STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

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F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews with resident, staff and the Medical Director (MD), the facility failed to transfer a dependent resident using the mechanical lift which resulted in an acute left femoral neck fracture for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #2). The findings included: Resident #2 was originally admitted to the facility on 09/11/15 with diagnoses which included osteoporosis, arthritis, and chronic pain. The significant change Minimum Data Set (MDS) assessment dated 03/22/19 assessed Resident #2 as being cognitively intact and requiring extensive assistance of two staff for transfers. The MDS further revealed Resident #2 had physical limitation due to right above knee amputation (AKA) and impaired vision. The Care Area Assessment (CAA) for Activities of Daily Living (ADL) associated with the 03/22/19 MDS indicated that Resident #2 required extensive assistance with bed mobility, transfer, and toileting. Resident #2 was a	F 689	Past noncompliance: no plan of correction required.	4/24/19

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

Electronically Signed | 04/24/2019

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Spanish-speaking resident who required an interpreter to communicate all needs.

Review of the care plan for ADL that was initiated on 06/14/18 and last revised on 04/01/19 revealed that Resident #2 had a self-care performance deficit related to right AKA, osteoporosis, and end-stage renal disease. The goal was that Resident #2 would improve current level of function in ADL through the next review date. Interventions included encouraging active participation in tasks, providing cueing with tasks as needed, and transferring with a mechanical lift with 2-person assist.

Review of the care plan for falls that was initiated on 06/14/18 and last revised on 04/02/19 revealed Resident #2 was at risk for falls related to balance problems during transition, right AKA, and impaired vision. The goal was that Resident #2 would be free of falls through the next review date. Interventions included anticipating and meeting Resident #2's needs, ensuring call light was within reach and encouraging Resident #2 to use it for assistance as needed, and following facility fall protocol.

A falls risk assessment completed on 12/13/18 revealed Resident #2 had high risk for fall due to right AKA and impaired vision.

A transfer evaluation dated 12/13/18 indicated that Resident #2 required caregivers to perform 100% of the transferring task with the use of the mechanical Lift.

A Situation Background Assessment Recommendation (SBAR) communication form reviewed for Resident #2 and dated 03/10/19

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noted: "Resident stated he felt his leg "crack" in the left upper groin during the 2-person transfer from chair to bed. Hoyer Lift was not used. Resident complained of severe pain after the transfer. Interpreter used for communication for 4 times. Resident complained of pain localized to the left groin only."

Review of progress notes documented by Nurse #1 revealed that the physician was notified on 03/10/19 at 7:10 PM when Resident #2 complained of severe pain at his left groin areas after being transferred from wheelchair to the bed. Resident #2's responsible party (RP) was notified and present at 7:20 PM.
Review of physician order dated 03/10/19 at 8:07 PM revealed an X-ray had been ordered for Resident #2.

Review of progress notes documented by the Director of Nursing (DON) revealed the facility received X-ray results on 03/11/19 at 9:52 AM which indicated Resident #2 was confirmed with an acute left femoral neck fracture. Emergency Medical Services (EMS) was called on the same day at 10:05 AM and Resident #2 was transported via stretcher by EMS to the hospital at 10:30 AM. Resident #2 was re-admitted to the facility on 03/15/19.

Review of incident report dated 03/11/19 revealed Resident #2 was being transferred from wheelchair to the bed on 03/10/19 by 2 nurse aides without using the mechanical lift, resulting in left femoral neck fracture. The investigation conducted by the facility was unable to determine if the fracture was caused by improper lifting or repositioning of Resident #2's leg in bed due to severe osteoporosis.

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During an interview conducted on 04/08/19 at 4:49 PM via translator over the phone, Resident #2 stated on 03/10/19 at around 7:00 PM, 2 nurse aides (NAs) transferred him from the wheelchair to the bed without using the mechanical lift. According to Resident #2, the male NA lifted him up with both arms underneath Resident #2's shoulder while the female NA lifted the leg by lifting his pant instead of putting both of her arms underneath the leg. During the transfer, Resident #2's left leg was stuck against the bed. He heard a cracking sound and felt extreme pain at his left groin when he landed on the bed. Resident #2 added that he suffered a broken hip and was hospitalized for 3-4 days.

During a phone interview conducted on 04/08/19 at 5:48 PM, Nurse #1 stated on 03/10/19 around 7:00 PM NA #1 and NA #2 transferred Resident #2 from the wheelchair to the bed without using the mechanical lift. During the transfer, Resident #2's left leg was unsupported and pressed against the bed, causing the crack. Resident #2 complained of pain at his left groin areas after the transfer. Nurse #1 assessed Resident #2 immediately, notified the physician and RP right after the incident. Then she requested the X-ray per physician order. Nurse #1 educated both NAs of the proper way to transfer Resident #2 with the mechanical lift.

During a phone interview conducted on 04/08/19 at 6:13 PM, NA #1 stated about one month ago around 7:00 PM Resident #2 requested repeatedly to be transferred from the wheelchair to the bed. NA #1 indicated that he was aware of the requirement to transfer Resident #2 by using the mechanical lift with 2-person assist but

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recalled the lift was around the corner and there was no lift pad underneath Resident #2 on the wheelchair. Since Resident #2 was not heavy and it was late, he decided to transfer him with the help of NA #2 without using the mechanical lift. NA #1 explained during the transfer, he lifted Resident #2 up with both arms underneath the shoulder and NA #2 grasped Resident #2's pants instead of putting her arms underneath the left leg. NA #1 denied hearing any cracking sound when Resident #2 landed on the bed. However, he did state Resident #2 complained of left leg pain after the transfer. NA #1 informed the nurse of the resident's pain immediately.

Multiple attempts to interview NA #2 via phone were unsuccessful. She was unavailable to answer the calls and did not call back.

During an interview conducted on 04/09/19 at 9:35 AM, the DON stated it was her expectation for all the staff to transfer residents as ordered in the care plan and follow manufacturer's directions during the transfer. The DON stated the corrective actions were started right after the incident on 3/11/19.

During a phone interview conducted on 04/09/19 at 10:27 AM, the physician stated that Resident #2 was diagnosed with severe osteoporosis and was ordered to use the mechanical lift with 2-person assist during transfer. He stated that Resident #2's bones were so fragile that a rough landing onto the bed could have caused the fracture of his hip. It was his expectation for all the nursing staff to follow the order during transfers.

During an interview conducted on 04/09/19 at

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F 689	Continued From page 5 1:38 PM, the Administrator stated that it was her expectation for all the nursing staff to follow the care plan as ordered and manufacturer's directions for a safe and appropriate transfer. The facility's corrective actions implemented after the incident to prevent a reoccurrence included the following: 1. Resident #2 was assessed by Nurse #1 right after the incident on 03/10/19 and his Responsible Party (RP) and the physician were contacted immediately. Order obtained for in-house X-ray and "as needed" pain medication in addition to scheduled pain medication. The NAs involved in this incident were re-educated and their knowledge of Resident #2's plan of care was verified on 03/10/19. Resident #2 was sent to the hospital for evaluation and treatment when the X-ray confirmed Resident #2 with acute left femoral neck fracture on 03/11/19. 2. On 03/11/19, NA's care guides for all residents were reviewed and updated with transfer status. On the same day, return demonstration of Mechanical Lift education began by Assistant DON or designee to ensure 100% education for all nursing staff. No employees would be allowed to begin an assigned shift without having return demonstration in place. From 03/11/19 through 03/14/19, all residents' transfer evaluations were audited by the MDS coordinator for accuracy. 3. Quality improvement monitoring was initiated on 03/13/19 after all training was completed to randomly observe transfer utilizing the Mechanical Lift daily for 14 days, 5 days per week for 4 weeks, and then 3 days per week for 6 weeks.	F 689		

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4. The results of the monitoring would be reported at the monthly Quality Assurance and Performance Improvement (QAPI) meeting until such time as substantial compliance had been achieved. The QAPI committee recommended quarterly oversight by the District Director Clinical Services to maintain compliance when completing clinical systems review. Ad Hoc QAPI meeting was held on 03/12/19 with the DON and the Administrator in attendance. The root cause statement dated 03/12/19 in this incident was: "The NAs opted to make a decision of the transfer status of a resident."

The facility's corrective actions were verified on 04/08/19 through 04/09/19 by record review, observations and interview with residents and staff.

The medical record of Resident #2 was reviewed. He was assessed by Nurse #1 immediately on 03/10/19. The Physician and RP were informed of the incident. Resident #2 was immediately sent to the hospital for evaluation and treatment when X-ray confirmed acute left femoral neck fracture.

The DON investigated the incident. The 24-hour and 5-day reports were sent to the State Agency in timely manner. The NAs involved in the 03/10/19 incident were re-educated and their knowledge of Resident #2's plan of care was verified.

In-service records were reviewed with training started on 03/11/19 and ongoing (as new staff reported for duty). All staff signed attendance sheets with in-services addressing Mechanical Lift education during transfer. A return

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demonstration of the Mechanical Lift was required by all the staff. All newly hired employees, nursing staff and agency staff working since 03/11/19 had received training and a system was in place to ensure all new facility staff and agency staff were properly trained and able to demonstrate return demonstration on use of all lifts.

During the investigation, observations of staff transferring dependent residents utilizing the Mechanical Lift were made. Interviews were conducted with dependent residents regarding assistance provided by the staff when utilizing Mechanical Lifts for transfers. No issues were identified with observations or interviews.

During the investigation, nurses and NAs (both facility and agency staff) were interviewed and verified that they received in-service on transferring residents with Mechanical Lifts with emphasis on unsafe acts or practices. Nursing staff reported that they had to demonstrate the use of the Mechanical Lift before they were allowed to start their assigned shifts. NAs stated that they had to review the care guides before every shift to identify any changes with transfer requirements for residents that they were assigned to care for.

The monitoring tools were reviewed and they included random checks for residents and staff from all shifts and in the time frame indicated. The monitoring was started on 03/13/19 and was ongoing at the time of the investigation. Review of the monitoring information revealed that no concerns were noted.