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| F 000 | INITIAL COMMENTS<br><br>An onsite complaint investigation was conducted from 11/21/22 through 11/23/22. Event ID # WLCQ11. Intake NC00194982 resulted in Immediate Jeopardy. Immediate Jeopardy was identified at:<br><br>CFR 483.25 at tag F689 at a scope and severity (J).<br><br>Immediate Jeopardy began on 11/13/22 and was removed on 11/23/22.<br><br>The tag F689 constituted Substandard Quality of Care. A partial extended survey was conducted.<br><br>The following intakes were investigated: NC00194529; NC00194636; and NC00194982. Three (3) of the 7 complaint allegations were substantiated resulting in deficiencies. | F 000 | | |
| F 689 SS=J | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident and staff interviews and record reviews, the facility failed to transfer a resident safely from her bed to a wheelchair while using a total mechanical lift for 1 of 3 residents reviewed for accidents (Resident #1). Resident | F 689 | 1. Resident was sent to the hospital on 11/13/2022 treated and sent back on same day.<br>2. On 11/14/2022, the Director of Nursing assessed current residents using | 12/12/22 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/12/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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#1 experienced a fall when two staff members failed to securely attach the sling to the lift which resulted in the sling jarring loose as the lift was moved and with the resident falling to the floor. Resident #1 was sent out to the hospital for evaluation / treatment with severe pain and was found to have a comminuted (a bone that is broken in at least two places) and displaced (where the bones are not in alignment) scapular body (shoulder blade) fracture, rib fractures involving the second through fifth right ribs.

Immediate Jeopardy began on 11/13/22 when Resident #1 was being transferred with a total mechanical lift and one of the four loops from the resident's sling detached from the lift, resulting in the resident falling to the floor and sustaining multiple fractures. Immediate Jeopardy was removed as of 11/23/22 when the facility implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a scope and severity level "D" (no actual harm with potential for more than minimal harm that is not immediate jeopardy) for the facility to continue staff education and ensure monitoring systems put into place are effective.

The findings included:

A review of the manufacturer's instructional video for the facility's total mechanical lift included directions for staff members using the lift. As the video demonstrated a lift being used to transfer a resident from a bed to a wheelchair, the narrator stated, "As the resident is being raised (slightly off of the bed), confirm the secure attachment of the sling to the cradle."

F 689

the mechanical lift to ensure residents were safely transferred without incident by interviewing the alert and oriented residents with a BIMs score of > 12. Residents with BIMs score < 12 the residents received a range of motion assessment to ensure no new onset of pain. On 11/14/2022, there were no other residents involved in any other incidents that were transferred with the mechanical lift. Currently the 18 other residents are being transferred using the total mechanical lift.

3. The Staff Development Coordinator, Director of Nursing, and Unit Managers educated the Licensed Nurses and the Certified Nursing Aides on the process of how to properly transfer using the mechanical lift using a video provided by the mechanical lift company and written information in a classroom setting. Education included ensuring the sling is the appropriate size for the resident. Staff are to ensure the colors of the straps match at the shoulder and at the head. They are to check the straps in the cradle to ensure they are seated properly and secure before the certified nursing aide operates the mechanical lift. Once this is completed the second certified nursing aide will position themselves on the same side of the bed as the mechanical lift to guide the resident in the completion of the transfer. The Director of Nursing will ensure no Licensed Nurse and Certified Nursing Aide will work without receiving this education. Any new hires, including agency staff, will receive education prior to providing resident care. Completed

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| F 689 | Continued From page 2<br>A review of the Food and Drug Administration (FDA) Patient Lifts Safety Guide included a compilation of best practices and general safety recommendations that when followed, can help mitigate the risks associated with patient lifts. The safety recommendations included the following sections, in part:<br>-- "Place Patient in Sling." A cautionary note read, "! Using the wrong sling or attaching the sling incorrectly may cause serious injury to the caregiver or patient." The steps included, "Ensure all clips or loops are secure and will stay attached as patient is lifted."<br>--"Perform Safety Check." This section provided the following instructions: "Before lifting the patient, perform safety check: Examine all hooks and fasteners to ensure they will not unhook during use. Double-check position and stability of straps and other equipment before lifting patient. Ensure clips, latches and bars are securely fastened and structurally sound."<br>-- Lift the Patient." The recommendations included: "Lift patient two inches off the surface to make sure patient is secure. Check the following: Sling straps are confined by guard on sling bar and will not disengage. Weight is spread evenly between straps. Patient will not slide out of sling or tip backward or forward."<br><br>Resident #1 was admitted to the facility on 1/15/16. Her cumulative diagnoses included multiple sclerosis (MS) and paraplegia (paralysis of the legs and lower body).<br><br>The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated 8/26/22. The MDS reported Resident #1 had intact cognition. She required extensive assistance with two plus (2+) persons physical | F 689 | 11/22/2022<br>4. The Director of Nursing and/or designee will observe 2 residents that are transferred using the mechanical lift on random shifts 3 times weekly (including weekends) x 4 weeks to ensure proper usage for safely transferring residents. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further problem resolution if needed. The Administrator will review the results of weekly audits to ensure any issues identified are corrected. | |

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assist for transfers. The resident was 65 inches tall and weighed 191 pounds (#).

The resident's Care Plan included the following area of focus, in part:
--Resident has an Activities of Daily Living (ADL) self-care performance deficit related to activity intolerance, paraplegia, impaired balance, MS (Date Initiated: 12/6/20; Revision on: 8/16/22). The care plan interventions indicated the resident was totally dependent on and was transferred by a total mechanical lift with 2 staff members. (Date Initiated: 12/6/20).

The resident's electronic medical record (EMR) included a Situation-Background-Assessment-Recommendation (SBAR) Summary dated 11/13/22 at 10:45 AM and authored by Nurse #1. The Summary indicated Resident #1 had a fall. Her Primary Care Provider was notified and an order received to send the resident to the hospital for evaluation.

An interview was conducted with Resident #1 on 11/21/22 at 12:28 PM. The resident was awake, alert, and oriented as she was lying on her bed. When asked about the fall she sustained while being transferred with a total mechanical lift, the resident reported two "veteran" nurse aides (NAs) came in to transfer her from the bed to her wheelchair using a total mechanical lift. She was able to identify the two NAs who transferred her (NA #1 and NA #2). Resident #1 reported she had been transferred with the total mechanical lift for several years and thought all would be well because these two aides had worked with her several times in the past. She stated there was a problem with the "pad (the lift's sling) not being hooked up right." Upon further inquiry, she stated

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| F 689 | Continued From page 4<br>she was raised above the bed just fine. However, when the lift moved towards the wheelchair, she was "flipped" out off of the sling and dropped onto the floor. At the time of her fall, she reported she thought both of the NAs were standing behind the lift (not within reach of her). The resident stated, "It all happened very quickly." She reported she thought she hit her back on the base of the lift when she landed on the floor. Immediately after the fall, Resident #1 reported she was in a great deal of pain and could hardly breathe. The hall nurse (Nurse #1) came in, assessed her, and the facility called 911. The paramedics transferred her from the floor to the stretcher, then took her to the hospital. The resident reported she has been in a considerable amount of pain since sustaining the fall on 11/13/22. She stated the NAs told her they were sorry about the incident.<br><br>A telephone interview was conducted on 11/22/22 at 6:48 PM with NA #1. NA #1 was identified as one of the nurse aides who was transferring Resident #1 with the total mechanical lift when she fell on 11/13/22. During the interview, the NA recalled she was working on obtaining weights for the residents on that date. The NA stated she already had the total mechanical lift with her when a coworker wanted to borrow it to get Resident #1 up in her wheelchair. "I told her we would get her in the chair and get the weight at the same time." NA #1 stated the resident was already laying on the sling on her bed and was ready for the transfer. NA #2 assisted her and was on the resident's left side with NA #1 on the right side. She recalled both sides of the bottom part of the sling were hooked up to the lift using the blue loops while both sides of the top part of sling were hooked up to the lift using the orange loops. The NA reported, "I had the controls. I proceeded | F 689 | | |

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to move the (brand name of mechanical lift)." She stated the lift's legs were open and when the lift was moved, it jerked a little because it got caught on a wire under the bed. She stated, "So we proceeded to move her and when we moved her, the lift's pad (sling) on the top right hand side gave way and she (Resident #1) yelled." She reported that Resident #1 fell in such a way that she was lying on the legs of the total mechanical lift. NA #2 ran and got Nurse #1 while she stayed with the resident.

The telephone interview continued on 11/22/22 at 6:48 PM with NA #1. During the interview, the NA was asked if she looked at the resident's sling after the fall. She stated, "No, I didn't." When asked if she had any reason to believe there was a problem with the sling, the NA only stated that she threw the sling away in the garbage after the fall just in case there had been a problem with it. NA #1 reported she recalled hearing a "pop" during the lift transfer but stated she did not know where the noise came from. The NA was also asked if either of the NAs had a hand on the resident to provide guidance to her body during the transfer. She reported they did not. NA #1 stated she had the control and was turning the lift while NA #2 had come around the foot of the bed as she was getting the wheelchair ready for transfer.

An interview was conducted with NA #2 on 11/22/22 at 3:54 PM. NA #2 was identified as one of the nurse aides who was transferring Resident #1 with the total mechanical lift when she fell on 11/13/22. As the NA recalled the incident, she reported NA #1 was planning to weigh the resident prior to transferring her to the wheelchair and NA #2 was going to assist her. The NA

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recalled Resident #1 had her own sling and she remembered examining the sling (straps and loops) to make sure everything was in order before using it. NA #2 stated she started out on the resident's left side with the other NA on the right side of the bed with the control for the lift. She recalled each of the NAs hooked the orange color-coded loop on the top of the sling to the lift; and each hooked the blue color-coded loop at the bottom of the sling to the lift. She noted these were the loops typically used to for Resident #1. NA #2 stated after the loops were hooked to the lift, she came around to the right side of the bed to help straighten the resident onto the middle of both the bed and the sling. NA #1 started to lift the resident up with the mechanical lift, then pulled the lift backwards. As she came backwards with the lift, NA #2 turned and grabbed the wheelchair to position it for the transfer. NA #1 turned the lift towards the wheelchair while NA #2 was grabbing the wheelchair. NA #2 stated, "That's when the resident started to lean backwards in the sling." She reported at the time when the resident was leaning backwards, there was no one touching her. The resident continued to go backwards and fell directly on the base (legs) of the lift. The NA recalled it all happened very quickly. After Resident #1 fell, the NA recalled she went outside, called the nurse, and the nurse called 911.

The interview continued with NA #2 on 11/22/22 at 3:54 PM. During the interview, the NA was asked if there was a problem with the sling. She stated, "I don't think there was. I didn't understand how the fall happened." NA #2 reported she looked at the sling after the fall and did not see a problem with it. She stated NA #1 told her the loop came off and "she actually said it

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broke." Upon further inquiry, NA #2 stated she looked at the loop on the sling and did not see a break in the loop. When asked, the NA reported she did not hear anything unusual (any noises) from the lift or sling during Resident #1's transfer to indicate there may be a problem. The NA was also asked if at least one person would have typically had a hand on the resident to provide guidance to her body during the transfer. The NA responded by saying, "Sometimes we do...both of us normally have a hand on her right side because she tends to lean in that direction."

A telephone interview was conducted on 11/23/22 at 8:19 AM with Nurse #1. Nurse #1 was identified as the nurse who was assigned to care for Resident #1 on 11/13/22 (the date of her fall). As the nurse recalled the incident, she stated she was at the medication cart in the hall close to Resident #1's room. Immediately after hearing a loud noise and scream, she went to the room. Resident #1 was crying and moaning from pain. The nurse noticed her head was laying on the leg of the lift and said right away she needed to go to the hospital due to the resident hitting her head. The nurse reported the resident's vital signs were obtained and her physician was called. An order was received to send the resident out to the hospital. The nurse reported the resident continued to be alert and oriented. She did not complain of head pain but did have some shortness of breath. Nurse #1 administered a dose of the resident's tramadol (an opioid pain medication ordered to be given to Resident #1 on an as needed basis). When asked, the nurse reported she did not have any additional conversations with the NAs regarding the fall. She was also asked if she examined the resident's sling after the fall. The nurse stated

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she did not.

A Nursing Note dated 11/13/22 at 11:08 AM and authored by Nurse #1 reported the resident was transferred to the hospital for evaluation after the fall due to right shoulder pain.

Resident #1's hospital record indicated the resident arrived in the Emergency Department (ED) on 11/13/22 at 11:25 AM. The ED Triage Notes read in part: "Per EMS patient was in (brand name of mechanical lift) at a height of 4 - 5 ft (feet) in the air and fell out of the sling. Patient fell on R (right) shoulder and hit head. Patient denies loss of consciousness." The resident's history reported, "they were moving her when they dropped her onto her right side onto the floor." The resident reported having "severe sharp searing pain 9 out of 10 in her right shoulder which does not radiate is worse anytime she tries to move it and she reports she did hit her head and has a mild right-sided headache and some neck pain ...She does not take any anticoagulation. They gave her tramadol at the facility with minimal improvement in the pain. The history is provided by the patient and the EMS personnel."

Findings from the 11/13/22 hospital x-ray and computerized tomography (CT) radiology indicated the resident had
a comminuted and displaced scapular body fracture, a nondisplaced fracture of the right anterior (located towards the front of the body) second rib, a nondisplaced fracture of the right lateral (located towards the side of the body) third rib, and minimally displaced right lateral fourth and fifth rib fractures. Orthopedics was consulted. The physician noted, " ...She has

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advanced MS, is wheelchair-bound, and unfortunately this is her primary functional upper extremity. She can use her fingers wrist and hand, and can even use her shoulder if she can tolerate, but I doubt she will be able to do much. Plan for nonsurgical management and follow-up in the office in 1 to 2 weeks." Additional pain control was provided and a sling recommended for comfort.

The resident was transferred back to the facility on 11/13/22. A Nursing Note dated 11/13/22 at 6:00 PM (authored by Nurse #1) reported Resident #1 returned from the hospital and was reported to be pain free at that time. The resident continued to receive the following pain medications as previously ordered: 50 milligrams (mg) tramadol to be given as two tablets by mouth every 6 hours as needed for pain (Start Date 8/21/21); and 325 mg acetaminophen to be given as two tablets by mouth every 8 hours as needed for mild to moderate pain (Start Date 9/16/21). The resident's level of pain was reported to range from 0 to 8 on a scale of 0 - 10 (with zero indicative of no pain) on 11/13/22 and 11/14/22. A physician's order was received on 11/15/22 for 5 mg / 325 mg oxycodone / acetaminophen (a combination opioid pain medication) to be given as one tablet by mouth every 6 hours as needed for moderate to severe pain.

An Ad Hoc Quality Assurance and Performance Improvement (QAPI) Meeting/Four Point Plan of Correction Agenda and Summary dated 11/14/22 was provided by the facility for review. This Summary identified an opportunity for improvement with the following description: "On 11/13/22, a resident fell during a 2-person (brand

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name of mechanical lift) transfer and sustained a closed rib fracture and a scapula fracture. After a thorough investigation, incident reenactment and staff interviews the facility determined the root cause of resident fall was related to staff failure to properly secure sling loops which allowed resident to fall during transfer."

1) The Corrective Action in the Action Plan reported the total mechanical lift was verified as properly functioning and sling size and condition was good. The results of the root cause analysis determined that while nurse aide (NA) was knowledgeable on performing a proper lift transfer, they did not ensure proper loop securement.

2) Residents who require use of a total mechanical lift were identified as being at risk.

3) The Systemic Changes made based on results of the root cause analysis noted the facility would ensure nursing staff were knowledgeable and competent of the proper use of total mechanical lifts and the facility would monitor compliance of total mechanical lift transfers by making rounding observations of identified residents and staff during transfers. All licensed nurses and nurse aides were to be educated on the proper use of total mechanical lifts during transfers. This education would also be included in orientation and at least annually.

4) Monitoring of the Plan of Correction would be done by completing audits of staff observations during care to ensure proper technique with total mechanical lift transfers and reporting results of the audits to during QAPI monthly meetings.

The Four Point Plan of Correction did not specify a date as to when the plan would be fully implemented.

A review of the facility's In-Service education

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records on "(Brand name of mechanical lift) Lift Safety" provided for nurses and nurse aides was completed. This review revealed the following:
--On 11/15/22, 19 nursing staff members (nurses, medication aides or MAs, and nurse aides) worked without being documented as having received the "(Brand name of mechanical lift) Lift Safety" in-service education.
--On 11/16/22, 13 nursing staff members worked without being documented as having received the "(Brand name of mechanical lift) Lift Safety" in-service education.
--On 11/17/22, 21 nursing staff members worked without being documented as having received the "(Brand name of mechanical lift) Lift Safety" in-service education.
--On 11/18/22, 20 nursing staff members worked without being documented as having received the "(Brand name of mechanical lift) Lift Safety" in-service education.
--On 11/19/22, 25 nursing staff members worked without being documented as having received the "(Brand name of mechanical lift) Lift Safety" in-service education.
--On 11/20/22, 21 nursing staff members worked without being documented as having received the "(Brand name of mechanical lift) Lift Safety" in-service education.

An interview was conducted on 11/21/22 at 2:35 PM with NA #3. NA #3 was assigned to care for Resident #1 during 1st shift on 11/21/22. During the interview, the NA reported she was "new" to the facility. She stated she was an Agency NA (temporary staff) who started at the facility 2-3 days ago. When asked how she would know if a mechanical lift was required to safely transfer a resident, the NA stated she primarily relied on colleagues to tell her about the residents' needs

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| F 689 | Continued From page 12<br>for assistance and care when she received report at the change of shift. If no one was available for additional questions she may have, the NA stated she could look in the resident's Kardex (an electronic overview of the individual resident's care needs). When asked if she received any orientation to the facility when she first started, she reported orientation was primarily provided by her Agency. Upon inquiry regarding Resident #1, NA #3 reported the resident preferred not to get out of bed today.<br><br>An interview was conducted on 11/21/22 at 4:55 PM with the facility's DON. During this interview, the DON discussed Resident #1's fall from the total mechanical lift. She reported two NAs were transferring the resident from her bed to the wheelchair when the fall occurred. From her investigation, she believed the NAs were using the correct lift sling for the resident. The facility ultimately concluded the NAs did not properly hook the sling onto the total mechanical lift. The DON reported the facility took additional measures to ensure the safety of transfers using a total mechanical lift. Resident #1's sling was discarded and an audit was done to assess the condition of all lift slings in the facility. She reported a total of three slings were discarded as a result of the audit and new slings were ordered.<br><br>As the interview continued on 11/21/22 at 4:55 PM, the DON provided two in-service sign-in sheets from a "(Brand name of mechanical lift) Lift Safety" In-Service. The signature list included NAs, MAs, and nurses. At that time, the DON was told the 1st shift NA assigned to care for Resident #1 on this date (11/21/22) had been interviewed. Review of the documentation of the "(Brand name of mechanical lift) Lift Safety" | F 689 | | |

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in-services did not indicate NA #3 had received this education. The DON reported the in-services on "(Brand name of mechanical lift) Lift Safety" were initiated on 11/13/22 (the day Resident #1 experienced her fall). When asked, the DON stated all nursing staff should have received the "(Brand name of mechanical lift) Lift Safety" in-service before the start of their shift.

Upon their request, an interview was conducted on 11/22/22 at 9:49 AM with the facility's Administrator and DON. During the interview, the Administrator and DON reported the facility had two total mechanical lifts currently in use. New slings were ordered last week (specifically for their brand of total mechanical lift) to replace all of the older slings in the facility. The new slings were delivered on 11/21/22 and distributed on this date (11/22/22) along with staff educated on the proper use of the slings.

An interview was conducted on 11/22/22 at 11:00 AM with the facility's Staff Development Coordinator (SDC). During the interview, the SDC reported she was working at the facility on 11/13/22 (the day Resident #1 had a fall). She recalled interviewing and reenacting the total mechanical lift transfer with NA #1 and NA #2 on that date. The SDC reported concerns were identified at that time regarding the need to make sure the loops of the sling were properly clamped (secured) into place. The SDC reported she started education with the nursing staff on 11/13/22 and it was on-going since then. When asked about the content of the education, she stated the in-service placed an emphasis on making sure two staff members were always used for total mechanical lifts so one person would be available to guide the resident's feet,

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| F 689 | Continued From page 14<br>ensuring either the DON or Administrator were notified of any holes or fraying on a sling so it could be promptly replaced, and making sure the color-coded loops on the sling were hooked up properly to the lift. The SDC explained staff were educated to make sure the color-coded loops on the sling matched on each side so the two loops at the top would be the same color and the two loops at the bottom of the sling would be the same color. She reported it was concluded that either the color-coded loops of the sling were not matched up on each side or they weren't clamped down all the way and secured on the lift when Resident #1 fell on 11/13/22. She reported if the loop to the sling was not hooked all the way under black locking piece on each side of the lift's cradle, the loop could dislodge. The SDC stated, "Something dislodged."<br><br>As the interview continued on 11/22/22 at 11:00 AM, The SDC further described the in-service education provided on "(Brand name of mechanical lift) Lift Safety" consisted of verbal information, printed material, and the manufacturer's instruction video for the lift (viewed by some of the staff). She noted that some nursing staff members also performed a return demonstration. When asked, the SDC reported she had in-serviced nurses, NAs, and management staff who worked directly with the residents. She stated the goal was to provide this education to the nursing staff before the start of his/her shift. The SDC reported although the in-service documentation did not indicate NA #3 received the in-service education, she recalled the NA actually had been in-serviced (but was unsure of the date). When asked if she had been able to in-service all nursing staff members before the start of their shift, the SDC stated, "Yes | F 689 | | |

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| F 689 | Continued From page 15 | F 689 | | |

...for the most part."

On 11/22/22 at 11:43 AM, the SDC used a total mechanical lift and sling to demonstrate the key points emphasized in the "(Brand name of mechanical lift) Lift Safety" in-service. The SDC reported each resident had his/her own sling kept in their room with extra slings stored in the laundry department. A follow-up interview was conducted with the SDC on 11/22/22 at 12:15 PM. At that time, a partial review of the "(Brand name of mechanical lift) Lift Safety" in-service documentation was compared to the nursing staff schedule for 11/15/22 to 11/20/22. The SDC acknowledged there were several nursing staff members who worked a shift on these dates prior to receiving the in-service education.

The Administrator was notified of immediate jeopardy on 11/22/22 at 2:00 PM. The facility provided an acceptable credible allegation on 11/23/22 at 8:03 AM.

Identify those residents who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance:

The facility failed to transfer Resident #1 safely from surface to surface while using a total mechanical lift. While transferring a resident with a total mechanical lift, two Nurse Aides did not hook the sling to the lift according to manufacturer's instruction resulting in the sling jarring loose when moving the resident in the lift and Resident #1 falling to the floor. Root Cause Analysis was conducted as a result of the investigation. The factors that were identified were as follows; Certified Nursing Aide #1 did not ensure the right shoulder strap was secured to

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| F 689 | Continued From page 16<br>the cradle before operating mechanical lift. Certified Nursing Aide #1 proceeded to operate mechanical lift while Certified Nursing Aid #2 was located at the foot of the bed. Certified Nursing Aid #2 was not located in the proper position to help guide the resident.<br><br>On 11/14/2022, the Director of Nursing assessed current residents using the mechanical lift to ensure residents were safely transferred without incident by interviewing the alert and oriented residents with a BIMs score of > 12. Residents with BIMs score < 12 the residents received a range of motion assessment to ensure no new onset of pain. On 11/14/2022, there were no other residents involved in any other incidents that were transferred with the mechanical lift. Currently the 18 other residents are being transferred using the total mechanical lift.<br><br>Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:<br><br>The Staff Development Coordinator, Director of Nursing, and Unit Managers educated the Licensed Nurses and the Certified Nursing Aides on the process of how to properly transfer using the mechanical lift using a video provided by the mechanical lift company and written information in a classroom setting. Education included ensuring the sling is the appropriate size for the resident. Staff are to ensure the colors of the straps match at the shoulder and at the head. They are to check the straps in the cradle to ensure they are seated properly and secure before the certified nursing aide operates the mechanical lift. Once this is completed the | F 689 | | |

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| F 689 | Continued From page 17<br>second certified nursing aide will position themselves on the same side of the bed as the mechanical lift to guide the resident in the completion of the transfer. The Director of Nursing will ensure no Licensed Nurse and Certified Nursing Aide will work without receiving this education. Any new hires, including agency staff, will receive education prior to providing resident care. Education will be completed by 11/22/2022 by the Staff Development Coordinator, Director of Nursing, and Unit Managers. The staff members will document the date and time on the education form to show education was provided prior to providing resident care.<br><br>The Director of Nursing and/or designee will observed 2 residents that are transferred using the mechanical lift on random shifts 3 times weekly (including weekends) x 4 weeks to ensure proper usage for safely transferring residents.<br><br>Effective 11/22/2022 the Administrator will be ultimately responsible to ensure implementation of this immediate jeopardy removal for this alleged non-compliance<br><br>Alleged Date of IJ Removal: 11/23/2022<br><br>The facility's credible allegation of Immediate Jeopardy removal was validated on 11/23/22. The validation was evidenced by observations of lift transfers using a total mechanical lift and an interview with the Staff Development Coordinator regarding the system put into place to ensure nursing staff were provided the necessary in-service education prior to working their shift. Multiple interviews with both licensed nursing staff and non-licensed nursing staff (NAs) currently | F 689 | | |

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| F 689 | Continued From page 18<br>working at the facility were conducted. The nursing staff consistently reported they received in-service education on "(Brand name of mechanical lift) Lift Safety" and were able to verbalize key measures necessary to ensure a resident's safety during the lift transfers, including ensuring the sling's color-coded loops were securely attached to the total mechanical lift. Immediate Jeopardy was removed on 11/23/22 at 12:00 PM. | F 689 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, | F 880 | | 12/12/22 |

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| F 880 | Continued From page 19<br>but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary. | F 880 | | |

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| F 880 | Continued From page 20<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff interview, the facility failed to perform hand hygiene between residents during meal tray pass and meal assistance for 1 of 3 nursing assistants observed for hand hygiene. (Nursing Assistant #4)<br><br>Findings included:<br><br>A review of the facility "Hand Hygiene" policy dated 11/1/20 documented that hand hygiene was required for all care in between each resident encounter.<br><br>On 11/22/22 at 12:23 pm an observation was done of lunch meal tray pass on Hall 100. Nursing Assistant (NA) #4 was observed to enter Room 107 bed B with a lunch tray and place the tray and set up. NA #4 was not observed to use hand hygiene after exiting the room. NA #4 entered Room 108 with a lunch tray obtained from the dietary cart. NA #4 was observed to touch/move the tray table and touch resident items in the room. NA #4 had set up the lunch tray for the resident to eat. NA #4 returned to the dietary cart to pick up another lunch tray to deliver and was stopped and asked to perform hand hygiene. An interview was concurrently completed with NA #4. NA #4 stated she was not aware she needed to use hand hygiene between lunch trays and that hand hygiene was expected when staff touched items in the resident's room before handling another resident's lunch tray or entering another resident's room to assist.<br><br>On 11/22/22 at 12:43 pm an interview was conducted with the Administrator. He was | F 880 | 1. Nurse Aide #4 received education on performing hand hygiene between residents on 11/22/2022.<br>2. All residents have the potential to be affected by the alleged deficiency.<br>3. The staff developer coordinator and/or designees educated current staff on performing proper hand hygiene between residents. Any new hires, including agency staff, will receive education prior to providing resident care. Completed by 12/12/2022.<br>Director of Nursing and/or designees will audit 3 staff members per floor to ensure preforming proper hand hygiene between residents 3 x weekly x 4 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further problem resolution if needed. The Administrator will review the results of weekly audits to ensure any issues identified are corrected. | |

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| F 880 | Continued From page 21<br>informed that NA #4 had not used hand hygiene between resident care/passing of lunch tray which included touching items in the resident's room (Rooms 107 and 108). The Administrator stated he would share the infection control report with the Director of Nursing (DON).<br><br>On 11/22/22 at 1:02 pm an interview was conducted with the DON. The DON stated staff was required to use hand hygiene after caring for each resident. | F 880 | | |