STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345458	A. BUILDING _____ B. WING _____	C 03/19/2018

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TREYBURN REHABILITATION CENTER	2059 TORREDGE ROAD DURHAM, NC 27712

(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
F 000	INITIAL COMMENTS A recertification and a complaint survey was conducted from 3/13/18 through 3/16/18. On 3/19/18, the survey team went back to the facility to conduct an extended survey and complete the survey. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity (J) CFR 483.25 at tag F689 at a scope and severity (J) CFR 483.90 at tag F908 at a scope and severity (J) The tags F600 and F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 02/02/18 and was removed on 03/16/18. An extended survey was conducted. No deficiencies were cited as a result of the complaint investigation survey of 3/19/18. Event ID# 58ZQ11.	F 000		
F 600	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 600		4/10/18

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

Electronically Signed | 03/30/2018

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F 600	Continued From page 1 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews with the resident, facility staff, and the physician, the facility failed to prevent neglect by transferring a resident from the bed to the wheelchair with a mechanical lift knowing that the mechanical lift was not functioning properly and was not safe to use. The mechanical lift's leg positioning device did not lock in place resulting in the lift tilting, the resident being dropped suddenly in the wheelchair and the overhead beam on the lift striking the resident's head. The facility staff continued to use the malfunctioning lift after the incident. This was evident for one of three residents reviewed for neglect (Resident #106). Immediate Jeopardy (IJ) began on 02/02/18, when Resident #106 was transferred from the bed to the chair with a malfunctioning lift. The lift tilted resulting in the resident being dropped suddenly into the wheelchair and the overhead beam on the lift striking the resident's head. The immediate jeopardy was removed on 03/16/18 when the facility provided and implemented an acceptable credible allegation of IJ removal. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete staff training and ensure that monitoring systems put into place are effective to prevent neglect. The findings included:	F 600	F600 Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. The Hoyer lift in question was removed from service and repaired by the Maintenance Director on 3/16/18 and remained out of service until it was evaluated by an outside technician and deemed safe for use. ¿Preventative maintenance has been increased from monthly to at least weekly inspections to be done according to the manufacturer□s recommendations of the lifts to identify and fix any part that has started to loosen. There was no injury to Resident #106 thus no other corrective action could be taken for this resident. The resident was assessed by the licensed nurse, there was no redness, swelling, laceration, or bruising. The resident did not report any pain and no pain medication was administered. Neuro checks were implemented per facility policy with no	

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F 600	Continued From page 2 The manufacturer's User Manual for [brand name of lift] provided a Maintenance Safety Inspection Checklist on pages 40-42 that detailed 10 areas for monthly institutional inspection or adjustment. Included was ensuring the "shifter handle locks [the] adjustable base whenever engaged." The User Manual advised lift operators on page 21 that "If the shifter handle is NOT positioning completely into its mounting slot, DO NOT use the patient lift ...Otherwise, injury and/or damage may occur." Resident #106 was admitted to the facility on 08/30/17 with diagnoses of infection and inflammation due to a left hip prosthesis, chronic congestive heart failure and type 2 diabetes mellitus. The quarterly Minimum Data Set (MDS) dated 02/22/18 documented that the resident was cognitively intact. Resident #106 was occasionally incontinent and required extensive assistance for bed mobility and toileting. Two persons were needed for transfers. The current care plan (most recently reviewed on 12/04/17) had entries for complications following left hip replacement, falls risk and deficits related to the performance of activities of daily living. The care plan included the use of a mechanical lift for resident transfers. A nursing progress note dated 02/02/18 by Nurse #7 recorded that Resident #106 "was being transferred from bed to chair and was struck on the forehead" at approximately 9:45 a.m. Vital signs were obtained, neurological checks instituted, and the physician notified.	F 600	negative outcomes. The resident did go to the hospital after an appointment four days after the event secondary to infection of her hip replacement prostheses which was not related to the event. Root cause is the facility did not follow policy and procedure regarding removing the lift from service and filling out a maintenance request due to the lack of training in the process regarding reporting and removing equipment from service when faulty equipment is noted The incident reports for last six months were reviewed by the Director of Nursing on 3/16/18 to determine if there were any other incidents related to hoyer lifts. No other incidents were identified. The Maintenance Director examined all mechanical lifts in the facility on 3/16/18 to ensure the lifts are functioning properly. ¿Any lift needing repair was addressed and removed from service. An ad hoc QAPI committee meeting was held on 3/16/18 with Interim Administrator, ADON, Rehab Manager, Unit Managers, Vice President of Operations and the Regional Clinical Director in attendance. Medical Director attended via telephone. The agenda included determining the root cause of the event, what process would be used to identify other residents that may have been affected, determining what education needed to be completed, the content of that education, and who would be responsible for completing the education. The means for validation of	

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F 600	Continued From page 3 In an interview on 03/15/18 at 3:20 p.m., Resident #106 stated she was "scared to death" when the mechanical lift did not work correctly on 02/02/18. She said both nurse aides were behind the wheelchair when the top bar fell toward her. She indicated the bar gave her a "knot" on her head. The resident was unclear in her description of the incident. She was concerned that the impact of being dropped into the wheelchair had opened up her left hip incision line which started to ooze over the following days. In an interview on 03/19/18 at 4:45 p.m., the facility Medical Director indicated her familiarity with Resident #106 and the hospitalizations related to her left hip replacement. She stated that, based on her review of the clinical documentation, there was no indication that the incident with the mechanical lift contributed to the seepage/drainage from the left hip area that eventually led to her hospitalization four days after the incident. In an interview on 03/16/18 at 10:42 a.m., Nurse Aide #4 and Nurse Aide #5 provided a demonstration of what had happened on 02/02/18 during Resident #106's transfer. The DON was present during the interview. The mechanical lift used for the demonstration was present on the 300 Hall and was the same lift used on 02/02/18 for Resident #106. The machine was permanently assigned for use on the 100 and 300 Halls. When needed, the lift was transferred to the other side of the building for temporary use and then returned to the unit. During the demonstration, Nurse Aide #4 indicated that she was operating the lift on 02/02/18 with Nurse Aide #5 guiding the lift pad	F 600	the training was discussed and how the facility was going to monitor the processes and system changes to ensure the event does not reoccur. The goal of the meeting was to determine the root cause of why the event occurred, develop a plan for correcting any identified issues, develop a plan for monitoring to ensure the event does not reoccur. The outcome was a definitive plan was put in place to abate and prevent reoccurrence of the event. Licensed and non-licensed staff re-education regarding Abuse/Neglect prohibition and policy was conducted by the Director of Nursing, the Unit Managers, the MDS Nurses and the Staff Development Coordinator starting 3/16/18 and will continue until all staff are educated. No staff will be able to work after 3/16/18 until they receive the education. The education consisted of the definition of neglect meaning Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. It also emphasized that it is neglect to discover faulty equipment and not report it, and it is neglectful to knowingly use equipment that is faulty or malfunctioning. It was explained that it is the employee□s responsibility to tag and remove the equipment from service themselves. Unexplained injuries or injuries that are inconsistent with a person□s medical condition may indicate abuse. The	

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F 600	Continued From page 4 holding the resident. The wheelchair was positioned between the two legs of the lift with the open seat facing one of the legs. During the lowering of the Resident #106 into the chair, they described the machine "suddenly dropping" and depositing the resident in the wheelchair. She was not seated squarely in the wheelchair but did not land on the floor. She was "dropped" from a height of approximately one foot into the chair. The aides stated that the resident was screaming during the incident. When asked for clarification, Nurse Aide #4 confirmed that as the mechanical lift tilted to the left, both wheels of the leg on the right side of the lift lifted off the ground. The overhead beam of the lift holding the attached swivel bar and sling struck Resident #106 on the top of her forehead. Both aides indicated that they were able to grab the bar as it was happening to prevent a major injury to the resident. Nurse Aide #5 stated that she reported the injury and equipment malfunction to the charge nurse immediately, and Nurse Aide #4 stated she placed a sign on the machine and removed it from the unit to the back service hall. During the interview 03/16/18 at 10:42 a.m., Nurse Aide #4 shared that the mechanical lift was still prone to malfunctioning up to the time of this interview. Using the tall shifter handle connected to the base of the machine, she showed that the locking mechanism did not engage correctly. The shifter handle repositioned the legs of the machine as designed to do but did not lock them into place. When the shifter handle was moved to the left and up, the legs closed in a parallel position. When the shifter handle was moved to the right and up, the legs opened out at an angle to provide a more stable foundation when weight	F 600	education presented will be revised or updated based on updated research or feedback from random validation interview audits conducted to ensure understanding of the education presented. Newly hired employees will be educated regarding Abuse and Neglect Prohibition upon hire. The Director of Nursing and the Maintenance Director were in-serviced by the Regional Clinical Nurse regarding the process of investigating and reporting neglect that includes: Facility supervisors will immediately correct and intervene in reported or identified situations in which abuse and neglect is at risk for occurring. The facility will conduct an investigation of any incidents or accidents The importance of reporting equipment failure and removing the equipment from service to alleviate the potential for injury. The Director of Nursing was in-serviced by an outside consultant pertaining to the facility and accident program with an emphasis on who and when to complete investigations and Root Cause Analysis on 3/16/18. The procedure for the Incident/Accident Management Investigation process was revised on 3/16/18 to include: Initiate an investigation The DON/designee is responsible for making sure an investigation is completed. Administrator/ DON will ensure all investigation items are in order, complete, and maintained. A complete investigation will include interviews and witness statements,	

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F 600	Continued From page 5 was lifted in the air. The shifter handle on this machine, however, did not engage in the up position and fell back to neutral, preventing proper locking of the legs in both the open and closed positions. Nurse Aides #4 and #5 both offered this as the reason the legs did not lock and the lift tilted during the resident's transfer on 02/02/18. Nurse Aide #4 moved the mechanical lift in the short part of the hall to demonstrate that the legs did not stay locked when rolled across the floor. She stated that she did not trust the machine after the incident with Resident #106 and now when using it, she placed one leg on the base with most of her body weight on it to provide extra stability. When asked about training, both aides confirmed that they had a skills assessment on using mechanical lifts on hire and then received refresher training annually from the facility. In an interview on 03/19/18 at 11:50 a.m., Nurse Aide #6 stated she has been working on the 100 and 300 Halls for over a year. She confirmed that the lift that malfunctioned during the incident of 02/02/18 was the same one that had been used on the unit since her assignment. The lift continued to be used for Resident #106 who has resided on the 300 Hall since admission to the facility last summer. In an interview on 03/16/18 at 10:33 a.m., Nurse #7 recounted her assessment of Resident #106 following the incident on 02/02/18. The resident was lying in bed complaining of pain. There was a red mark on her forehead without laceration, bleeding or bruising. Nurse #7 informed the Unit Supervisor and the DON of the incident. She did not do anything with the mechanical lift at the	F 600	medical record review and a Root Cause Analysis. Preventative maintenance will be completed weekly per manufacturer□s recommendations to ensure the lifts are in working order. Preventative Maintenance Documentation Form for the mechanical lift was revised to include tracking for individual lifts and specific items regarding the lift to be checked per manufacturer recommendations. Incident investigations will be reviewed/audited by the Interdisciplinary Team during the weekly focus meetings until 100% compliance is maintained for two consecutive months to ensure investigations are complete and include a root cause analysis, and interventions are put in place to prevent reoccurrence. The Administrator or designee will review/audit the Maintenance Request book and the Preventative Maintenance log weekly until 100% compliance is maintained for 2 consecutive months to ensure that once the request is filled out, repairs are completed in a time frame appropriate for the type of repair and preventative maintenance is completed as scheduled Outcomes of those reviews/audits will be presented to the steering QAPI committee monthly. The steering committee will direct further analysis and interventions based on reported outcomes and direct further investigations.	

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F 600	Continued From page 6	F 600		

time.

A progress note dated 02/06/18 by Nurse #7 noted that Resident #106 was "transported to MD (medical doctor) appointment at approximately 9 a.m., informed by SW [social worker] that patient was transferred to hospital from MD appointment." The resident was later diagnosed with a prosthetic joint infection of the left hip.

In an interview on 03/16/18 at 11:20 a.m., the Maintenance Director inspected the mechanical lift used for Resident #106's transfer and that continued to be used on the 100 and 300 Halls until its removal on 03/16/18 at 11:15 a.m. He acknowledged that the base mechanism was too loose to keep the shifter handle engaged in locking the legs in either the open or closed position. He was unable to provide any written documentation that the mechanical lift had been repaired after the transfer incident on 02/02/18 and stated that neither he nor his assistant remember working on the machine at that time.

He stated that the Maintenance department did routine monthly preventative maintenance checks on equipment and he provided a completed checklist dated 02/06/18. The facility's five-page Preventative Maintenance Monthly Checklist for the year 2018 included 20 areas for monitoring. One recommended check was listed under Medical Equipment Management: "Check all patient lifting equipment, [mechanical lift] and [sit to stand] lifts for defects." Checkmarks indicated that this check was performed in January and February.

The Maintenance Director further stated he used

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the general facility checklist rather than a checklist designed specifically for that lift model. The Maintenance Director confirmed that the model used on the 100 and 300 Halls was the only model of that lift in the building.

During the interview, the Maintenance Director stated that he did not notice a need for any adjustments to the machine when he inspected it on 02/06/18. He also inspected the lift recently on 03/12/18 when he had it in the shop for repair of the scale component for weighing residents. He did not examine the base of the machine. He stated that, in addition to his monthly monitoring of facility equipment, he relied on nurse aides and other staff members to report concerns or problems with the mechanical lifts. The Maintenance Director moved the machine from the back service hall to the shop area.

On 03/16/18 at 5:15 p.m. an inspection of the lift machine was performed after return from the shop. The machine was stored behind the locked door of the Restorative room. Operation of the shifter handle verified that appropriate adjustments had been made. The mechanism holding the shifter handle was tighter, and the handle did not slip out of position when engaged.

In an interview on 03/19/18 at 9:30 a.m., the Maintenance Director indicated that the lift had since been removed from the building.

In an interview on 03/19/18 at 3:16 p.m., the Director of Nursing (DON) stated she assessed Resident #106's injury after the incident on 02/02/18. The resident was anxious and weeping when interviewed. The DON also stated she had instructed Nurse Aide #4 to place a tag on the

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mechanical lift identifying it as needing repair and to remove it from the unit to the back service hall. The DON stated that she did not see the lift later that day on the unit but could not confirm that the matter had come to the attention of Maintenance for follow-up. She shared that at the time she was more concerned about the possible malfunctioning of the lift than the aides' proper operation of it. She stated that one of the aides had many years of experience operating mechanical lifts. She was not aware of the aides' concern about the stability of the machine before the interview and demonstration on 03/16/18. She acknowledged that the mechanical lift used to transfer Resident #106 was still in use on the 100 and 300 Halls until that morning and had not been working properly.

The DON acknowledged in the interview that staff members were continuing to use a mechanical lift with identified safety hazards to transfer residents, endangering those who relied on safe operation during transfer and exposing residents to potential trauma. Her expectation was that staff members tag malfunctioning equipment for repair and remove it immediately from resident care areas to prevent further use.

The Administrator and Director of Nursing were informed of the immediate jeopardy on 03/16/18 at 4:21 p.m. On 03/16/18 at 9:41 p.m., the facility provided the following credible allegation of IJ removal:

The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited:

"A resident was being transferred from bed to

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wheelchair utilizing a mechanical lift with two CNAs [certified nurse aides] present who followed policy and procedure during the transfer. The lift legs retracted related to the handle that locks the legs was loose, and did not fully engage to the locked position, causing the bar to swing and the resident to be hit in the head with the bar from the lift. The facility failed to protect residents from neglect by failing to remove a lift from service.

Root cause is the facility did not follow policy and procedure regarding removing the lift from service and filling out a maintenance request due to lack of training in the process regarding reporting and removing equipment from service when faulty equipment is noted."

The procedure for implementing the acceptable plan of correction for the specific deficiency cited:

1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice:

"The [brand name] lift in question was removed from service and repaired by the Maintenance Director on 3/16/18 and will remain out of service until it has been evaluated by an outside technician and deemed safe for use. Preventative maintenance has been increased from monthly to at least weekly inspections, to be done according to the manufacturer's recommendations, of the lifts to identify and fix any part that has started to loosen.

There was no injury to Resident #106 thus no other corrective action could be taken for this resident. The resident was assessed by the licensed nurse, there was no redness, swelling,

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laceration, or bruising. The resident did not report any pain and no pain medication was administered. Neuro checks were implemented per facility policy with no negative outcomes. The resident did go to the hospital after an appointment four days after the event secondary to infection of her hip replacement prostheses which was not related to the event."

2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:

"The incident reports for last six months were reviewed by the Director of Nursing on 3/16/18 to determine if there were any other incidents related to the mechanical lifts. No other incidents were identified. The Maintenance Director examined all mechanical lifts in the facility on 3/16/18 to ensure the lifts are functioning properly. Any lift needing repair was addressed and removed from service. There was one other mechanical lift and two sit and stand lifts. One of the sit and stand lifts was identified with slight wear of one wheel. It has been removed from service until the wheel is replaced. Wearing of the wheels will be monitored by weekly preventative maintenance inspections so they can be replaced as necessary."

3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not occur:

A. "An ad hoc QAPI (quality assurance and performance improvement) committee meeting was held on 3/16/18 with Interim Administrator, ADON (assistant director of nursing), Rehab

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Manager, Unit Managers, Vice President of Operations and the Regional Clinical Director in attendance. Medical Director attended via telephone. The agenda included determining the root cause of the event, what process would be used to identify other residents that may have been affected, determining what education needed to be completed, the content of that education, and who would be responsible for completing the education. The means for validation of the training was discussed and how the facility was going to monitor the processes and system changes to ensure the event does not reoccur. The goal of the meeting was to determine the root cause of why the event occurred, develop a plan for correcting any identified issues, develop a plan for monitoring to ensure the event does not reoccur. The outcome was a definitive plan was put in place to abate and prevent reoccurrence of the event.

B. Licensed and non-licensed staff re-education regarding Abuse/Neglect prohibition and policy was conducted by the Director of Nursing, the Unit Managers, the MDS Nurses and the Staff Development Coordinator starting 3/16/18 and will continue until all staff are educated. No staff will be able to work after 3/16/18 until they receive the education. The education consisted of the definition of neglect meaning "Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. It also emphasized that it is neglect to discover faulty equipment and not report it, and it is neglectful to knowingly use equipment that is faulty or malfunctioning. It was explained that it is the employee's responsibility to tag and remove

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the equipment from service themselves. Unexplained injuries or injuries that are inconsistent with a person's medical condition may indicate abuse. The education presented will be revised or updated based on updated research or feedback from audits. Newly hired employees will be educated regarding Abuse and Neglect Prohibition upon hire. The Director of Nursing and the Maintenance Director were in-serviced by the Regional Clinical Nurse regarding the process of investigating and reporting neglect that includes:

- Facility supervisors will immediately correct and intervene in reported or identified situations in which abuse and neglect is at risk for occurring.
- The facility will conduct an investigation of any incidents or accidents.
- The importance of reporting equipment failure and removing the equipment from service to alleviate the potential for injury.

A. The Director of Nursing was in-serviced by an outside consultant pertaining to the facility and accident program with an emphasis on who and when to complete investigations and Root Cause Analysis on 3/16/18.

B. The procedure for the Incident/Accident Management Investigation process was revised on 3/16/18 to include:

- Initiate an investigation. The DON/designee is responsible for making sure an investigation is completed. Administrator/ DON will ensure all investigation items are in order, complete, and maintained. A complete investigation will include interviews and witness statements, medical record review and a Root Cause Analysis.
- Preventative maintenance will be completed weekly per manufacturer's recommendations to

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ensure the lifts are in working order. Preventative Maintenance Documentation Form for the mechanical lift was revised to include tracking for individual lifts and specific items regarding the lift to be checked per manufacturer recommendations.

The title of the person responsible for implementing the acceptable plan of correction: Administrator

The credible allegation of IJ removal was validated on 03/19/18 at 6:30 p.m. The facility's history for abuse and neglect training was reviewed. The most recent training was initiated on 03/16/18 and was ongoing. Staff members were trained on policy and procedures for reporting, investigating and documenting abuse and neglect.

The facility's mechanical lifts were checked to ensure they were working according to manufacturer's specifications. Staff members were given refresher training on the proper use of the lift with return demonstrations. Two persons managed the lift with one operating the mechanical component and the other in front for support and positioning of the resident. Staff members checked for proper positioning and safety of the lift pad, positioning of the resident's body in the lift pad and functioning of the equipment. Staff members performed safety checks before, during and after the lifts procedure. The mechanical lift involved in the incident was removed from the unit and placed out of service. New mechanical lifts were ordered and the broken lift was removed from service.

Staff members were trained 03/16/18 on the need

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F 600	Continued From page 14 to document and report and malfunctioning equipment and to complete a Maintenance Request Form. The training record was reviewed and several staff members were interviewed regarding the reporting and documenting process for incidents and accidents. The facility ordered new mechanical lifts. In-service training on the use of lifts for resident transfer as well as proper functioning was provided with return demonstration by staff members. Training included reporting practices for malfunctioning or broken lifts and equipment. Staff members were instructed to remove the equipment from the unit and place an orange out-of-service sign with their name, date and time the equipment or lifts were removed. Mechanical lifts were to be placed in the back service area. The Maintenance Department was expected to check the service area daily to ensure items to be repaired were serviced and the repair was documented when it was completed. Orange out-of-service signs were present in the Maintenance Books available at each of the two nursing stations. Severity/Scope = 4/1	F 600		
F 655	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-	F 655		4/10/18

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F 655	Continued From page 15 (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a baseline care plan within 48 hours of admission with measurable objectives and timetables to address the	F 655	F655 Preparation and execution of this plan of correction does not	

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F 655	Continued From page 16 immediate needs for 1 of 2 sampled residents with a urinary catheter's Resident (#212). Findings included: Resident #212 was admitted to the facility on 3/12/18. Diagnoses included in part, Diabetes Mellitus, Heart failure, chronic kidney disease, and hypertension. The Minimum Data Set (MDS) 5 day assessment dated 3/14/18 revealed that Resident #212 was cognitively intact. The assessment was still in progress. A review of the care plan dated 3/12/18 revealed there were no care plans or interventions regarding the indwelling urinary catheter. An observation of Resident #212 on 3/14/18 at 11:10AM revealed Resident lying with her eyes closed and the indwelling catheter draining yellow urine. An interview was conducted with the MDS Nurse #3 on 3/15/18 at 2:23PM who indicated the registered nurse in the MDS department started the interim care plan in Point Click Care(PCC) the electronic health record (EHR). An interview was conducted with Nurse #2 on 3/15/18 at 3:01 PM who indicated the MDS nurse provided the interim care plan in PCC. An interview was conducted with MDS Nurse #1 indicated the staff nurse started the care plan. An interview was conducted with the Regional Consultant on 3/15/18 at 3:09 PM who indicated there was no care plan for an indwelling urinary	F 655	constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. A Baseline Care Plan with interventions and measurable objectives and timetable to address the immediate need of the urinary catheter was developed for resident #212. The nurse that completed the admission for resident #212 was in-serviced by the Director of Nursing on 4/2/18 regarding the regulation pertaining to the development of baseline care plans with interventions and measurable objectives and timetable to address the immediate needs of the resident. Root cause is the nurse that completed the admission acted singularly and violated the standard of care regarding the admission process. The facility also identified a lack of system process for tracking the completion of admissions to ensure all aspects of the admission are done. The Administrative Nursing Team reviewed the admissions for the last 30 days to ensure baseline care plans were developed for identified issues. Any resident identified with issues not addressed on the care plan were corrected. The nursing staff was in-serviced by the	

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F 655	Continued From page 17 catheter for Resident #212. An interview was conducted with the Director of Nursing on 3/15/18 at 3:39PM who indicated the reason that Resident #212 didn't have a care plan was because the chart review wasn't conducted. She stated her expectation was the interim care plan to be completed.	F 655	Staff Development Coordinator 3/29-19 to 4/2/16 regarding the regulation and policy addressing baseline care plans and the importance of developing the care plans as part of the admission process. New admissions will be reviewed within 48 hours of admission by a member of the Administrative Nursing Team to ensure all aspects of the admission are completed including the baseline care plan. The Director of Nursing or designee will audit new admissions until 100% compliance is met for two consecutive months to determine if they have a urinary catheter and to ensure a baseline care plan is in place for the catheter. Outcomes of those audits will be presented to the steering QAPI committee monthly. The steering committee will direct further analysis and interventions based on reported outcomes and direct further investigations.	
F 689	Severity/Scope = 2/1 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	F 689		4/10/18

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F 689	Continued From page 18 by: Based on observation, record review and interviews with the resident, facility staff, and the physician, the facility failed to safely transfer a resident from the bed to the wheelchair by using a malfunctioning mechanical lift. The mechanical lift's leg positioning device did not lock in place resulting in the lift tilting, the resident being dropped suddenly in the wheelchair and the overhead beam on the lift striking the resident's head. The facility staff continued to use the malfunctioning lift after the incident. This was evident for one of three residents reviewed for accidents (Resident #106). Immediate Jeopardy (IJ) began on 02/02/18, when Resident #106 was transferred from the bed to the wheelchair with a malfunctioning lift. The lift tilted resulting in the resident being dropped suddenly into the wheelchair and the overhead beam on the lift striking the resident's head. The Immediate Jeopardy was removed on 03/16/18 when the facility provided and implemented an acceptable credible allegation of IJ removal. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete staff training and ensure that monitoring systems put into place are effective to prevent accidents. The findings included: The manufacturer's User Manual provided a Maintenance Safety Inspection Checklist on pages 40-42 that detailed 10 areas for monthly institutional inspection or adjustment. Included was ensuring the "shifter handle locks [the]	F 689	F689 Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. The Hoyer lift in question was removed from service and repaired by the Maintenance Director on 3/16/18 and remained out of service until it was evaluated by an outside technician and deemed safe for use. ¿Preventative maintenance has been increased from monthly to at least weekly inspections to be done according to the manufacturer□s recommendations of the lifts to identify and fix any part that has started to loosen There was no injury to Resident #106 thus no other corrective action could be taken for this resident. The resident was assessed by the licensed nurse, there was no redness, swelling, laceration, or bruising. The resident did not report any pain and no pain medication was administered. Neuro checks were implemented per facility policy with no negative outcomes. The resident did go to the hospital after an appointment four days after the event secondary to infection of her hip replacement prostheses which was not related to the event.	

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F 689	Continued From page 19 adjustable base whenever engaged." The User Manual advised lift operators on page 21 that "If the shifter handle is NOT positioning completely into its mounting slot, DO NOT use the patient lift ...Otherwise, injury and/or damage may occur." Resident #106 was admitted to the facility on 08/30/17 with diagnoses of infection and inflammation due to a left hip prosthesis, chronic congestive heart failure and type 2 diabetes mellitus. The quarterly Minimum Data Set (MDS) dated 02/22/18 documented that the resident was cognitively intact. Resident #106 was occasionally incontinent and required extensive assistance for bed mobility and toileting. Two persons were needed for resident transfers. The current care plan (most recently reviewed on 12/04/17) had entries for complications following left hip replacement, falls risk and deficits related to the performance of activities of daily living. The care plan included the use of a mechanical lift for transfers. A nursing progress note dated 02/02/18 by Nurse #7 recorded that Resident #106 "was being transferred from bed to chair and was struck on the forehead" at approximately 9:45 a.m. Vital signs were obtained, neurological checks instituted, and the physician notified. The Director of Nursing (DON) provided the incident report with the names of the two nurse aides (Nurse Aide #4 and Nurse Aide #5) who were operating the mechanical lift at the time along with their written statements. When asked, the DON stated that no written investigation of the	F 689	Root cause is the facility did not follow policy and procedure regarding removing the lift from service and filling out a maintenance request due to the lack of training in the process regarding reporting and removing equipment from service when faulty equipment is noted The incident reports for last six months were reviewed by the Director of Nursing on 3/16/18 to determine if there were any other incidents related to hoyer lifts. No other incidents were identified. The Maintenance Director examined all mechanical lifts in the facility on 3/16/18 to ensure the lifts are functioning properly. ¿Any lift needing repair was addressed and removed from service. An ad hoc QAPI committee meeting was held on 3/16/18 with Interim Administrator, ADON, Rehab Manager, Unit Managers, Vice President of Operations and the Regional Clinical Director in attendance. Medical Director attended via telephone. The agenda included determining the root cause of the event, what process would be used to identify other residents that may have been affected, determining what education needed to be completed, the content of that education, and who would be responsible for completing the education. The means for validation of the training was discussed and how the facility was going to monitor the processes and system changes to ensure the event does not reoccur. The goal of the meeting was to determine the root	

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incident had been completed by management.

The witness statements provided a brief description. Nurse Aide #4 wrote "...the [brand name] lift spreader bar closed and the [brand name] lift was tilted back and the lift hit her (the resident) in the face." Nurse Aide #5 wrote "...we adjusted the [resident's] leg while lowering her in the chair and the lift just closed in on her and hit her forehead."

In an interview on 03/15/18 at 3:20 p.m., Resident #106 stated she was "scared to death" when the mechanical lift didn't work correctly on 02/02/18. She said both aides were behind the wheelchair when the top bar fell toward her. She indicated the bar gave her a "knot" on her head and it brushed against her thigh giving her a bruise. The resident was unclear in her description of the incident. She was concerned the incident had opened up her left hip incision line which started to ooze in the following days. She was readmitted to the hospital on 02/06/18 and diagnosed with a prosthetic joint infection of the left hip.

In an interview on 03/19/18 at 4:45 p.m., the facility Medical Director indicated her familiarity with Resident #106 and the hospitalizations related to her left hip replacement. She did not recall being contacted about the head injury which occurred on 02/02/18. She stated that, based on her review of the clinical documentation, there was no indication that the incident with the mechanical lift contributed to the seepage/drainage from the left hip area that eventually led to her hospitalization four days after the incident. If staff members or the resident had any concerns about disruption to the incision line after the impact of her landing in the chair,

cause of why the event occurred, develop a plan for correcting any identified issues, develop a plan for monitoring to ensure the event does not reoccur. The outcome was a definitive plan was put in place to abate and prevent reoccurrence of the event.
Licensed and non-licensed staff re-education regarding Abuse/Neglect prohibition and policy was conducted by the Director of Nursing, the Unit Managers, the MDS Nurses and the Staff Development Coordinator starting 3/16/18 and will continue until all staff are educated. No staff will be able to work after 3/16/18 until they receive the education. The education consisted of the definition of neglect meaning Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. It also emphasized that it is neglect to discover faulty equipment and not report it, and it is neglectful to knowingly use equipment that is faulty or malfunctioning. It was explained that it is the employee□s responsibility to tag and remove the equipment from service themselves. Unexplained injuries or injuries that are inconsistent with a person□s medical condition may indicate abuse. The education presented will be revised or updated based on updated research or feedback from random validation interview audits conducted to ensure understanding of the education presented. Newly hired employees will be educated regarding

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F 689	Continued From page 21 she was not aware of it. In an interview on 03/16/18 at 10:42 a.m., Nurse Aide #4 and Nurse Aide #5 provided a demonstration of what had happened during Resident #106's transfer on 02/02/18. The DON was present during the interview. The mechanical lift used for the demonstration was present on the 300 Hall and was the same lift used on 02/02/18 for Resident #106. The machine was permanently assigned for use on the 100 and 300 Halls. When needed, the lift was transferred to the other side of the building for temporary use and then returned to the unit. During the demonstration Nurse Aide #4 indicated that she was operating the lift on 02/02/18 with Nurse Aide #5 guiding the lift pad holding the resident. The wheelchair was positioned between the two legs of the lift with the open seat facing one of the legs. During the lowering of Resident #106 into the chair, they described the machine "suddenly dropping" and depositing the resident in the wheelchair. She was not seated squarely in the chair but did not land on the floor. She was "dropped" from a height of approximately one foot into the chair. The aides stated that the resident was screaming during the incident. When asked for clarification, Nurse Aide #4 confirmed that both wheels of the leg on the right side of the machine lifted from the ground as the mechanical lift tilted to the left. The overhead beam of the lift holding the attached swivel bar and sling struck Resident #106 on the top of her forehead. They stated they were able to grab the bar as it was happening to prevent a major injury to the resident. Neither aide saw the beam hit the resident's thigh as the	F 689	Abuse and Neglect Prohibition upon hire. The Director of Nursing and the Maintenance Director were in-serviced by the Regional Clinical Nurse regarding the process of investigating and reporting neglect that includes: Facility supervisors will immediately correct and intervene in reported or identified situations in which abuse and neglect is at risk for occurring. The facility will conduct an investigation of any incidents or accidents The importance of reporting equipment failure and removing the equipment from service to alleviate the potential for injury. The Director of Nursing was in-serviced by an outside consultant pertaining to the facility and accident program with an emphasis on who and when to complete investigations and Root Cause Analysis on 3/16/18. The procedure for the Incident/Accident Management Investigation process was revised on 3/16/18 to include: Initiate an investigation The DON/designee is responsible for making sure an investigation is completed. Administrator/ DON will ensure all investigation items are in order, complete, and maintained. A complete investigation will include interviews and witness statements, medical record review and a Root Cause Analysis. Preventative maintenance will be completed weekly per manufacturer□s recommendations to ensure the lifts are in working order. Preventative Maintenance	

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F 689	Continued From page 22 resident claimed, and she did not complain of hip pain at the time of the incident. Nurse Aide #5 stated that she reported the injury and equipment malfunction to the charge nurse immediately, and Nurse Aide #4 stated she placed a sign on the machine and removed it from the unit. During the interview, Nurse Aide #4 shared that the mechanical lift was still prone to malfunctioning. Using the tall shifter handle connected to the base of the machine, she showed that the locking mechanism did not engage correctly. The shifter handle repositioned the legs of the machine as designed to do but did not lock them into place. When the shifter handle was moved to the left and up, the legs closed in a parallel position. When the shifter handle was moved to the right and up, the legs opened out at an angle to provide a more stable foundation when weight was lifted in the air. The shifter handle on this machine, however, did not engage in the up position and fell back to neutral, preventing proper locking of the legs in both the open and closed positions. Nurse Aides #4 and #5 both offered this as the reason the legs did not lock and the lift tilted during the resident's transfer on 02/02/18. Nurse Aide #4 moved the mechanical lift in the short part of the hall to demonstrate that the legs did not stay locked when rolled across the floor. She stated that she did not trust the machine after the incident with Resident #106 and now when using it, she placed one foot on the base with most of her body weight shifted on it to provide extra stability. When asked about training, both aides confirmed that they had a skills assessment on using mechanical lifts on hire and then received refresher training annually	F 689	Documentation Form for the mechanical lift was revised to include tracking for individual lifts and specific items regarding the lift to be checked per manufacturer recommendations. Incident investigations will be reviewed/audited by the Interdisciplinary Team during the weekly focus meetings until 100% compliance is maintained for two consecutive months to ensure investigations are complete and include a root cause analysis, and interventions are put in place to prevent reoccurrence. The Administrator or designee will review the Maintenance Request book and the Preventative Maintenance log weekly until 100% compliance is maintained for 2 consecutive months to ensure that once the request is filled out, repairs are completed in a time frame appropriate for the type of repair and preventative maintenance is completed as scheduled Outcomes of those reviews will be presented to the steering QAPI committee monthly. The steering committee will direct further analysis and interventions based on reported outcomes and direct further investigations.	

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from the facility.

The malfunctioning lift was moved to the back service hall behind closed doors after the nurse aides' demonstration by the Maintenance Director and Corporate Vice President of Operations in order to prevent staff members from using it.

In an interview on 03/19/18 at 11:50 a.m., Nurse Aide #6 stated she has been working on the 100 and 300 Halls for over a year. She confirmed that the lift that malfunctioned during the incident of 02/02/18 was the same one that had been used on the unit since her assignment. The lift continued to be used for Resident #106 who has resided on the 300 Hall since admission to the facility last summer.

In an interview on 03/16/18 at 10:33 a.m., Nurse #7 recounted her assessment of Resident #106 following the incident on 02/02/18. The resident was lying in bed complaining of pain. There was a red mark on her forehead without laceration, bleeding or bruising. The resident had not mentioned any injury to the thigh or hip. She informed the Unit Supervisor and the DON of the incident. Nurse #7 did not do anything with the mechanical lift at the time.

A review of the medical records revealed no documentation of hip or thigh injury or bruising from the transfer procedure. A nursing progress note dated 02/05/18 by the Wound Treatment Nurse stated that she evaluated Resident #106 for a "clear fluid-filled area 6.8 x 1.8 c.m. [centimeters] along surgical incision line of left thigh lateral aspect, surrounding tissue intact, warm to touch compared to right leg and edema ..."

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A progress note the following day by Nurse #7 noted that Resident #106 was "transported to MD [medical doctor] appointment at approximately 9 a.m., informed by SW [social worker] that patient was transferred to hospital from MD appointment."

In an interview on 03/16/18 at 11:20 a.m., the Maintenance Director inspected the mechanical lift used for Resident #106's transfer and that continued to be used on the 100 and 300 Halls until its removal on 03/16/18 at 11:15 a.m. He acknowledged that the base mechanism was too loose to keep the shifter handle engaged in locking the legs in either the open or closed position. He was unable to provide any written documentation that the mechanical lift had been repaired after the transfer incident on 02/02/18 and stated that neither he nor his assistant remember working on the machine at that time.

He stated that the Maintenance department did routine monthly preventative maintenance checks on equipment, and he provided a completed checklist dated 02/06/18. The facility's five-page Preventative Maintenance Monthly Checklist for the year 2018 included 20 areas for monitoring. One recommended check was listed under Medical Equipment Management: "Check all patient lifting equipment, [brand name mechanical lift] and [brand name sit-to-stand] lifts for defects." Checkmarks indicated that this check was performed in January and February.

The Maintenance Director further stated that he used the general facility checklist rather than a checklist designed specifically for that model of

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lift. The Maintenance Director confirmed that the model used on the 100 and 300 Halls was the only model of that lift in the building.

During the interview, the Maintenance Director stated that he did not notice a need for any adjustments to the machine when he inspected it on 02/06/18. He also inspected the lift recently on 03/12/18 when he had it in the shop for repair of the scale component for weighing residents. He did not examine the base of the machine. The Maintenance Director then moved the machine from the back service hall to the shop area.

On 03/16/18 at 5:15 p.m. an inspection of the lift machine was performed after return from the shop. The machine was stored behind the locked door of the Restorative room. Operation of the shifter handle verified that appropriate adjustments had been made. The mechanism holding the shifter handle was tighter, and the handle did not slip out of position when engaged.

In an interview on 03/19/18 at 9:30 a.m., the Maintenance Director indicated that the lift had since been removed from the building.

In an interview on 03/19/18 at 3:16 p.m., the DON stated she assessed Resident #106's injury after the incident on 02/02/18. She had instructed Nurse Aide #4 to place a tag on the mechanical lift identifying it as needing repair and to remove it from the unit to the back service hall. The DON stated that she did not see the lift later that day on the unit but could not confirm that the matter had come to the attention of Maintenance for follow-up. She shared that at the time she was more concerned about the possible malfunctioning of the lift than the aides' proper

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operation of it. She stated that one of the nurse aides had many years of experience operating mechanical lifts. She was not aware of the aides' concern about the stability of the machine before the interview and demonstration on 03/16/18. She acknowledged that the mechanical lift used to transfer Resident #106, and still in use on the 100 and 300 Halls until that morning, had not been working properly, placing residents at risk for injury due to the potential for accidents.

The Administrator and Director of Nursing were informed of the immediate jeopardy on 03/16/18 at 4:21 p.m. On 03/16/18 at 9:41 p.m., the facility provided the following credible allegation of IJ removal:

"A resident was being transferred from bed to wheelchair utilizing a mechanical lift with two CNAs [Certified Nurse Aides] present who followed policy and procedure during the transfer. The lift legs retracted related to the handle that locks the legs was loose, and did not fully engage to the locked position, causing the bar to swing and the resident to be hit in the head with the bar from the lift. The facility failed to protect residents from neglect by failing to remove a lift from service.

Root cause is the facility did not follow policy and procedure regarding removing the lift from service and filling out a maintenance request due to lack of training in the process regarding reporting and removing equipment from service when faulty equipment is noted."

The procedure for implementing the acceptable corrective action for the specific deficiency cited:

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1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice:

"The [brand name] lift in question was removed from service and repaired by the Maintenance Director on 3/16/18 and will remain out of service until it has been evaluated by an outside technician and deemed safe for use. Preventative maintenance of the lifts has been increased from monthly to at least weekly inspections, and will be completed per manufacturer's recommendations, to identify and fix any part that has started to loosen.

There was no injury to Resident #106 thus no other corrective action could be taken for this resident. The resident was assessed by the licensed nurse, there was no redness, swelling, laceration, or bruising. The resident did not report any pain and no pain medication was administered. Neuro checks were implemented per facility policy with no negative outcomes. The resident did go to the hospital after an appointment four days after the event secondary to infection of her hip replacement prostheses which was not related to the event."

2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:

"The incident reports for the last six months were reviewed by the Director of Nursing on 3/16/18 to determine if there were any other incidents related to the mechanical lifts. No other incidents were identified. The Maintenance Director examined all mechanical lifts in the facility on 3/16/18 to ensure the lifts are functioning

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properly. Any lift needing repair was addressed and removed from service. There was one other [brand name] lift and two [brand name sit-to-stand] lifts. One of the [brand name sit-to-stand] lifts was identified with slight wear of one wheel. It has been removed from service until the wheel is replaced. Wearing of the wheels will be monitored by weekly preventative maintenance inspections so they can be replaced as necessary."

3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not occur:

A. "An ad hoc QAPI (quality assurance and performance improvement) committee meeting was held on 3/16/18 with Interim Administrator, ADON (assistant director of nursing), Rehab Manager, Unit Managers, Vice President of Operations and the Regional Clinical Director in attendance. Medical Director attended via telephone. The agenda included determining the root cause of the event, what process would be used to identify other residents that may have been affected, determining what education needed to be completed, the content of that education, and who would be responsible for completing the education. The means for validation of the training was discussed and how the facility was going to monitor the processes and system changes to ensure the event does not reoccur. The goal of the meeting was to determine the root cause of why the event occurred, develop a plan for correcting any identified issues, develop a plan for monitoring to ensure the event does not reoccur. The outcome was a definitive plan was put in place to abate and prevent reoccurrence of the event.

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B. CNAs and licensed nurses were educated by the Director of Nursing, the Unit Managers, the MDS Nurses and the Staff Development Coordinator regarding transfers utilizing mechanical lifts with return demonstration starting 3/12/18 and will continue until 100% CNAs and licensed nurses are educated. The in-service included inspecting the lifts and slings prior to use, operation of the lift with return demonstration, reporting and not using the equipment if any faults/issues are noted, the employee is responsible for tagging and immediately removing the equipment from service and placing in the service hall, and completing the maintenance request.

C. All facility staff regardless of position or title education regarding process for reporting and removing malfunctioning equipment and completion of the Maintenance Request Form. The in-service emphasized it is the staff members responsibility to tag and remove the equipment from service by placing it in the service hallway and not using the equipment until it has been cleared by the maintenance staff for use.

D. Incidents will be reviewed in the weekly focus meeting to ensure the incident had been investigated, a root cause analysis is completed, and interventions are put in place to prevent reoccurrence."

The title of the person responsible for implementing the acceptable plan of correction: Administrator

The credible allegation of IJ removal was validated on 03/19/18 at 6:30 p.m. All

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mechanical lifts were inspected. Staff members were observed while demonstrating proper use of mechanical lifts. Two persons managed the lift with one operating the mechanical component and the other in front for support and positioning of the resident. Staff members checked for proper positioning and safety of the lift pad, positioning of the resident's body in the lift pad and proper functioning of the equipment. Staff members performed safety checks before, during and after the lift procedure. Staff members reported they were provided in-service training on resident transfers with use of a lift on 03/12/18 through the weekend of 03/17/18. The mechanical lift involved in the incident was removed from the unit and placed out of service.

The Maintenance Department was provided in-service training on expected maintenance checks and procedures for equipment with manufacturer instructions on the proper use and maintenance checks for different types of mechanical lifts. Lift inspections were added to the maintenance checklist to ensure they were being inspected more frequently. The Preventive Maintenance Documentation Form for mechanical lifts was revised to include tracking for individual lifts. The Preventive Maintenance Documentation Form for mechanical lifts present in each nursing station's Maintenance Book was reviewed.

Staff members were trained 03/16/18 on the need to document and report and malfunctioning equipment and to complete a Maintenance Request Form. The training record was reviewed and several staff members were interviewed regarding the reporting and documenting process for incidents and accidents.

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F 689	Continued From page 31 The facility ordered new mechanical lifts. In-service training on the use of lifts for resident transfer as well as proper functioning was provided with return demonstration by staff members. Training included reporting practices for malfunctioning or broken lifts and equipment. Staff members were instructed to remove the equipment from the unit and place an orange out-of-service sign with their name, date and time the equipment or lifts were removed. Mechanical lifts were to be placed in the back service area. The Maintenance Department was expected to check the service area daily to ensure items to be repaired were serviced and the repair was documented when it was completed. Orange out-of-service signs were present in the Maintenance Books available at each of the two nursing stations. Severity/Scope = 4/1	F 689		
F 690	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that	F 690		4/10/18

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F 690	Continued From page 32 catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and observations, the facility failed to have a documented diagnosis and order for the use of an indwelling urinary catheter for 1 of 2 sampled residents (#212). Findings included: Resident #212 was admitted to the facility on 3/12/18. Diagnoses included in part, Diabetes Mellitus, Heart failure, chronic kidney disease, and hypertension. The Minimum Data Set (MDS) 5 day assessment dated 3/14/18 revealed that resident was cognitively intact. The assessment was still in progress Review of the discharge orders dated 3/12/18 revealed no order for an indwelling catheter.	F 690	F690 Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. The physician was contacted and the diagnosis and physician order was obtained for use of the urinary catheter. The nurse that completed the admission for resident #212 was in-serviced by the Director of Nursing on 4/2/18 regarding	

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F 690	Continued From page 33 Review of the admission nursing note dated 3/12/18 revealed no documentation of the indwelling urinary catheter. Review of the urinary output documentation beginning on 3/12/18 indicated an indwelling urinary catheter. An observation of Resident #212 on 3/14/18 at 11:10AM revealed Resident lying with her eyes closed and the indwelling catheter draining yellow urine. An interview was conducted on 3/15/18 at 12:03 PM Nurse #1 indicated Resident #212 had an indwelling catheter. She stated that there was no order in the electronic healthcare record (EHR). Review of the hard chart revealed there was no order for the indwelling urinary catheter. An interview was conducted on 3/15/18 at 3:01 PM Nurse #2 indicated the admitting nurse checked the admission orders and put them into the EHR. When she reviewed the hard chart she indicated that Health and Physical (H&P) assessment dated 2/21/18 Resident #212 had a catheter for urinary retention. An interview was conducted on 3/15/18 at 3:09 PM with the Regional Consultant indicated there was no order for the indwelling catheter. An interview was conducted on 3/15/18 at 3:39 PM with the Director of Nursing reviewed Residents #212 hard chart and EHR indicated that there was no order or diagnoses for an indwelling urinary catheter. She indicated that if the resident had a catheter she expected the nurse to obtain an order for the catheter.	F 690	the regulation and policy and procedure pertaining to the appropriate diagnoses for the use of urinary catheters and importance of obtaining orders for the catheter and care of the catheter. Root cause is the nurse that completed the admission acted singularly and violated the standard of care regarding the admission process. The facility also identified a lack of system process for tracking the completion of admissions to ensure all aspects of the admission are done. The Administrative Nursing Team reviewed the charts of the residents identified with urinary catheters to determine if appropriate diagnoses and orders are present for those residents. Any resident identified missing diagnoses and orders were corrected. The nursing staff was in-serviced by the Staff Development Coordinator 3/29/18 to 4/2/18 regarding the regulation addressing the guidelines for use of urinary catheters. New admissions will be reviewed within 48 hours of admission by the Administrative Nursing Team to ensure all aspects of the admission are completed including the diagnosis and appropriate orders for urinary catheters. The Director of Nursing or designee will audit new admissions until 100% compliance is met for two consecutive months to ensure they have a urinary catheter and to ensure an appropriate	

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F 690	Continued From page 34 Attempts to reach via telephone Nurse #4 who admitted Resident #212 on 3/12/18 was unsuccessful on 3/16/18 at 2:51 PM and on 3/19/18 at 2:06 PM. An interview was conducted on 3/16/18 at 3:00 PM Nurse # 3 indicated the physician orders were checked by the admitting nurse or the nurse supervisor, and then 2 nurses checked that the order entry was accurate. An interview conducted on 3/16 at 3:48 PM Nurse # 6 indicated that orders were received from the hospital and checked, then transcribed into the EHR. A second nurse checked the orders for accuracy.	F 690	diagnosis and physician orders are present. Outcomes of those audits will be presented to the steering QAPI committee monthly. The steering committee will direct further analysis and interventions based on reported outcomes and direct further investigations.	
F 908	Severity/Scope = 2/1 Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews with the resident and facility staff, the facility failed to keep a mechanical lift working properly to ensure a resident was safely transferred from the bed to a wheelchair. The mechanical lift's leg positioning device did not lock in place resulting in the lift tilting, the resident being dropped suddenly in the chair and the overhead beam on the lift striking the resident's head. The facility staff continued to use the malfunctioning lift after the incident. This was evident for one of three residents reviewed for	F 908	F908 Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws.	4/10/18

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F 908	Continued From page 35 accidents (Resident #106). Immediate Jeopardy (IJ) began on 02/02/18, when Resident #106 was transferred from the bed to the wheelchair with a malfunctioning lift. The lift tilted resulting in the resident dropping suddenly into the wheelchair and the overhead beam on the lift striking the resident's head. The Immediate Jeopardy was removed on 03/16/18 when the facility provided and implemented an acceptable credible allegation of IJ removal. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete staff training and ensure that monitoring systems put into place are effective to ensure equipment are maintained and working properly before use to transfer residents. The findings included: The manufacturer's User Manual for [brand name of lift] provided a Maintenance Safety Inspection Checklist on pages 40-42 that detailed 10 areas for monthly institutional inspection or adjustment. Included was ensuring the "shifter handle locks [the] adjustable base whenever engaged." The User Manual advised lift operators on page 21 that "If the shifter handle is NOT positioning completely into its mounting slot, DO NOT use the patient lift ...Otherwise, injury and/or damage may occur." Resident #106 was admitted to the facility on 08/30/17 with diagnoses of infection and inflammation due to a left hip prosthesis, chronic congestive heart failure and type 2 diabetes	F 908	The Hoyer lift in question was removed from service and repaired by the Maintenance Director on 3/16/18 and remained out of service until it was evaluated by an outside technician and deemed safe for use. ¿Preventative maintenance has been increased from monthly to at least weekly inspections to be done according to the manufacturer□s recommendations of the lifts to identify and fix any part that has started to loosen There was no injury to Resident #106 thus no other corrective action could be taken for this resident. The resident was assessed by the licensed nurse, there was no redness, swelling, laceration, or bruising. The resident did not report any pain and no pain medication was administered. Neuro checks were implemented per facility policy with no negative outcomes. The resident did go to the hospital after an appointment four days after the event secondary to infection of her hip replacement prostheses which was not related to the event. Root cause is the facility did not follow the policy and procedure regarding preventative maintenance, there was a lack in processes of review to ensure preventative maintenance was completed, and it was determined the preventative maintenance log did not specify which lift or which part of the lift was checked per the manufacturer□s recommendations. The Maintenance Director examined all mechanical lifts in the facility on 3/16/18 to	

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F 908	Continued From page 36 mellitus. The quarterly Minimum Data Set (MDS) dated 02/22/18 documented that the resident was cognitively intact. Resident #106 was occasionally incontinent and required extensive assistance for bed mobility and toileting. Two persons were needed for resident transfers. The current care plan (most recently reviewed on 12/04/17) had entries for complications following left hip replacement, falls risk and deficits related to the performance of activities of daily living. The care plan included the use of a mechanical lift for resident transfers. A nursing progress note dated 02/02/18 by Nurse #7 recorded that Resident #106 "was being transferred from bed to chair and was struck on the forehead" at approximately 9:45 a.m. Vital signs were obtained, neurological checks instituted, and the physician notified. The Director of Nursing (DON) provided the incident report with the names of the two nurse aides (Nurse Aide #4 and Nurse Aide #5) who were operating the mechanical lift at the time along with their written statements. When asked, the DON stated that no written investigation of the incident had been completed by management. Witness statements provided a brief description. Nurse Aide #4 wrote " ...the [brand name] lift spreader bar closed and the [brand name] lift was tilted back and the lift hit her (the resident) in the face." Nurse Aide #5 wrote " ...we adjusted the [resident's] leg while lowering her in the chair and the lift just closed in on her and hit her forehead."	F 908	ensure the lifts are functioning properly. ¿Any lift needing repair was addressed and removed from service. There was one other hoyer lift and two Sara lifts. One of the Sara lifts was identified with slight wear of one wheel. It has been removed from service until the wheel is replaced. Wearing of the wheels will be monitored by weekly preventative maintenance inspections so they can be replaced as necessary. An ad hoc QAPI committee meeting was held on 3/16/18 with Interim Administrator, ADON, Rehab Manager, Unit Managers, Vice President of Operations and the Regional Clinical Director in attendance. Medical Director attended via telephone. The agenda included determining the root cause of the event, what process would be used to identify other residents that may have been affected, determining what education needed to be completed, the content of that education, and who would be responsible for completing the education. The means for validation of the training was discussed and how the facility was going to monitor the processes and system changes to ensure the event does not reoccur. The goal of the meeting was to determine the root cause of why the event occurred, develop a plan for correcting any identified issues, develop a plan for monitoring to ensure the event does not reoccur. The outcome was a definitive plan was put in place to abate and prevent reoccurrence of the event. Education of the Maintenance Director	

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F 908	Continued From page 37 In an interview on 03/15/18 at 3:20 p.m., Resident #106 stated she was "scared to death" when the mechanical lift did not work correctly on 02/02/18. She said both nurse aides were behind the wheelchair when the top bar fell toward her. She indicated the bar gave her a "knot" on her head. The resident was unclear in her description of the incident. In an interview on 03/16/18 at 10:33 a.m., Nurse #7 recounted her assessment of Resident #106 on 02/02/18 following the incident. The resident was lying in bed complaining of pain. There was a red mark on her forehead without laceration, bleeding or bruising. Nurse #7 informed the Unit Supervisor and the DON of the incident. She did not do anything with the mechanical lift at the time. A progress note dated 02/06/18 by Nurse #7 noted that Resident #106 was "transported to MD [medical doctor] appointment at approximately 9 a.m., informed by SW [social worker] that patient was transferred to hospital from MD appointment." The resident was later diagnosed with a prosthetic joint infection of the left hip. In an interview on 03/16/18 at 10:42 a.m., Nurse Aide #4 and Nurse Aide #5 provided a demonstration of what had happened during Resident #106's transfer. The DON was present during the interview. The mechanical lift used for the demonstration was present on the 300 Hall and was the same lift used on 02/02/18 for Resident #106. The machine was permanently assigned for use on the 100 and 300 Halls. When needed, the lift was transferred to the other side of the building for temporary use and then returned to the unit.	F 908	regarding the Preventative Maintenance Policy and Procedure by the Regional Vice President of Operations on 3/16/18.All facility staff regardless of position or title education regarding process for reporting and removing malfunctioning equipment and completion of the Maintenance Request Form. The in-service emphasized it is the staff members responsibility to tag and remove the equipment from service by placing it in the service hallway and not using the equipment until it has been cleared by the maintenance staff for use. The Preventative Maintenance Documentation Form for the mechanical lift was revised to include tracking for individual lifts and specific items regarding the lift to be checked per manufacturer recommendations. Preventative maintenance of other equipment utilized in the facility will be reviewed by the Director of Operations to ensure the equipment is reviewed per manufacturer□s recommendations. Preventative maintenance related to hoyer lifts will be completed by the Maintenance Director or designee per manufacturer□s recommendations. The Administrator or designee will review Preventative Maintenance Log to ensure preventative maintenance is being completed as scheduled weekly until 100% compliance is maintained for 2 consecutive months. Outcomes of those reviews will be presented to the steering QAPI committee monthly. The steering committee will direct further analysis and interventions	

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F 908	Continued From page 38 During the demonstration Nurse Aide #4 indicated that she was operating the lift on 02/02/18 with Nurse Aide #5 guiding the lift pad holding the resident. The wheelchair was positioned between the two legs of the lift with the open seat facing one of the legs. During the lowering of Resident #106 into the chair, they described the machine "suddenly dropping" and depositing the resident in the wheelchair. She was not seated squarely in the wheelchair but did not land on the floor. She was "dropped" from a height of approximately one foot into the chair. The aides stated that the resident was screaming during the incident. When asked for clarification, Nurse Aide #4 confirmed that both wheels of the leg on the right side of the machine lifted from the ground as the mechanical lift tilted to the left. The overhead beam of the lift holding the attached swivel bar and sling struck Resident #106 on the top of her forehead. Nurse Aide #5 stated that she reported the injury and equipment malfunction to the charge nurse immediately, and Nurse Aide #4 stated she placed a sign on the machine and removed it from the unit. During the interview Nurse Aide #4 shared that the mechanical lift was still prone to malfunctioning. Using the tall shifter handle connected to the base of the machine, she showed that the locking mechanism did not engage correctly. The shifter handle repositioned the legs of the machine as designed to do but did not lock them into place. When the shifter handle was moved to the left and up, the legs closed in a parallel position. When the shifter handle was moved to the right and up, the legs opened out at an angle to provide a more stable foundation when weight was lifted in the air. The shifter handle on this machine, however, did not engage	F 908	based on reported outcomes and direct further investigations.	

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in the up position and fell back to neutral, preventing proper locking of the legs in both the open and closed positions.

Nurse Aides #4 and #5 both cited this as the reason the legs did not lock and the lift tilted during the resident's transfer on 02/02/18. The aides were aware that the locking mechanism bolt became loose over time, and that it had been sent to the maintenance shop on other occasions. During this transfer on 02/02/18, apparently the bolt was loose enough to prevent locking of the lift legs, causing injury to the resident when her weight was mid-air and the machine tilted.

Nurse Aide #4 moved the mechanical lift in the short part of the hall to demonstrate that the legs did not stay locked when rolled across the floor. She stated that she did not trust the machine after the incident with Resident #106 and now when using it, she placed one foot on the base with most of her body weight shifted on it to provide extra stability. When asked about training, both aides confirmed that they had a skills assessment on using mechanical lifts on hire and then received refresher training annually from the facility.

The malfunctioning lift was moved to the back service hall behind closed doors after the nurse aides' demonstration by the Maintenance Director and Corporate Vice President of Operations in order to prevent staff members from using it.

In a later interview on 03/16/18 at 3:15 p.m., Nurse Aide #4 stated that she has been "constantly complaining" about the machine used on the 100 and 300 Halls. When asked for

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clarification, she indicated that this was over the course of months and involved both face-to-face communication and written communication in the Maintenance Book at the nurses' station. She further stated that at one point she had physically shown the lift to the DON and the former Administrator while expressing her concerns. (The former Administrator left his position at the facility on 02/14/18.)

In an interview on 03/19/18 at 11:50 a.m., Nurse Aide #6 stated she has been working on the 100 and 300 Halls for over a year. She confirmed that the lift that malfunctioned during the incident of 02/02/18 was the same one that had been used on the unit since her assignment. The lift continued to be used for Resident #106 who has resided on the 300 Hall since admission to the facility last summer. She estimated the lift "had been like that for over a year." She indicated that both she and Nurse Aide #4 have written it in the Maintenance Book requesting repairs. She stated that staff members in the Therapy Department had reported concerns about this particular lift as well as staff members assigned to the 200, 400 and 500 Halls.

In an interview on 03/19/18 at 12:50 p.m., the Rehabilitation Manager shared that some therapy staff members were aware of the mechanical lift used on the 100 and 300 Halls being repaired and returned to the unit, but that none of the staff she spoke with had personally submitted a Maintenance request form.

In an interview on 03/16/18 at 11:20 a.m., the Maintenance Director inspected the mechanical lift used for Resident #106's transfer and that continued to be used on the 100 and 300 Halls

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until its removal from use on 03/16/18 at 11:15 a.m. He acknowledged that the base mechanism was too loose to keep the shifter handle engaged in locking the legs in either the open or closed position. He was unable to provide any written documentation that the mechanical lift had been repaired after the transfer incident on 02/02/18 and stated that neither he nor his assistant remember working on the machine at the time.

He stated that the Maintenance department did routine monthly preventative maintenance checks on equipment, and he provided a completed checklist dated 02/06/18. The facility's five-page Preventative Maintenance Monthly Checklist for the year 2018 included 20 areas for monitoring. One recommended check was listed under Medical Equipment Management: "Check all patient lifting equipment, [brand name mechanical lift] and [brand name sit-to-stand] lifts for defects." Checkmarks indicated that this check was performed in January and February.

The Maintenance Director further stated that he used the general facility checklist rather than a checklist designed specifically for that model of lift. The Maintenance Director confirmed that the model used on the 100 and 300 Halls was the only model of that lift in the building.

During the interview, the Maintenance Director stated that he did not notice a need for any adjustments to the machine when he inspected it on 02/06/18. He also inspected the lift recently on 03/12/18 when he had it in the shop for repair of the scale component for weighing residents. He did not examine the base of the machine. He stated that, in addition to his monthly monitoring of facility equipment, he relied on nurse aides and

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other staff members to report concerns or problems with the mechanical lifts. The Maintenance Director then moved the machine from the back service hall to the shop area.

On 03/16/18 at 5:15 p.m. an inspection of the lift machine was performed after return from the shop. The machine was stored behind the locked door of the Restorative room. Operation of the shifter handle verified that appropriate adjustments had been made. The mechanism holding the shifter handle was tighter, and the handle did not slip out of position when engaged.

In an interview on 03/19/18 at 9:30 a.m., the Maintenance Director indicated that the lift had since been removed from the building.

In an interview on 03/19/18 at 4:00 p.m., Regional Consultant #1 confirmed that the facility had no written policy and procedure on faulty or broken resident-care equipment.

In an interview on 03/19/18 at 3:16 p.m., the DON stated she assessed Resident #106's injury after the incident on 02/02/18. She also stated she had instructed Nurse Aide #4 to place a tag on the mechanical lift identifying it as needing repair and to remove it from the unit to the back service hall. The DON stated that she did not see the lift later that day on the unit but could not confirm that the matter had come to the attention of Maintenance for follow-up. She shared that at the time she was more concerned about the possible malfunctioning of the lift than the aides' proper operation of it. She stated that one of the aides had many years of experience operating mechanical lifts. She was not aware of the aides' concern about the stability of the machine before

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the interview and demonstration on 03/16/18. She acknowledged that the mechanical lift used to transfer Resident #106, and still in use on the 100 and 300 Halls until that morning, had not been working properly, placing residents at risk for injury from potential accidents.

She stated she was not aware of staff members' ongoing concerns with the functioning of the lift. There had been issues with the battery pack in the machine, and she said she referred those to Maintenance. She did not remember either her or the Administrator being shown the faulty locking mechanism.

The DON acknowledged in the interview that staff members were continuing to use a mechanical lift with identified safety hazards to transfer residents, endangering those who relied on safe operation during transfer and exposing residents to potential trauma. Her expectation was that staff members tag malfunctioning equipment for repair and remove it immediately from resident- care areas to prevent further use.

The Administrator and Director of Nursing were informed of the immediate jeopardy on 03/16/18 at 4:21 p.m. On 03/16/18 at 9:41 p.m., the facility provided the following credible allegation of IJ removal:

"A resident was being transferred from bed to wheelchair utilizing a [brand name] lift with two CNAs [Certified Nurse Aides] present who followed policy and procedure during the transfer. The lift legs retracted related to the handle that locks the legs was loose, and did not fully engage to the locked position, causing the bar to swing and the resident to be hit in the head with the bar

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from the lift. The facility failed to protect residents from neglect by failing to remove a lift from service."

"Root cause is the facility did not follow the policy and procedure regarding preventative maintenance, there was a lack in processes of review to ensure preventative maintenance was completed, and it was determined the preventative maintenance log did not specify which lift or which part of the lift was checked per the manufacturer's recommendations."

The procedure for implementing the acceptable plan of correction for the specific deficiency cited:
1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice:

"The [brand name] lift in question was removed from service and repaired by the Maintenance Director on 3/16/18 and will remain out of service until it has been evaluated by an outside technician and deemed safe for use. Preventative maintenance has been increased from monthly to at least weekly inspections, to be done according to the manufacturer's recommendations, of the lifts to identify and fix any part that has started to loosen.

There was no injury to Resident #106 thus no other corrective action could be taken for this resident. The resident was assessed by the licensed nurse, there was no redness, swelling, laceration, or bruising. The resident did not report any pain and no pain medication was administered. Neuro checks were implemented per facility policy with no negative outcomes. The resident did go to the hospital after an

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appointment four days after the event secondary to infection of her hip replacement prostheses which was not related to the event."

2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:

"The Maintenance Director examined all mechanical lifts in the facility on 3/16/18 to ensure the lifts are functioning properly. Any lift needing repair was addressed and removed from service. There was one other [brand name] lift and two [brand name sit-to-stand] lifts. One of the [brand name sit-to-stand] lifts was identified with slight wear of one wheel. It has been removed from service until the wheel is replaced. Wearing of the wheels will be monitored by weekly preventative maintenance inspections so they can be replaced as necessary."

3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not occur:

A. "An ad hoc QAPI (quality assurance and performance improvement) committee meeting was held on 3/16/18 with Interim Administrator, ADON (assistant director of nursing), Rehab Manager, Unit Managers, Vice President of Operations and the Regional Clinical Director in attendance. Medical Director attended via telephone. The agenda included determining the root cause of the event, what process would be used to identify other residents that may have been affected, determining what education needed to be completed, the content of that education, and who would be responsible for completing the education. The means for

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validation of the training was discussed and how the facility was going to monitor the processes and system changes to ensure the event does not reoccur. The goal of the meeting was to determine the root cause of why the event occurred, develop a plan for correcting any identified issues, and develop a plan for monitoring to ensure the event does not reoccur. The outcome was a definitive plan was put in place to abate and prevent reoccurrence of the event.

B. Education of the Maintenance Director regarding the Preventative Maintenance Policy and Procedure by the Regional Vice President of Operations on 3/16/18.

C. All facility staff regardless of position or title education regarding process for reporting and removing malfunctioning equipment and completion of the Maintenance Request Form. The in-service emphasized it is the staff members responsibility to tag and remove the equipment from service by placing it in the service hallway and not using the equipment until it has been cleared by the maintenance staff for use.

D. Preventative Maintenance Documentation Form for the mechanical lift was revised to include tracking for individual lifts and specific items regarding the lift to be checked per manufacturer recommendations. Preventative maintenance of other equipment utilized in the facility will be reviewed by the Director of Operations to ensure the equipment is reviewed per manufacturer's recommendations."

The monitoring procedure to ensure the plan of correction is effective and that specific deficiency

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	345458	A. BUILDING _____ B. WING _____	C 03/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	2059 TORREDGE ROAD DURHAM, NC 27712

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cited remains corrected and/or in compliance with the regulatory requirements:

To remain in compliance and under the direction of the Administrator or designee, beginning 3/16/18:

A. "Preventative maintenance related to [brand name] lifts will be completed by the Maintenance Director or designee per manufacturer's recommendations.

B. The Administrator or designee will review Preventative Maintenance Log to ensure preventative maintenance is being completed as scheduled weekly until 100% compliance is maintained for 2 consecutive months."

The title of the person responsible for implementing the acceptable plan of correction: Administrator

The credible allegation of IJ removal was validated on 03/19/18 at 6:30 p.m. All mechanical lifts were inspected. Staff members were observed while demonstrating proper use of mechanical lifts. Two persons managed the lift with one operating the mechanical component and the other in front for support and positioning of the resident. Staff members checked for proper positioning and safety of the lift pad, positioning of the resident's body in the lift pad and functioning of the equipment. Staff members performed safety checks before, during and after the lifts procedure. Staff members reported they were provided in-service training on resident transfers with use of a lift on 03/12/18 through the weekend of 03/17/18. The mechanical lift involved in the incident was removed from the

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unit and placed out of service.

The Maintenance Department was provided in-service training on expected maintenance checks and procedures for equipment with manufacturer instructions on the proper use and maintenance checks for different types of mechanical lifts. Lift inspections were added to the maintenance checklist to ensure they were being inspected more frequently. The Preventive Maintenance Documentation Form for mechanical lifts was revised to include tracking for individual lifts. The Preventive Maintenance Documentation Form for mechanical lifts present in each nursing station maintenance book was reviewed.

Staff members were trained 03/16/18 on the need to document and report and malfunctioning equipment and to complete a Maintenance Request Form. The training record was reviewed and several staff members were interviewed regarding the reporting and documenting process for incidents and accidents.

The facility ordered new mechanical lifts. In-service training on the use of lifts for resident transfer as well as proper functioning was provided with return demonstration by staff members. Training included reporting practices for malfunctioning or broken lifts and equipment. Staff members were instructed to remove the equipment from the unit and place an orange out-of-service sign with their name, date and time the equipment or lifts were removed.

Mechanical lifts were to be placed in the back service area. The Maintenance Department was expected to check the service area daily to

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F 908	Continued From page 49 ensure items to be repaired were serviced and the repair was documented when it was completed. Orange out-of-service signs were present in the Maintenance Books available at each of the two nursing stations. Severity/Scope = 4/1	F 908		