STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345472	A. BUILDING _____ B. WING _____	C 08/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWOOD NURSING AND RETIREME	180 SOUTHWOOD DRIVE BOX 708 CLINTON, NC 28328

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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 reviews, observation, resident interview, Nurse Practitioner (NP) interview and staff interviews, the facility failed to correctly secure a resident in a mechanical lift when using the lift to perform a resident transfer for 1 of 3 sampled residents reviewed for accidents (Resident #56). As a result of not properly securing Resident #56 in the mechanical lift and hitting the resident ' s wheelchair against the lift during the transfer the resident fell from the lift to the floor and hit her head on the floor. The resident sustained head lacerationand was sent to the emergency room for treatment and required 8 staples and six sutures to close her right scalp laceration. The findings included: A review of the manufacturer ' s manual instructions for the mechanical lift used at the facility, dated April 2012, included the following instructions: "Ensure that the mechanical lift is close enough to be able to attach the sling ' s shoulder clips to the spread bar. Once the mechanical lift is in position, attach the shoulder strap attachment clips to the sling attachment lugs on the spreader bar. Press down on the	F 689	Past noncompliance: no plan of correction required.	9/13/18

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

Electronically Signed | 09/13/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345472	A. BUILDING _____ B. WING _____	C 08/30/2018

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F 689	Continued From page 1	F 689		

positioning handle on the spreader bay and attach the leg strap attachment clips." Review of the manufacturer ' s manual also revealed the lift could be used by one staff during transfer of a person.
Resident # 56 was admitted on 1/2/2018 with diagnoses of cortical blindness, anemia and transient ischemic attack (TIA).

The quarterly Minimum Data Set (MDS), dated 7/11/2018, indicated Resident # 56 ' s cognition had been moderately impaired and she had been totally dependent with assistance of 2 staff for bed mobility and toileting. MDS also indicated Resident # 56 had been totally dependent with the assistance of 1 staff for transfers. The MDS indicated Resident #56 was not steady when moving from a seated position to a standing position and was only able to stabilize with staff assistance.

Resident # 56 ' s care plan, updated on 7/11/2018 indicated Resident # 56 required "assistance for mobility due to weakness." The interventions included the following: transfers using mechanical lift, use yellow sling (121 lbs-165 lbs)." Resident # 56 weighed 127 lbs. The care plan did not specify the number of staff required when using the mechanical lift during the transfers.
A review of Resident #56 ' s current Care Guide dated 8/3/2018 indicated the following: "the resident required Activity of Daily Living (ADL) care. Transfers: Total mechanical lift." The care guide did not specify the number of staff required when using the mechanical lift during the transfers.

A review of the nurse ' s note, dated 8/3/2018 and

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	345472	A. BUILDING _____ B. WING _____	C 08/30/2018

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SOUTHWOOD NURSING AND RETIREME	180 SOUTHWOOD DRIVE BOX 708 CLINTON, NC 28328

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F 689	Continued From page 2	F 689		

written by Nurse #1, indicated "I was on the hall passing medication when Nurse Aide (NA) # 1 called me to room. Resident # 56 was noted lying on the floor on the left beside the bed. NA # 1 reported she was transferring Resident # 56 from wheelchair to bed and the resident fell from the lift. The blood was noted from wound to right side of head. Wound care was provided. Resident # 56 was alert and verbal. Nurse Practitioner (NP) was notified and assessed Resident # 56. She gave order to transfer the resident to Emergency Room for evaluation."

A review of the Emergency Room report dated 8/3/2018 indicated Resident # 56 head exam found a 3 centimeter linear laceration to right side of her head frontal/temporal aspect with mild active bleeding. Resident # 56 ' s laceration was closed with 8 staples and 6 sutures.

A review of the facility ' s investigation report dated 8/3/2018 revealed "Resident # 56 returned from hemodialysis in her wheelchair. Dialysis lift pad removed from under her and replaced with the facilities total lift pad. NA # 1 named in report stated she went to return resident to bed from the wheelchair and resident fell out of lift face first. NA # 1 reported Resident # 56 was secured in the lift by hooking the lower clasp first between legs then the upper clasp lastly. Lift elevated resident from the wheelchair. While airborne NA# 1 attempted to move wheelchair improperly by trying to roll the wheelchair over the legs of the lift. In doing so she bumped the resident and the lower leg clasp became unloosened resulting in the resident sliding out of the sling onto the legs of the lift. "The investigation report further indicated "Resident # 56 received 8 staples to right side of her head due to scalp laceration."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345472	A. BUILDING _____ B. WING _____	C 08/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWOOD NURSING AND RETIREME	180 SOUTHWOOD DRIVE BOX 708 CLINTON, NC 28328

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F 689	Continued From page 3	F 689		

A review of NA # 1 ' s statement dated 8/3/2018 indicated NA # 1 "entered the room at 4:00 p.m. Resident # 56 was in her room sitting in her wheelchair. I got the total lift pad and put up under her and connected lift pad to the machine. She was in the upright position in the air. So I pulled the wheelchair from under her and she fell on the floor on her stomach. I called for help to Nurse # 1 and she and some other nurses came to help. Resident # 56 was in good spirits and the ambulance came and got her but she said she was alright."

During an interview with Resident #56 ' s on 8/28/2018 at 10:00 AM, Resident # 56 reported about 4 weeks ago, she came back to the facility from dialysis and during the process of NA # 1 getting ready to transfer her from the wheelchair to bed, she dropped her on the floor. Resident # 56 further reported since she was blind, she was not sure what had just happened. Resident # 56 further reported she found herself on the floor and felt blood coming from the side of her head. Resident # 56 stated currently she was doing fine.

During an interview with Nurse #1 on 8/28/2018 at 3:20 PM, Nurse # 1 stated she had been assigned to care for Resident #56 on 8/3/2018. Nurse #1 stated NA # 1 reported to her that Resident # 56 had fallen off the lift after she (NA # 1)was trying to move wheel chair under the lift and had improperly secured the resident on the lift by hooking the lower clasp first between legs then the upper clasp lastly. Nurse # 1 also reported she saw the resident on the floor lying under the lift and the blood was observed on the floor. Nurse # 1 stated she reported the incident to Nurse Practitioner (NP) who was present in the facility. Nurse # 1 stated she called 911 as the NP

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345472	A. BUILDING _____ B. WING _____	C 08/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWOOD NURSING AND RETIREME	180 SOUTHWOOD DRIVE BOX 708 CLINTON, NC 28328

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F 689	Continued From page 4	F 689		

was holding a gauze on Resident # 56 ' s wound to stop the blood from flowing from the scalp.

During an interview with the Nurse Practitioner (NP) on 8/28/2018 at 3:30 PM, the NP indicated on 8/3/2018 while she was at the facility, she was made aware of Resident # 56 falling from a lift. NP reported she immediately went to Resident # 56 room and saw the resident on the floor with blood coming from the side of her scalp. NP states she proceeded to put a gauze on Resident # 56 ' s scalp to stop the bleeding while waiting for the EMS to arrive. She reported the resident was alert and oriented to herself and her surroundings.

During an interview with the MDS nurse on 8/28/2018 at 3:40PM, the MDS nurse reported when Resident # 56 ' s fell from a mechanical lift on 8/3/2018, the resident ' s care plan not indicate the number of staff required when transferring Resident # 56 using the mechanical lift. The MDS nurse stated Resident # 56 mechanical lift transfers from bed to chair were being done by one person at the time of the resident ' s fall on 8/3/18.

During an interview with the Staff Development Coordinator (SDC) on 8/28/2018 at 3:50 PM, the SDC stated on 8/3/2018, NA # 1 failed to secure Resident # 56 properly on a mechanical lift by hooking the lower clasp first between legs then the upper clasp mechanical lift, causing Resident # 56 to fall off the mechanical lift. SDC stated the NAs used one staff to transfer Resident # 56 which was according to the training on the use of the total mechanical lift. SDC stated the staff at the facility had been in serviced in reference to proper use of the mechanical lift and NA # 1 was

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	345472	A. BUILDING _____ B. WING _____	C 08/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWOOD NURSING AND RETIREME	180 SOUTHWOOD DRIVE BOX 708 CLINTON, NC 28328

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F 689	Continued From page 5 last trained 10/1/2017 During an interview with the Director of Nursing (DON) on 8/28/2018 at 4:00 PM, the DON reported on 8/3/2018, she was made aware immediately of Resident # 56 ' s falling off the lift. The DON indicated her expectation of the nursing staff would have been to have to follow the manufacturer manual guidelines to prevent any accident at the facility. She indicated NA# 1 was trained before she started working on the floor when using the mechanical lift to hook the upper clasp first then lower clasp between legs. DON reported after Resident # 56 came back from dialysis and NA # 1 was attempting to transfer the resident and she raised the resident up in the lift. While the resident was in the sling, NA # 1 began to attempt to remove the wheel chair from underneath the resident by pulling/picking it over the lift legs. During this movement the lower leg attachment became unhooked and the resident slipped from the sling and fell to the floor. DON stated the clasp should not have loosened if NA # 1 had secured it per manufacturer ' s instruction. She added the facility had already completed 100 % in-service training on the proper use of a mechanical lift. DON also reported during the investigation they were unable to identify the reason NA # 1 used the lift inappropriately while transferring Resident # 56 by hooking the lower clasp first between legs then the upper clasp, causing Resident # 56 to fall off the mechanical lift. DON stated before Resident # 56 ' s fall incident of 8/3/2018, NA#1 had been trained on proper use of a mechanical lift on 10/1/2017. DON further indicated after the accident, the lift was removed from the resident ' s room and inspected. No concerns were found with mechanical lift. She stated there were no tears or	F 689		

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	345472	A. BUILDING _____ B. WING _____	C 08/30/2018

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SOUTHWOOD NURSING AND RETIREME	180 SOUTHWOOD DRIVE BOX 708 CLINTON, NC 28328

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F 689	Continued From page 6	F 689		

something wrong with the clips. DON also reported before 8/3/2018, Resident # 56 was transferred using one staff and that was appropriate according to the manufacturer instruction. She added the facility is now using 2 staff for total mechanical lift transfers at the facility for precaution. DON stated she did reenactment in her office and it was found the resident fell because the straps were done in the wrong order and also NA# 1 attempting to remove the chair underneath the mechanical lift which knocked the straps and caused the resident to fall on the floor.

During an interview with the Administrator on 8/28/2018 at 4:40 PM, the Administrator reported on 8/3/2018, she was made aware immediately of the incident of Resident #56 ' s falling off the mechanical lift. The Administrator stated his expectation would have been for the staff to follow the manufacturer manual guidelines so that they can prevent accidents from occurring. She further indicated an in-service on the proper use of the mechanical lift had been completed.
During an observation of a mechanical lift transfer made on 8/29/2018 at 10:30 AM, Resident # 56 ' s was secured properly on the total mechanical lift. 2 nurse assistants assisted with the transfer. NA#1 who was accused of improper use of a total mechanical lift was unavailable for interview. She (NA #1) was terminated from employment on 8/3/2018.

The corrective action for past non-compliance dated 8/3/2018 included:

1-The NA # 1demonstrated a reenactment of the lift procedure: On 08/03/2018 at approximately

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	345472	A. BUILDING _____ B. WING _____	C 08/30/2018

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SOUTHWOOD NURSING AND RETIREME	180 SOUTHWOOD DRIVE BOX 708 CLINTON, NC 28328

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F 689	Continued From page 7	F 689		

4:30PM, NA #1 took the resident to her room to place her back to bed after the resident returned from dialysis. The NA #1 utilized the Total Mechanical Lift and a yellow sling. After removing the dialysis sling, the NA # 1 placed the yellow sling under the resident and attached the lower leg attachments to the sling and then attached the upper shoulder attachments to the to the lift attachment points. The NA # 1 then raised the resident up in the lift. While the resident was in the sling, NA # 1began to attempt to remove the wheel chair from underneath the resident by pulling/picking it over the lift legs. During this movement the lower leg attachment became unhooked and the resident slipped from the sling and fell to the floor. Immediately the NA # 1 called out for assistance. The resident was assessed by the nurse and noted a wound to the right side of her head. The Nurse Practitioner (NP) was onsite and made aware of the fall as well as the Responsible Party (RP). The resident was alert and oriented at all times and was transferred to the ER for evaluation. The resident was returned to the facility with 7 staples to her scalp wound.

2-The resident was tasked for 2 assistants when transferring the resident on 08/03/2018 by the MDS Nurse. Task will fire to the Nurse ' s Aide for notification to use a mechanical lift with a yellow sling and 2 assistants. A review of the NA# 1 employee file revealed that on hire 10/17/2017 the employee went through the new hire orientation process, the NA #1 was skills checked on the use of the Mechanical lifts by the SDC.

3-On 08/09/2018 the MDS Nurse, Director of Nursing, and Therapy Director audited 100 % current residents to ensure that if the resident was assigned a lift Total or stand aide, that the lift

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	345472	A. BUILDING _____ B. WING _____	C 08/30/2018

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F 689	Continued From page 8	F 689		

was tasked to the resident kardex along with the sling size to use. This was completed on 08/10/2018.

4-100 % Employees to receive education. The DON will ensure that all staff receive the education prior to working starting on 08/08/2018. Additional education was provided to the SDC and DON by the nurse consultant regarding completing skills check off with all nurses and NA ' s on hire. During orientation, the mechanical lift Return demonstration check off list for the Maxi-move and Sara 300 lifts should be utilized. After showing the Mechanical lift videos, each nurse and Nurse Aides will perform a return demonstration to the SDC and performance will be documented on the mechanical lift skills check list. This was completed on 08/08/2018. This training was incorporated into the general orientation program and will be discussed during all general orientation programs that is completed for identified staff. Completion date 8/10/2018

5- The DON will monitor mechanical lift skills check completion on all new hires and observe transfers utilizing the total mechanical lift weekly for 2 weeks and monthly for 3 months for completion of skills check off on hire and observe total mechanical lift for correct procedure. Reports will be presented to the weekly Quality Assurance (QA) committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, and the Dietary Manager.

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F 689	Continued From page 9 The Administrator will be the person responsible for implementing the Quality Improvement Plan. As part of the validation process on 8/30/2018, the entire plan of correction was reviewed including re-education of staff and observations of the use of a lift transfer on residents (Resident # 56) at the facility. Interviews of the nurse aides and nurses revealed they were aware of proper usage of the mechanical lift for the transfer of the residents at the facility. A review of the monitoring tools revealed that the facility had completed the 100 % in-service of the use of mechanical lift and return demonstration on 8/8/2018. The facility ' s completion date of 8/10/18 was validated.	F 689		