated she could not remember NA #1 stating she was unsure if the waist buckles had been secured. She added based on Resident #1's last assessment, 2 staff people should have been present during the transfer. The DON added if NA #1 had been unsure of how many staff were required for the transfer, she should have asked the nurse. The DON stated she was unable to determine if the fall could have been prevented, but stated when Resident #1 let go of the lift it increased his chance of falling.

During an interview with Resident #1 on 2 /15/17 at 10:20 AM, he acknowledged he had been really sick during January 2017 that left him

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345514	A. BUILDING _____ B. WING _____	C 02/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF NASH	**1210 EASTERN AVENUE NASHVILLE, NC 27856**

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weak. The resident stated he was unsure what had caused the fall on 2/9/17, but confirmed the NA had fastened the straps behind his knees, around his waist and under his arms. He was unable to remember if he had let go of the lift and stated all he knew was he ended up on the floor. Resident #1 confirmed and demonstrated his inability to voluntarily lift his left foot/leg or left arm/hand.
The Administrator added on 2/15/17 at 10:44 AM that on Friday, 2/10/17, he visited the resident in the hospital. At that point, the resident stated he felt he had been buckled in the lift.

The resident's PCP, was interviewed via phone on 2/15/17 at 11:20 AM. She indicated that due to Resident #1's size he needed 2 staff people to assist with transfers. The PCP added that due to the fall on 2/9/17, Resident #1 had sustained a pelvic fracture requiring surgical repair and broken ribs.