

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345370	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/27/2016
NAME OF PROVIDER OR SUPPLIER PINEHURST HEALTHCARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 300 BLAKE BOULEVARD PINEHURST, NC 28374		
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F 323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to use a sling specifically designed for the lift for 3 (Residents #1, #3 & #4) of 3 sampled residents who used a lift for transfer resulting in injury to Resident #1. The facility failed to ensure that slings did not show signs of damage or wear for 1 (Resident #1) of 3 sampled residents who used a lift for transfer. Findings included: Review of the electronic records of Resident #1 revealed that Resident #1 was admitted to the facility on 6/14/12 with multiple diagnoses including motor vehicle accident with chronic brain syndrome, quadriplegia and vegetative state. The quarterly Minimum Data Set (MDS) assessment dated 11/9/15 indicated that Resident #1 had memory and decision making problems and needed extensive assistance with 2 plus person assist with transfer. The facility's policy on the lift procedure dated 11/2015 was reviewed. The policy indicated that the lift would be used when determined appropriate to provide safe transfer for the non-ambulatory resident. The procedures instructed staff to: explain the lift process to the resident; to utilize two or more staff to use the lift;</p>	F 323	<p>For the resident found to have been affected by the alleged deficient practice, (1), the mechanical lift was removed from service and was prohibited to be used on that resident on 1-27-16. The mechanical lift pad was removed on 1-27-16 and a new mechanical lift pad was order and received on 1-28-16. The EZ lift was removed from service on 01/27/16. On 1-19-16, the two CNAs involved in the alleged deficient practice were in-serviced on mechanical lift safety and to ensure all equipment is in good working condition. For those residents having the potential to be affected by the same alleged deficient practice, all lifts in the building were serviced by the maintenance director on 1-19-16 and all were in good working condition. The mechanical lift in question (E/Z lift) was completely taken out of service on 1-27-16. All License staff and CNAs were in-serviced by the Clinical Supervisors, DON, Administrator, and Human Resource Director on Mechanical Lift Safety on 1-19-16. All License staff and CNAs were in-serviced by Clinical</p>	2/1/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/01/2016

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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F 323	<p>Continued From page 1</p> <p>request instruction on the equipment use, if necessary, and provide lifting and transfer training upon hire, annually and as needed. The Food and Drug Administration (FDA) safety guide for patient lifts used by the facility to educate the staff was reviewed. The safety guide indicated "only use a sling specifically designed for your lift, using the wrong sling may cause serious injury, most lifts require two or more caregivers to safely operate lift and handle patient and examine sling and attachment areas for tears, holes and frayed seams. Do not use sling with any signs of wear. "</p> <p>The care plan dated 12/15/15 was reviewed. One of the care plan problems was " (name of resident) is immobile due to quadriplegia, has contracture right and left hands. " The goal was (name of resident) will remain passive range of motion of bilateral upper extremities and hands through range of motion, splinting and positioning through next review. The approaches included, " lift transfer with assist of two. "</p> <p>The incident reports were reviewed. The report dated 1/18/16 at 5:40 PM indicated, " Resident was transferred from chair to bed using a motorized lift (lift #1), and after resident was placed in the bed she began to jerk uncontrollably and caused the metal bar on the lift to strike her in the face below her right eye. " The report also indicated that redness was noted but no apparent signs of swelling or bruising.</p> <p>The statements from the two nurse's aides who assisted with the transfer were reviewed. The statement from NA #1 dated 1/18/16 indicated that she was assigned to Resident #1 on 1/18/16. At 11:45 AM, Resident #1 was transferred from bed to the Geri chair by NA #1. Around 4:30 PM, NA #1 with the help of NA #2 had transferred Resident #1 back to bed using a lift. After the</p>	F 323	<p>Supervisors and DON on our new two person assist transfer procedure and using only Invacare compatible lift pads on 1-27-16. The Administrator, Clinical Supervisors and the DON went through the facility on 1-27-16 and removed 20 mechanical Lift pads and reordered 17 Invacare lift pads that arrived at the facility on 1-28-16. A new mechanical lift was ordered to replace the E/Z lift which was taken out of service on 1-27-16. 100% CNAs have had their Hoyer Lift Transfer Skills Competency redone by 02-01-16 by Clinical Supervisors.</p> <p>To ensure that this alleged deficient practice does not reoccur, the following measures will be put into place. Clinical Supervisors and Weekend Supervisor will complete Administrative Nurse Rounds daily for 2 weeks, 3 times a week for 3 months and then 1 time a week quarterly. These Administrative Nurse rounds include reporting the condition of the equipment being used for resident care. The Clinical Supervisors and Director of Nursing will watch staff perform 2 mechanical lifts a day for 4 weeks this includes weekends and all three shifts, 3 mechanical lifts a week for 3 months and 4 mechanical lifts a quarter. The Housekeeping Supervisor will have laundry staff to check and removed worn/frayed mechanical lift pads daily during laundry service. The Housekeeping Supervisor will inform the Administrator of discarded mechanical lift pads in order to replace/order new pads. The maintenance director will perform bi weekly checks on</p>		

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F 323	<p>Continued From page 2</p> <p>resident was back in bed, NA #2 left the room leaving NA #1 by herself. The resident started to have a spasm really bad and the lift bar began to shake and fell off hitting the resident's face. The statement from NA #2 dated 1/19/16 indicated that she was helping NA #1 put Resident #1 back to bed. She was operating the lift when the resident started to jerk. NA #2 further indicated that she did not observe the bar hit the resident because she was looking at the lift and operating the lift.</p> <p>On 1/19/16 there was a doctor's order for x-ray of the facial bones and the report revealed " no fracture. "</p> <p>The nurse's notes were reviewed. The notes dated 1/19/16 at 1:27 PM indicated that Nurse #1 was called to the room of Resident #1 on 1/18/16 by Nurse Aide (NA) #1. NA #1 informed Nurse #1 that while transferring Resident #1 from the chair to the bed using the lift, the resident began to jerk and the metal bar on the lift struck the resident underneath her right eye. Nurse #1 immediately assessed the resident and observed some redness underneath the right eye. There was no swelling or apparent bruising noted at that time. There was a red line approximately 1.5 inches underneath the right eye. Ice pack was applied to prevent swelling. The attending physician and the family were notified of the incident. On 1/19/16 at 2:40 PM, the notes indicated that a new bruise was noted to the right side of face/eye area. The notes dated 1/22/16 at 2:58 AM indicated that the resident continued to have dark ecchymosis on her right cheek just below her right eye.</p> <p>The skin assessment dated 1/20/16 at 12:30 PM indicated that Resident #1 had bruises on her right eye and face.</p> <p>On 1/26/16 at 9:16 AM, Resident #1 was</p>	F 323	<p>mechanical lifts and complete a service log that will be turned in to the administrator biweekly. All new employees will be educated on mechanical lift safety and functioning by Clinical Supervisors and have a competency done on hire and on their annual reviews. The DON and Clinical Supervisors will review/audit our compliance weekly for four weeks, then monthly for four months.</p> <p>In order to monitor our performance and to make sure that these solutions are sustained, all information obtained in nursing rounds will be brought to the morning meeting M-F to discuss current interventions and whether these interventions are working. All competency will be discussed in the nursing meeting after the morning meeting Monday through Friday. All interventions put in place by these two committees will be brought to our monthly QA meeting by the Director of Nursing.</p>		

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F 323	<p>Continued From page 3</p> <p>observed in bed. She was nonverbal, both hands were contracted and both feet had foot drop. Small bruises were noted around her right eye and a fifty cent size yellowish discoloration under the right eye.</p> <p>On 1/26/16 at 9:20 AM, Resident #1 was observed during transfer from bed to chair using lift #1. Two NAs (NA #3 & NA #4) were assisting with the transfer. A blue mesh sling was used during the transfer.</p> <p>On 1/26/16 at 9:30 AM, the lifts at the facility were observed. There were 2 different brand of lifts in use at the facility. There were two lifts (battery operated (lift #1) and a manual (lift #2)) on station 1. There were also two additional lifts (battery operated (lift #3) and a manual (lift #4)) on station 2. Lifts #1 and #2 were of one brand and lifts #3 & #4 were of another brand.</p> <p>On 1/26/16 at 11:20 AM, administrative staff #1 was interviewed. The administrative staff indicated that the two NAs (NA #1 and NA #2) involved during the transfer were interviewed and statements were obtained. The administrative staff indicated that he was not informed that NA #2 left the room before the resident was off the lift. His expectation was that two aides always assisted with the transfer when using the lift, from the start to finish and to hold the bars because the bars had a tendency to swing. He also revealed that there was an incident in the past where the bar fell off, but the resident did not have an injury from it.</p> <p>On 1/26/16 at 10:56 AM, NA #1 was interviewed via phone. NA #1 indicated that she was assigned to Resident #1 on 1/18/16. She asked NA #2 to help her transfer Resident #1 to bed using lift #1. NA#2 operated the lift while she guided the resident to the bed. When the resident was laid in bed, NA #2 left the room to</p>	F 323			

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F 323	<p>Continued From page 4</p> <p>take care of her residents. She started to unhook the straps of the sling on the left side and went around the bed to unhook the bottom strap on the right side when the resident started to jerk. When she unhooked the bottom strap, the bar came off and hit the resident's face. She added that their practice was for two NAs always assisted with the transfer but after the resident was in bed, the other NA can leave the room.</p> <p>On 1/26/16 at 10:59 AM, NA #2 was interviewed. She stated that she was asked by NA #1 to help her transfer Resident #1 back to bed. They were using lift #1 during the transfer. She was operating the lift. When the resident was in bed she left the room to attend to her residents. She further indicated that she was not in the room when the bar fell off. She also stated that she was assigned to Resident #1 in the past and the resident had never jerk on her.</p> <p>On 1/26/16 at 12:40 PM, administrative staff #2 was interviewed. She stated that the expectation was for 2 staff members to assist in transferring a resident using a lift, from the start of the transfer until the lift was not in use.</p> <p>On 1/26/16 at 3:12 PM, Nurse #1 was interviewed. He was assigned to Resident #1 during the incident. NA #1 informed him that Resident #1 jerked and the bar on the lift hit the resident on the face. Nurse #1 stated that Resident #1 barely moves and she was in a vegetative state.</p> <p>On 1/27/16 at 8:40 AM, NA #1 was interviewed. She stated that she was not informed in the past that two NAs had to stay in the room during transfer using the lift until the lift was out of the room. She further stated that to prevent the incident from happening again, two staff members had to stay until the resident was not</p>	F 323			

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F 323	<p>Continued From page 5</p> <p>hooked to the lift, one person to hold the bar on each side.</p> <p>On 1/27/16 at 9:50 AM, NA #1 demonstrated how the bar fell off the lift. She stated that she had unhooked the straps of the sling on the left side and when she was removing the bottom strap of the sling on the right side, the resident started to jerk and the bar came off with the top strap on and landed on the resident's face. NA #1 also showed the type of sling used to transfer Resident #1. It was a comfort glide sheet made by (brand name). This sheet was intended for positioning resident only and not for transferring a resident using a lift. NA #1 stated that she always used this sheet in transferring Resident #1 from bed to chair and vice versa.</p> <p>On 1/27/16 at 10:10 AM, NA #1 was observed transferring Resident # 3 from bed to chair using lift #1. A solid blue sling was used during the transfer. NA #1 indicated that almost all the residents had their own sling in their rooms. NA #1 did not know the brand of the sling.</p> <p>On 1/27/16 at 10:15 AM, the slings in each rooms were observed. There were solid blue cotton slings and blue mesh slings observed. The slings had either no tags in them or the tags were unreadable. In the room of Resident #1, there were 2 slings observed, one comfort glide sheet and a blue mesh sling. The blue mesh sling had a 2 inch tear beside the strap.</p> <p>On 1/27/16 at 10:14 AM, NA #3 was interviewed. She stated that she used the blue mesh sling for Resident #1. NA #3 did not know the brand of the sling. She also stated that she did not notice the tear on the sling.</p> <p>On 1/27/16 at 10:20 AM, administrative staff #3 observed the comfort glide sheet and the blue mesh sling that had a tear on it. At 10:30 AM, she acknowledged that the comfort glide sheet</p>	F 323			

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F 323	Continued From page 6 was intended for positioning only and not for transfer using a lift. She also indicated that the solid blue sling and the blue mesh sling were intended for use for lifts #3 and lifts #4 only and not for lifts #1 and #2. She also indicated that lifts #1 and #2 were taken out and not to be used at all starting today (1/27/16) because they have only 2 slings available for those lifts. She also indicated that the management staff were going around checking the slings for any damage or wear. Administrative staff #3 stated that nobody from the staff was aware that they have to use a sling designed for the specific lift. On 1/27/16 at 11:30 AM, administrative staff #1 was interviewed. He indicated that there were 21 residents who were using a lift for transfer. He indicated that after checking all the slings, he had tossed 7 blue mesh slings and 13 solid blue slings out due to wear and tear. There were 6 blue mesh slings and 2 solid blue slings left at the facility for use at the present time.	F 323			