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F 689 SS=J	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, and staff and physician interviews, the facility failed to secure a resident in a mechanical lift for 1 of 3 sampled residents (Resident #3) reviewed for supervision to prevent accidents during transfers. The resident fell from the total mechanical lift, hit her head on the floor and sustained a hemorrhage contusion to the right frontal lobe of the brain. Findings included: Resident #3 was most recently re-admitted to the facility on 11/15/17 with diagnoses including hydrocephalus, epilepsy, generalized muscle weakness and cognitive deficit. The quarterly Minimum Data Set (MDS) dated 11/24/17 specified the resident was severely cognitively impaired, had no behaviors noted, and required total assistance for bed mobility and transfers. The MDS also revealed the resident had not had any falls since the prior assessment on 8/7/17. Resident #3's Care Plan (revised 12/1/17) stated the resident was to be transferred with a total mechanical lift, using a medium sling.	F 689	Past noncompliance: no plan of correction required.	2/13/18

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

Electronically Signed | 02/13/2018

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Review of the clinical record revealed a Progress Note by Nurse #1 which included that at approximately 11 AM on 1/27/18, "Heard a scream and a loud noise from [Resident #3's room]. Entered room and saw resident under the [total mechanical] lift with body across the [lift's] legs and head on the floor." The note went on to say the resident was not moved and that the Emergency Medical System (911) was called and the resident was transferred to Hospital #1. The note also indicated the Physician Assistant and Resident Representative were notified.

Review of the Emergency Department (ED) Physician Evaluation from Hospital #1 revealed a Computed Tomography (CT) scan was negative for injury. The ED Physician's finding specified there was no evidence of intracerebral, subarachnoid or subdural hemorrhage and no evidence of skull fracture. The resident's vital signs revealed a pulse of 82, respirations were 16 and blood pressure was 179/95. The ED Physician's note indicated the physician had spoken with the Resident Representative and explained symptoms to watch for and that follow-up should be with the physician at the facility. The note also indicated the elevated blood pressure could have been elevated as a result of the pain from the fall and that there was no sign of a hypertensive emergency.

Another note from Nurse #1 on 1/27/18 indicated the resident returned to the facility at approximately 4:15 PM and neurological checks were started. Her vital signs included a blood pressure of 167/100 and the note indicated Resident #3 had a dark bruise surrounding the right eye.

The Progress Note on 1/27/18 at 9:30 PM, was

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by Nurse #2 and indicated the Resident Representative was in to visit with Resident #3. During the visit, the resident's blood pressure was 142/100. The Resident Representative became concerned about the elevated blood pressure and requested the resident be sent to Hospital #2. A call was placed to the physician and the resident was transferred out of the facility to Hospital #2 at 10:30 PM on 1/27/18.

Review of ED Physician's documentation from Hospital #2 revealed that a CT scan showed a small right intraparenchymal bleed (bleeding into the brain tissue itself). It also specified that a Neurosurgeon was consulted, intervention was not deemed necessary and the resident was appropriate to return to the nursing home where she lived.

A Progress Note on 1/28/18 at 6:33 PM by Nurse #1, revealed Resident #3 had returned to the facility at 2:30 PM. Nurse #1 specified in the note that neuro checks were within normal limits and that the resident indicated she was glad to be back.
On 2/1/18 the facility provided documentation that an investigation of the incident was initiated on 1/27/18. It was determined the root cause of the fall was failure of Nursing Assistant (NA) #1 to inspect the mechanical lift before initiating the Resident #3's transfer and failure to assess for the appropriate lift pad size according to the manufacturers recommendations for Resident #3's weight.

The facility investigation included, "NA #1 placed a yellow lift pad size medium per the resident care guide under [Resident #3]. NA #1 hooked the top straps of the [full mechanical lift] sling to

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the right side of the lift sling bar, then applied the top strap to the left side of lift sling bar. NA #1 crisscrossed the bottom strap of the [full mechanical lift] sling and pulled up the left strap and hooked it to the right side bar. Then NA#1 pulled up the right strap and hooked it to the left side of the sling bar. NA #1 did not inspect lift prior to initiating transfer. NA #1 next raised the lift using the manual control and pulled resident off the edge of the bed. NA #2 was positioned between the [Resident #3's specialty wheelchair] and the [full mechanical lift] with her back to [Resident #3]. The lift strap on the right side of the sling bar came loose and [Resident #3] fell to the floor striking head on the floor."

The investigation specified the resident was sent to Hospital #1 and that the physician, the resident representative and the Director of Nursing (DON) were notified about the fall. The lift was removed from service immediately. The Administrator and DON began an investigation within 30 minutes of the fall. They obtained statements from staff and NAs #1 and 2 were suspended from work. The Investigation indicated the resident returned from Hospital #1 at 4:15 PM, an assessment was completed and neuro checks were initiated per facility protocol. At 9:30 PM the same day, the Resident Representative requested a second evaluation at Hospital #2 due to Resident#3's elevated blood pressure. The resident's physician was contacted, gave an order for transfer and the resident was sent to Hospital #2 at 10:30 PM.

Both hospital reports were attached to the investigation. The investigation specified the resident returned from Hospital #2 the next day (1/28/18) at 2:28 PM and neuro checks were resumed per protocol. The investigation also

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included evidence that on March 23, 2017 NA #1 was observed with return demonstration for use of the full mechanical lift utilizing the annual nurse assistant skills checklist by the staff facilitator and on March 17, 2017, NA #2 had been observed with return demonstration for use of the full mechanical lift utilizing the annual nurse assistant skills checklist by the staff facilitator.

An interview was conducted with NA #2 on 2/1/18 at 1:44 PM. As she had written in her statement, NA #2 said she had not participated in putting the resident onto the sling or hooking the sling straps to the mechanical lift, but instead was positioning the resident's chair to receive the resident from the lift transfer. NA #2 said, "I turned around with the chair and saw the clip pop out and the straps came off of the bar. I tried to get to her but the chair was in front of me." When asked how the straps had popped off the sling bar, NA #2 said "I have no idea. It has never happened to me." NA #2 stated the resident slid out of the pad and her head hit the floor. The NA specified that she stayed with the resident until she was transferred to the hospital and then gave a written statement to the DON and has been suspended from work since the incident.

An interview was conducted with NA #1 on 2/1/18 at 2:56 PM. As she had written in her statement, NA #1 said she had checked Resident #3's care guide in the closet which indicated the full mechanical lift and medium sling were to be used for transfers. "I went to get her up, put the pad under her and hooked up the straps. When I was lifting her off the bed, [NA #2] was getting the chair. When I was pushing her toward the chair the straps came off (the sling bar) and she fell." When asked how the straps had come off the

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sling bar hook, NA #1 said, "I don't know. It happened so fast. When I saw her falling I tried to reach and catch her but the right side gave out and she fell away to the side. The nurse was coming down the hall and I had screamed and she came in and said 'don't move her' and she called 911." NA #1 stated she was suspended after she gave her written statement. When asked what she might do differently next time NA #1 said, "Double check everything. Make sure the lift is in working order and straps are where they are supposed to be."

The full mechanical lift used to transfer Resident #3 was observed on 2/1/18 at 5:55 PM. The sling bar had a hook on each end that was approximately 2 inches deep to hold the sling straps. Each hook also had a clip to help prevent the sling strap from sliding up/off the sling bar. The sling bar clip on the right side of the sling bar was dislodged from it's position.
Resident #3's Physician was interviewed by phone on 2/2/18 at 8:30 AM. The Physician stated she had been made aware of Resident #3's fall and that the resident had been sent out to the two different hospitals on 1/27/18 with the resulting diagnosis from the second ED visit of a brain bleed that did not require intervention.

Nurse #1 was interviewed on 2/2/18 at 9:31 AM regarding Resident #3's fall on 1/27/18. Nurse #1 said she had been at the computer near Resident #3's room when she heard a scream. Nurse #1 went immediately to the room and saw the resident on the floor. When asked how far the resident was from the bed, Nurse #1 said "They had not gotten far from the bed from what I could determine. Her head was on the floor and turned to the right, her back was across one of the lift

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legs and her legs were across the other lift leg." Nurse #1 went on to say, "I said don't move her. She was breathing and looking around and I wanted 911 fast so I went across the hall, called 911 to tell them we had a resident fall from the lift." Nurse #1 returned to the room to further assess the resident, and asked what happened. A pillow was placed under the resident's head. "I sent [NA #1 out to get equipment for vital signs but by the time she got back 911 was here." Nurse #1 indicated that after the resident left for Hospital #1, the physician's office was notified, the family was called and she called the DON. Both the DON and the Administrator came in and started an investigation. Nurse #1 said both she and the DON assessed the resident when she returned from Hospital #1 about 4:15 PM. Neurological checks were started at that time.

The Maintenance Director was interviewed on 2/2/18 at 11:04 AM about the condition of the lifts. He stated, "We check them weekly but also when I walk by in the halls I am always looking at them." The Maintenance Director said the full mechanical lift in question had been checked the morning of 1/27/18 and it was in good working condition. He said that after Resident #3's fall, "I found the sling bar clip was askew on the right hand side." but he couldn't say when the clip had become dislodged from its proper position. He further explained that the sling bar clips were intended to keep the sling straps in place on the lift sling bar. The Maintenance Director indicated the full mechanical lift used for Resident #3 remained out of service.

Nurse #2, who worked the evening shift on 1/27/18, was interviewed by phone on 2/2/18 at 11:39 AM. Nurse #2 said, "I came on at 7:00 PM

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that Saturday. I did an assessment then, and did neuro checks through the evening. She stated the family came in around 9:30 PM and were concerned about Resident #3's blood pressure being high at the hospital and that it continued to be a little higher than usual. They wanted her sent out for a second evaluation and specified Hospital #2.

The Administrator and Director of Nursing were interviewed on 2/2/18 at 4:32 PM. They stated they had done an investigation, initiated audits and in-services for nursing staff and put a Plan of Correction (POC) in place that began on 1/27/18. The DON explained that they had determined that in addition to the sling straps that had come off the sling bar, the large lift sling should have been used for Resident #3's transfer on 1/27/18. Resident #3 was 2 pounds over the manufacture recommended weight for the medium sling. They had addressed this by auditing and listing the residents who required a mechanical lift for transfers and reviewed all the Care Plans and Care Guides to ensure staff were using correct the slings. The DON added that if a resident's weight changed, the MDS Coordinator was made aware in the weekly Weight Committee meetings, so she would update the Care Plan and put out a new Care Guide in the resident's room. The Quality Assurance Nurse also received a list of weights as they were completed and she was to contact the MDS nurses with changes. The Administrator stated she and the DON had begun audits and inservices within hours of Resident #3's fall. She stated the Corporate Consultants came in and helped inservice on Sunday, 1/28/18 and Monday, 1/29/18. When asked how the sling strap had come off the sling bar in Resident #3's fall, neither the DON nor the Administrator could

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F 689	Continued From page 8 explain how it might have happened. The DON added that she would expect her residents to be safe during a transfers. The Administrator said, "I would expect the staff to follow the manufacture instructions for transfers." CORRECTIVE ACTION On 1/29/2018 the DON ordered new safety latch composite clips to replace safety latch universal sling bar clips for 3 of 4 [full mechanical lifts]. The composite clips will provide an extra safety feature and a friction clip that will not allow the harness to come out of hook on slide bar. 100% Audit of all [sit-to-stand and full mechanical lifts] to include Viking lift #1 was completed by the Maintenance Supervisor on 1/27/18 to assure that all lifts are working properly; sling bar will lift and lower, sling bar is secure, sling bar clips are in place, manual emergency lowering works, lift wheels roll without problems, remote works properly, and battery charged. There was a total of 4 [full mechanical lifts]and 2 [sit-to-stand mechanical lifts] inspected. 100% audit of all [full mechanical and sit-to-stand lifts] slings were completed on 1/29/18 by the DON to assure that all lift pads were free of tears, fraying or damage from excessive wear. Any lift pad with noted tears, fraying or damage were immediately removed and discarded by the DON. No areas of concern were noted. 100% audit of all residents to include resident #1 was completed by the Nurse Managers on 1/29/18 to assure any resident who utilize mechanical lifts for transfers are care planned and have updated care guide for the appropriate lift sling size based on resident current weight. Any issues will be immediately corrected by the Quality Improvement (QI) nurse and care plan/care guides updated. There were no other	F 689		

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issues noted. Care plan and care guide of resident #1 was updated by the Minimum Data Set (MDS) nurse for Viking lift size large on 1/29/18 and care guide place in room.
100% re-training was initiated by the DON on 1/27/18 with all licensed nurses and NAs on the proper procedure for using Sabina and Viking mechanical lifts with return demonstration utilizing the [full mechanical and sit-to-stand lifts] Skills Checklist to include:
1. Checking the resident care guide and using correct size and type of sling for the resident and specified lift.
2. Visually inspect lift for external damage or excessive wear.
3. Checking that the lift pad is not torn, frayed or damaged from excessive wear.
4. Inspect lift to make sure that it is working properly: sling bar will lift and lower, sling bar is secure, sling bar clips are in place, manual emergency lowering works, lift wheels roll without problems, remote works properly, battery charged. Remember that wheel locks are unlocked during routine lifts.
5. If any areas of concern are noted during lift inspection, remove lift immediately from care area. Tag lift to indicate "out of order", complete a work order and report any broken area to the Administrator, DON, or Maintenance Supervisor immediately.
6. Before using lift always check the clips on the sling bar to ensure they are attached according to manufacture instructions.
Staff will visually inspect the clips on the lift bar, to ensure the clips are properly secured in the hole of the sling bar, and not completely out on one or both ends of the sling bar.
7. Checking that lift pads are properly positioned on resident: leg straps secure and crisscross on

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Viking lift, head straps always go on sling bar first.
8. Making sure that before the resident is clear of the lifting surface, that sling loops are fastened according to manufacture instructions once the straps are fully extended.
No licensed nurse or NA will be allowed to work until training with return demonstration is completed.
All newly hired licensed nurses and NAs will be trained by the Staff Facilitator during orientation on the proper procedure for using all mechanical lifts with return demonstration utilizing the [full mechanical and sit-to-stand lifts] Skills Checklist to include:
1. Checking the resident care guide and using correct size and type of sling for the resident and specified lift.
2. Visually inspect lift for external damage or excessive wear.
3. Checking that the lift pad is not torn, frayed or damaged from excessive wear.
4. Inspect lift to make sure that it is working properly: sling bar will lift and lower, sling bar is secure, sling bar clips are in place, manual emergency lowering works, lift wheels roll without problems, remote works properly, battery charged. Remember that wheel locks are unlocked during routine lifts per manufacture instructions.
5. If any areas of concern are noted during lift inspection, remove lift immediately from care area. Tag lift to indicate "out of order", complete a work order and report any broken area to the Administrator, DON, or Maintenance Supervisor immediately.
6. Before using lift always check the clips on the sling bar to ensure they are attached per manufacture instructions.
7. Checking that lift pads are properly positioned

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on resident: leg straps secure and crisscross on Viking lift, head straps always go on sling bar first.
8. Making sure that before the resident is clear of the lifting surface, that sling loops are fastened per manufacture instructions once the straps are fully extended.
An in-service was completed by the Facility Nurse Consultant with the DON, QI Nurse, MDS Coordinator and MDS nurse on 1/29/18 on updating care plan/care guides with weight changes to include:
1. QI nurse will review all weights obtained. Any change in weight must be checked against [full mechanical and sit-to-stand lifts] pad sizing chart to assure resident is using correct lift size for new recorded weight.
2. QI nurse will notify MDS nurse with any weight change requiring re-evaluation/change in lift pad size.
3. MDS/QI nurse will update care plan/care guide with new lift pad size and place new care guide in resident room

100% staff questionnaires were initiated and completed by the DON on 1/28/18 with all licensed nurses and NAs on lift transfers to include:
1. Have you had a lift that did not work properly (per manufacture instructions) during the last 2 weeks?
2. If so, who did you report it too?
3. What kind of issues did you report?
No staff will be allowed to work until lift questionnaire is completed. Administrator/DON will review and initialed all lift transfer questionnaires, any areas of concern were immediately addressed by the DON.
The Maintenance Supervisor will inspect all [full mechanical and sit-to-stand lifts] to include [full

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mechanical lift] #1 3 x week for 4 weeks, 2 x a week for 4 weeks then weekly x 1 month and document findings utilizing the Lift Inspection Tool to ensure lift is working properly; sling bar will lift and lower, cling bar is secure, sling bar clips are in place, manual emergency lowering works, lift wheels roll without problems, remote works per manufacture instructions, and battery is charged. The Administrator will initial Lift Inspection Tool weekly x 8 months then monthly x 1 month.
The Nurse Managers will audit 10% of all residents needing [full mechanical and sit-to-stand lifts] for transfers to include resident #1 utilizing the Lift Transfer Audit Tool to ensure proper placement, functionality and staff technique to include (1) checking care guide for appropriate lift and lift pad size and (2) inspection of lift before initiating transfer 3x a week for four weeks, then weekly for x 4 weeks, then monthly x 1 month. Any areas of concern will be immediately addressed by the DON and staff will be re-trained on lift transfers utilizing the Skills Checklist for Lift Transfers. The Administrator/DON will review and initial all Lift Transfer Audit Tools weekly x 8 weeks then monthly x 1 month.
10 % of all licensed nurses and NA staff will complete a staff Lift Transfer Questionnaire to ensure lifts are working per manufacture instructions and any areas of concern are reported immediately to the Maintenance Supervisor, DON or Administrator 3 x a week for 4 weeks, weekly X 4 weeks and monthly X 1 month. The Administrator/DON will review and sign the lift transfer questionnaires for completion weekly x 8 weeks then monthly x 1 month to ensure that any areas of concern are addressed appropriately.
The Patient Care Coordinator will review all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 02/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW HILL, NC 28580

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weights obtained to ensure any resident requiring use of mechanical lift for transfer with a weight change has been reassessed for the appropriate lift pad size based on weight and that the care plan/care guide has been updated utilizing the Weight/Lift Pad Audit Tool 5 x a week for 4 weeks, weekly x 4 weeks, then monthly x 1 month. The DON will review and initial the Weight/Lift Pad Audit Tool weekly x 8 weeks then monthly x 1 month.
On 1/30/18 the Administrator (via phone), Director of Nursing, and facility Medical Director had an impromptu Quality Improvement Executive Committee Meeting to specifically review the facility four point plan related to the in-services, completed audits, the Lift Transfer Audit Tool, Lift Inspection Tool and the Weight/Lift Pad Audit Tool with transfers.
The Administrator will forward the results of the Lift Transfer Questionnaires, Lift Transfer Audit Tool, Lift Inspection Tool, the Weight/Lift Pad Audit Tool and the Acute Change Audit Tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Lift Transfer Questionnaires, Lift Transfer Audit Tool, Lift Inspection Tool and the Weight/Lift Pad Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.
Final date of compliance 1/29/2018.
The Administrator and Director of Nursing will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the credible allegation of compliance for prevention of accidents.

As part of the validation process on 2/1/18

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F 689	Continued From page 14 through 2/2/18, the plan of correction was reviewed including the re-education of staff and observations of interventions put into place to ensure correct use of the slings and lift status. Resident #3 was not in the facility at the time of the investigation. Observations were made of other residents who required mechanical lifts and the transfers were all conducted according to Manufacturer's instructions. Interviews with licensed staff and nursing assistants revealed they were retrained to inspect the lifts before each transfer and to select the correct lift sling. A review of the monitoring tools revealed that the facility completed the audits of resident weights, who required mechanical lift transfers, which lifts were to be used, and sling sizes were noted for each resident. The facility alleges full compliance with this plan of correction effective 1/29/18.	F 689		