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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 08/11/20 through 08/14/20. 1 of the 1 complaint allegations was substantiated resulting in a deficiency. Event ID# UQK911.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, Physician Assistant and staff interviews, the facility failed to transfer a dependent resident using a mechanical lift with 2-person assist. This action resulted in the resident hitting his stump on the arm of the wheelchair which caused a staple to come out, opening and bruising his incision site for 1 of 3 resident's reviewed for accidents (Resident #1). Findings included: Resident #1 was admitted to the facility on 03/31/20 with diagnosis including bilateral below the knee amputation, atrial fibrillation, hypertension, peripheral vascular disease and arthritis. Review of Resident #1's discharge Minimum Data Set (MDS) dated 04/14/20 revealed he was alert and oriented. Resident #1 required extensive,	F 689	Past noncompliance: no plan of correction required.	8/25/20

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

Electronically Signed | 08/25/2020

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two-person assistance with most activities of daily living (ADL) and was dependent upon staff for transfers.

Review of a grievance dated 4/06/20 revealed Resident #1 was transferred from the bed to his wheelchair without use of a mechanical lift. The grievance stated Resident #1 had told the Nurse Aide (NA) to use a lift pad because dialysis needed it to transfer him. The NA disregarded the resident's request causing the resident to have to return from dialysis to the facility to be placed on a lift pad. The findings of the investigation revealed Resident #1 was sent back to the facility from the dialysis center due to not having a lift pad under him. The investigation revealed the facility had a resident roster which showed how each resident was supposed to be transferred. Resident #1's resident roster showed he was supposed to be a mechanical lift for transfers. The NA was removed from the schedule and the agency company was notified.

Review of Resident #1's undated resident roster revealed he required a mechanical lift with two staff members assistance for transfers and was to have a mechanical lift pad under him when going to the dialysis center.

Review of a facility reported incident dated 4/10/20 revealed NA #1 assisted Resident #1 into his wheelchair for dialysis on 4/6/20. Resident #1 stated, "I tried to explain to NA #1 what needed to be done". NA #1 lifted Resident #1 up and placed him in his wheelchair hitting his stump on the side of the wheelchair. The report revealed the facility discovered the resident was not properly transferred from the bed to his wheelchair as indicated on the resident roster. Resident #1 had

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attempted to direct NA #1 on how to transfer him and the importance of a lift pad for dialysis use. Resident #1's incision located on his left stump area opened up due to the incident and a staple was absent requiring the resident to see a surgeon on 4/7/20.

On 8/11/20 at 5:01 PM an interview was conducted with Resident #1. He stated on 4/6/20 he had dressed himself independently and was sitting on the side of his bed waiting on a two staff member assistance to his wheelchair. Resident #1 stated NA #1 came into his room alone and told him he was going to transfer him to the wheelchair. Resident #1 stated he told NA #1 he needed to use a mechanical lift with another staff member assistance. NA #1 stated to him he didn't need to use a mechanical lift and proceeded to put his arms under Resident #1's shoulders to lift him onto the wheelchair. Resident #1 stated his left stump hit the arm of the wheelchair causing pain and his stump area to bleed. The interview revealed Resident #1 had told another staff member about the incident prior to leaving for dialysis however he could not recall what staff member he told.

On 8/11/20 at 1:33 PM an interview was conducted with NA #1. During the interview he stated he was getting Resident #1 ready for dialysis on 4/6/20 and assisting him to transfer into his wheelchair. NA #1 stated his role was to make sure Resident #1 did not fall forward so he had placed his arms on the resident's shoulders. The interview revealed NA #1 did not go get a mechanical lift to transfer Resident #1 he instead decided to assist the resident himself. He stated he didn't know Resident #1 required a mechanical lift transfer and wasn't aware of what

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a resident roster was. NA #1 stated the resident had not hit his leg on the wheelchair arm and had never complained of pain during or after the transfer, so he did not notify the nurse. He stated Resident #1 did not complain of pain until he returned from dialysis.

On 8/11/20 at 3:30 PM an interview was conducted with Dialysis Nurse #1. She stated she was very familiar with Resident #1 and on 4/6/20 he told her NA #1 had transferred him incorrectly and hit his left stump area on the arm of his wheelchair. She stated she was concerned regarding the allegation from Resident #1 and had called the facility to tell them what had happened. The interview revealed she had spoken with someone from the facility however could not recall their name. She stated if a resident who required a mechanical lift transfer was sent to the dialysis clinic from a facility without a lift pad, they would send the resident back to the facility to get a lift pad prior to dialyzing the resident. The interview revealed Resident #1 had come to dialysis without a lift pad and was sent back to the facility.

On 8/11/20 at 2:01 PM an interview was conducted with Wound Nurse #1. She stated on 4/6/20 Resident #1 had returned from dialysis when she was alerted by another staff member to go look at his left below knee amputation stump. She stated when she entered the room Resident #1 told her NA #1 had lifted him into his wheelchair incorrectly and hit his stump area on the arm of the wheelchair. The interview revealed NA #1 had not reported the incident to the hall nurse and a 4-6-hour time frame had occurred from when the incident happened until she assessed it. She stated she unwrapped the ace

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bandage which had a dried red substance on the outside of the wrap and opened the dressing to find staples hanging out of the incision. The interview revealed she notified administrative staff and put a treatment plan in place. She stated she called the vascular surgeon.

On 8/12/20 at 8:00 AM an interview was conducted with the Director of Nursing (DON). She stated after Resident #1 returned from dialysis on 4/6/20 the wound nurse had observed changes to the wound and notified her. The interview revealed Resident #1 was upset with NA #1 who had gotten him ready for dialysis that morning. Resident #1 had stated to her he tried to explain to NA #1 what needed to be done but the NA was not listening. Resident #1 explained to her NA #1 picked him up and put him in the wheelchair. Resident #1 went on to state his stump was bumped on the wheelchair during the transfer which resulted in the facility calling the surgeon. She stated following the incident the unit managers on the hall conducted audits of resident transfers daily, weekly and then monthly.

On 8/11/20 at 1:27 PM an interview was conducted with the Administrator. She stated Resident #1 was alert and oriented. The interview revealed Resident #1 had told NA #1 how to transfer him however NA #1 ignored the resident completely and transferred him without using a mechanical lift which was the proper way. She stated when they conducted an interview with NA #1, he stated to them he had used a one man assist to transfer Resident #1 into his wheelchair and stated he didn't know where to find the resident rosters. The interview revealed NA #1 had received training on resident rosters and had signed the training form. Following the incident,

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NA #1 was removed from the facility. She stated staff had conducted 100% education on abuse, transferring residents and reviewing the resident rosters. The interview revealed the facility had incorporated transfers and falls into their April 2020 Quality Assurance and process improvement meeting and into their morning clinical interdisciplinary team meeting. She stated the Unit Manager had conducted transfer audits which were completed 5 times a week for the first 2 weeks, then once a week for the following 2 weeks and was currently conducting monthly audits.

Review of the transfer lift audits initiated on 4/20/20 revealed staff had conducted audits 5 times a week for 2 weeks, then once a week for the following 2 weeks and had conducted monthly audits for the months of July and August 2020.

On 8/12/20 at 9:25 AM an interview was conducted with the Nurse Practitioner (NP). She stated Resident #1 had a diagnosis of end stage renal disease and peripheral vascular disease. The interview revealed Resident #1's wound had dehisced, and he was saying it had opened up due to the trauma of being hit which she stated was possible.

On 8/12/20 at 10:10 AM an interview was conducted with Unit Manger #1. She stated following the incident the facility conducted 100% education to all staff members regarding resident transfers. The interview revealed once the in-servicing was completed on 4/20/20 she conducted transfer audits 5 times a week for the first 2 weeks, then once a week for the following 2 weeks and was currently conducting monthly audits.

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Review of the hospital records dated 4/8/20 revealed Resident #1 had experienced an incident at the nursing facility where he had trauma to his left below knee amputation when being transferred to a chair which caused his stump to dehisce.

On 8/13/20 at 4:20 PM an interview was conducted with the Surgeons Physician Assistant. She stated Resident #1 had a bilateral below the knee amputation as a result of peripheral vascular disease. She stated following the surgery he was placed into the nursing home for rehabilitation therapy. The interview revealed when Resident #1 was seen on 4/7/20 by the Surgeon he told the Surgeon the wound had opened due to being hit on the wheelchair during a transfer with a Nurse Aide. She stated upon examination the wound was open and bruised. The interview revealed the wound was not opened prior to the incident on 4/6/20. She stated the resident was alert and oriented, able to describe exactly what had happened and was hard to disregard however she did not witness the incident and could only speak for what she saw on 4/7/20 when she examined the resident.

The facility's corrective actions implemented after the incident to prevent a reoccurrence included the following:

1. Resident #1 was assessed by the Wound Nurse on 04/06/20. The surgeon was notified of the status of the incision site. A Physician appointment was scheduled for 4/07/20. The nursing assistant that transferred Resident #1 independently on 04/06/20 was counseled on 04/06/20 and a request was made to the staffing

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agency that he not return to the facility. Resident #1 was counseled by the Social Worker regarding the incident on 04/06/20.

2. All nursing staff (licensed nurses and nursing assistants) were re-educated on resident transfers and proper procedure with a return demonstration. All agency nursing staff (licensed nurses and nursing assistants) were re-educated on resident transfers and proper procedure with a return demonstration (prior to working at the facility). All nursing staff (licensed nurses and nursing assistants) were re-educated on where to locate the appropriate method of transfer for residents in the Resident Roster (which contained individual care needs for residents) and individual care plans. The re-education and return demonstration began on 04/20/20 through 04/23/20.

3. Quality improvement monitoring was initiated 04/27/20 after all training was completed to conducted audits 5 times a week for 2 weeks, then once a week for the following 2 weeks and had conducted monthly audits for the months of July and August 2020.

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 facility's corrective actions were verified on 8/11/20 by record review, observations and interviews with residents and staff.

The record of Resident #1 was reviewed. Resident #1 was assessed by the Surgeon on

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04/07/20. The physician and family member were informed of the incident and Resident #1 was immediately provided with treatment.

The DON investigated the incident. The 24 hour and 5-day report were sent to the State Agency on 04/06/20. The nursing assistant involved in the 04/06/20 incident was counseled, and a request was made to the staffing agency for her not to be sent again to the facility. The investigation was substantiated and closed on 04/10/20.

In-service records were reviewed with training started on 04/20/20 through 04/23/20. All staff signed attendance sheets with in-services addressing safe resident transfers and use of the resident roster. All newly hired employees, nursing staff and agency staff working since 04/06/20 had received training and a system was in place to ensure all new facility staff and agency staff were properly trained and demonstrated return demonstration on use of all lifts.

During the survey interviews were conducted with dependent residents regarding assistance provided by staff when utilizing lifts for transfers. No issues were identified with interviews. An observation was unable to be obtained due to no residents requring transfer assist using a mechanial lift while the surveyor was in the building.

During the survey nurses and nursing assistants (both facility and agency staff) were interviewed and verified they received in-service on transferring residents with a lift with emphasis on always having two staff present. Nursing assistants stated they reviewed the resident

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F 689	Continued From page 9 roster before every shift to identify any changes with transfer requirements for residents they were assigned to care for. On 08/11/20 at 2:30 PM the facility's plan for past noncompliance was validated by the following. Review of in-service training records revealed staff from all shift and disciplines had been in-serviced on 04/20/20 through 04/23/20 regarding safe resident transfers. Beginning at 3:00 PM on 08/11/20 multiple interviews were conducted with staff in different departments/shifts. These interviews validated staff had undergone training during the month of April regarding safe resident transfers.	F 689		