STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345109	A. BUILDING ______ B. WING ______	C 01/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY PLACE	24724 SOUTH BUSINESS 52 ALBEMARLE, NC 28001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 1/28/19 - 1/30/19. Past Non Compliance was identified at: 483.25 at F689 at scope and severity (J) Tag F689 constituted a substandard quality of care A partial extended survey was conducted. on 2/18/19, the 2567 was amended to change the facility compliance date at tag F689 from 12/27/18 to 11/30/18 per evidence provided by the facility.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the	F 580		3/14/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 02/18/2019

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 580	Continued From page 1 resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, and Physician and staff interview, the facility failed to fully inform the physician of the resident's condition when the resident was found to be unresponsive, not breathing and his face and neck had turned blue for 1 of 1 sampled resident reviewed for notification (Resident #1).	F 580	Submission of this response and plan of correction is not a legal admission that a deficiency exists that a statement of deficiencies was correctly cited and is not to be construed as an admission against interest by the residents, or any employees, agents of other individuals who drafted or may have discussed in the	

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F 580 Continued From page 2

Findings included:

Resident #1 was originally admitted to the facility on 5/25/17 with multiple diagnoses including Alzheimer's disease. The quarterly Minimum Data Set (MDS) assessment dated 8/13/18 indicated that Resident #1 had severe cognitive impairment.

Resident #1 nurse's note dated 10/12/18 at 2:11 PM (written by Nurse #3) revealed that Resident #1 was discharged to the emergency room (ER) for evaluation and treatment, post collapse and unresponsiveness.

The incident report dated 10/12/18 at 5:25 PM (written by Nurse #3) revealed that Resident #1 was in the shower room on his knees on a stand-up lift. His head was the side and his arms were holding onto the lift. He had a white tee shirt which was halfway on and at his neck. NA #1 also stated that Resident #1 was unconscious and Nurse #1 aroused him. NA #2 stated that Resident #1 turned purple and blue, his hands were very pale and he was drooling. His shirt was at his neck and his pants were up and shoes were on. The Physician was notified of the incident and he ordered to send the resident to the ER for further evaluation.

Interview with Nurse #1 on 1/28/19 at 1:50 PM revealed on 10/12/18 she observed Resident #1's face and neck were blue when she walked into the shower room. Nurse #1 stated that she shared this information to Nurse #3, the nurse assigned to Resident #1.

On 1/30/19 at 10:35 AM, the Physician was interviewed. He stated that he recalled being

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response to the plan of correction.

Corrective action was accomplished for resident #1 by the facility immediately contacting MD when resident had syncopal episode in shower room on 10/12/2018 at 1:10pm by nurse #3 (LPN). MD gave order to send resident out to hospital for evaluation on 10/12/2018 . Resident #1 was transferred to emergency room at 1:25pm by EMS (Emergency Management Service). Resident #1 returned to facility on 5:44pm. Lab worked obtained in emergency room was within normal limits, chest x-ray revealed no evidence of acute cardiopulmonary disease, and electrocardiogram reported sinus rhythm with occasional premature ventricular contractions. No new orders were given from physician at hospital or facility.

The facility reviewed other residents with the potential to have the same deficient practice for physician notification of change in residents condition. The review included change in condition notification from licensed nursing staff (RN/LPN) to MD and/or physician extender for all residents who had a change in condition that were transferred out of facility for further treatment. The timeframe of the audit was from October 12,2018 through January 30, 2019. The review was completed by the Director of Nursing and found out of 3 acute care changes requiring resident to be sent out of facility all 3 had notification to physician and/or physician extender with pertinent

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called about Resident #1 having an episode in the shower room and he ordered to send him to the emergency room (ER). He was not informed though that the resident's face and neck were blue. The Physician stated that it was important to know that the resident had turned blue so deeper work ups could have been done at the hospital or the hospital would have admitted him for more observation.

On 1/30/19 at 1:05 PM, Nurse #3 was interviewed. She stated that she was the nurse assigned to Resident #1 on 10/12/18. She stated that she could not remember if she had informed the Physician that Resident #1 had turned blue during the incident but agreed he should have been given this information. She had not observed the resident blue but Nurse #1 had informed her that the resident was blue on his face and neck. Nurse #3 stated that what she had written in the nurse's note or incident report was the information relayed to the physician.

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information communicated.

The measure put in place for systematic changes includes the following: All licensed nurses (RN's/LPN's) were provided education on how to properly communicate to physician and/or physician extender pertinent information regarding change in condition for resident. This education was provided by the staff development coordinator, RN on 1/31/2019. The monitoring for performance improvement will include the use of an audit tool in the electronic health record. The audit tool will include the information provided to the physician and/or physician extender during a change in condition to ensure all pertinent information is provided from the nurse to the MD and/or physician extender. The Director of Nursing and or Staff Development RN will review the audit tool. The audit tool will be reviewed 3 times a week for four weeks and then weekly until 3 months of compliance is sustained by the Director of Nursing or the Staff Development RN.

The facility will monitor the communication audit tool of change in condition 3 times a week for four weeks and then weekly until 3 months of compliance is sustained. This audit will be completed by the Director of Nursing or the Staff Development RN. The outcomes of the audit will be reported monthly at Quality Assurance Committee by the Director of Nursing until three months of compliance is sustained.

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F 689	Continued From page 4	F 689		
F 689 SS=J	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, observation of lift transfer and reenactment videos, Physician and staff interview, the facility failed to use 2 persons physical assist and failed to securely fasten the calf/leg straps according to the manufacturer's instruction before using the stand-up mechanical lift. Resident #1's upper body was found strapped to the stand-up lift with his tee shirt wrapped around his neck, unresponsive, not breathing and his face and neck were blue in color. This was evident for 1 of 3 sampled residents reviewed for accidents (Resident #1). Findings included: The manufacturer's guide checklist for the use of the stand-up lift was reviewed. One of the recommended checks before use was "5. Check knee pad adjuster is fastened securely". The manufacturer's competency checklist for the stand-up lift was also reviewed. This checklist was used by the facility during training of new employees on the use of the stand-up lift. Under usage, the checklist read "11. Place knees against kneepad, adjust kneepad for proper	F 689	Past noncompliance: no plan of correction required.	3/4/19

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height and secure calf strap".

Resident #1 was originally admitted to the facility on 5/25/17 with multiple diagnoses including Alzheimer's disease. The quarterly Minimum Data Set (MDS) assessment dated 8/13/18 indicated that Resident #1 had severe cognitive impairment and needed extensive with 2 plus persons physical assist with transfer. The assessment further indicated that the resident was not steady and only able to stabilize with staff assistance with surface to surface transfer.

Resident #1's weight on 10/3/18 was 208 pounds (lbs.).

Resident #1 was assessed by nursing for the type of lift on 3/10/18 and 5/7/18 and recommended to use a stand-up lift.

Resident #1's care plan dated 9/19/18 included the use of stand-up lift for transfers and on 10/12/18, the care plan was revised to include the total mechanical lift for transfers.

Resident #1 nurse's note dated 10/12/18 at 2:11 PM revealed that Resident #1 was discharged to the emergency room (ER) for evaluation and treatment, post collapse and unresponsiveness.

The nursing home to hospital transfer form dated 10/12/18 revealed that Resident #1 was transferred to the hospital due to unconsciousness in the shower room. The vital signs listed on the form taken on 10/12/18 at 12:05 PM were blood pressure of 162/84, pulse rate of 72, respiratory rate of 18, temperature of 97.3 degrees Fahrenheit (F) and oxygen saturation of 92% on room air.

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F 689	Continued From page 6	F 689		

The incident report dated 10/12/18 at 5:25 PM (written by Nurse #3) revealed that Resident #1 was in the shower room on his knees on a stand-up lift. NA #2 was heard calling Nurse #1 using her walkie talkie to come to the B hall shower room as soon as possible (ASAP). NA #2 again was heard calling Nurse #2 using her walkie talkie to come to the shower room ASAP. Nurse #2 and Nurse #3 went to the shower room and as they walked in the shower room they saw Resident #1 on his knees on the stand-up lift. His head was over to the side and his arms were holding onto the lift. He had a white tee shirt which was halfway on and at his neck. He had blue sweatpants and white tennis shoes. NA #1 was standing behind Resident #1 and Nurse #1 was standing in front of the lift. NA #2 was standing at the side of the lift. Nurse #2 asked the resident if he was okay and if he was in any pain and the resident stated that he was not in any pain and that he was okay. NA #1 stated that she thought that the resident got too hot and passed out. NA #1 also stated that Resident #1 was unconscious and Nurse #1 aroused him. NA #2 stated that Resident #1 turned purple and blue, his hands were very pale and he was drooling and his shirt was at his neck and his pants were up and shoes were on. Cold rag was placed on his head, vital signs were obtained and neuro check was completed. Resident #1 was gotten up with the use of total mechanical lift. The Physician was notified of the incident and he ordered to send the resident to the ER for further evaluation. Resident #1 was monitored until emergency medical services (EMS) arrived. Staff involved was NA #1, and teaching was provided on safe transfer techniques and the resident lift status was changed.

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The nurse's notes dated 10/15/18 at 10:43 AM, a late entry for 10/12/18 written by Nurse #2 revealed that Nurse Aide (NA) #2 called the nurse to the shower room reporting that Resident #1 was unresponsive. Upon entering the shower room, Resident #1 was noted to be responsive, his respiration was even and unlabored at present. Resident #1 was returned to bed and the Physician was notified who ordered to send Resident #1 to ER for evaluation and treatment.

The EMS report dated 10/12/18 revealed that upon arrival, the resident was found at the dining room table being fed by a staff member. Nursing staff advised EMS that the resident was in a lift after getting a shower when he had what appeared to be a syncopal episode. Staff stated that the resident became very pale and unresponsive for a brief moment before regaining consciousness. The resident has a history of dementia and did not recall the incident. The vital signs at 1:30 PM were 88 (heart rate), 112/76 (blood pressure) and 99% (oxygen saturation on room air) and the vital signs at 1:34 PM were 86 (heart rate), 131/71 (blood pressure) and 100% (oxygen saturation on room air).

The emergency room (ER) records dated 10/12/18 were reviewed. The records revealed that Resident #1 presented in the emergency department after an apparent syncopal event. The resident was chair-bound with history of coronary artery disease and congestive heart failure. The resident was reported to be in the shower and apparently syncopized for 2 seconds. There was no trauma reported. The resident was from the nursing home, and he had dementia. The resident was unable to provide adequate

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history and he denied that he was in any pain, fever/chills, trauma, headache, cough, chest pain, shortness of breath, abdominal pain, nausea/vomiting, diarrhea, back pain, dysuria, recent travel. There was no report of trauma and no signs of trauma on physical exam. Normal Saline 500 milliliter (ml) was given in the ER and the resident was discharged back to the nursing home facility. Discharged diagnoses were syncope and dehydration.

The doctor's progress notes were reviewed. The notes dated 10/19/18 revealed a 90 year old with history of vertigo, had a syncopal episode on 10/12/18 and was sent to ER for further evaluation and he was sent back to facility. He voiced no needs or concerns. Laboratory works were obtained in ER and the results were within normal limits, chest x-ray revealed no evidence of acute cardiopulmonary disease, and electrocardiogram (EKG) reported sinus rhythm with occasional Premature Ventricular Contractions (PVCs).

The written statement from NA #2 dated 10/12/18 was reviewed. The statement revealed that on 10/12/18, NA #1 called her over the walkie talkie to come to the B hall shower room as soon as possible (ASAP). When she got into the shower room, she observed Resident #1's knees barely on the stand-up lift. His shirt was up near his neck and he was turning red, blue and purple and his hands were pale. NA #1 asked her to help stand the resident up. She called the resident's name and when he didn't respond, she went out the room to get the nurse. When Nurse #1 got to the shower room, Resident #1 was unresponsive and began drooling and his shirt was still up near his neck. She went out again to get Nurse #2.

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NA #2 stated that NA #1 had told her that Resident #1 was responsive when she put his shirt on and when she got him into the stand-up lift his legs gave out and he stopped responding.

The written statement from Nurse #1 dated 1/23/19 (3 months after the incident) revealed that on 10/12/18, NA #2 called her to the shower room for an emergency. When she walked in the shower room, she found Resident #1 on his knees with his arms up in the stand-up lift. His tee shirt was around his neck. His face and neck were blue. NA #1 was standing behind Resident #1 and said "Don't just stand there, do something". She then grabbed Resident #1's tee shirt from his neck and he gasped. By this time, Nurse #2 came in and she told the NAs to lay the resident on the floor. She palpated resident's chest to arouse him. He started opening his eyes and spoke.

The written statement from Nurse #2 dated 1/24/19 (3 months after the incident) was reviewed. The statement revealed that on the morning of 10/12/18 she heard NA #2 calling over the walkie talkie but she was unable to hear what she was saying. She ran into the nurse's station saying there was an emergency in the shower room on B hall. Resident #1 was on his knees and arms extended up with staff lowering him. He had white under shirt up around upper chest and neck. Resident #1 was noted to be breathing. He was assisted in lying position on his right side. He was very lethargic. His respiration was unlabored. He was gotten up using a mechanical lift. He was oriented to person, skin pink, warm and dry. The Physician was called and he ordered to send the resident to ER.

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The written statement from NA #1 (undated) was reviewed. The statement revealed that she was giving Resident #1 a shower on B hall shower room. She washed his hair and his whole body. They were talking during the shower. He did everything she asked him to do. It was extremely hot in the bathroom. She dried his body off and tried to put on his hose. She couldn't get the hose on so she put on his pants, shoes and then his shirt. She put the strap around his waist and told him she had to get him ready for his wife. She hooked him up on the stand-up lift and called NA #2 and began to raise the lift. NA #2 came in and asked Resident #1 to stand up but his legs collapsed. NA #2 left the room to get help. Resident #1's ears turning red and his hand was pale. Few minutes later, 2 nurses came in and the resident was transferred to the wheelchair using the mechanical lift to get the resident out of the shower room.

An interview was conducted with Nurse #1 on 1/28/19 at 1:50 PM. Nurse #1 stated that she was working on A hall on 10/12/18 when NA #2 came and told her that she was needed in the shower now, it was an emergency. She went to the shower room immediately and found Resident #1 on his knees with both hands up on the stand-up bar with his head down and his face and neck were blue. His shirt was wrapped around his neck and he was unresponsive and not breathing. She grabbed the shirt from his neck and he gasped and his color started to change. Then, Nurse #2 came in and they assisted placing the resident down to the floor from the stand-up lift. When Resident #1 was lying on the floor, she started tapping his chest and he started responding. Nurse #1 stated that NA #1 was new

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F 689	Continued From page 11 to the facility when the incident happened. On 1/29/19 at 9:10 AM, Nurse #1 was again interviewed. She stated that when she entered the shower room door and found Resident #1's face blue, she was shocked and didn't know what to do. She was standing at the door and NA #1 told her "don't just stand there, do something". She then moved closer in front of the resident, grabbed the shirt from his neck and he gasped and his color started to change but he was still unresponsive. Nurse #2 came in the shower room and she assisted to lower the resident to the floor. When the resident was on the floor, Nurse #1 stimulated him by tapping his chest and he started to respond. The NAs got him up using a total mechanical lift to the wheelchair and he was placed in bed. Nurse #1 stated that she didn't pay attention if the resident's legs/knees were secured to the lift or not. An interview was conducted with NA #1 on 1/28/19 at 2:54 PM. NA #1 stated that she started working as a NA at the facility in September 2018. NA #1 stated that on 10/12/18 she was assigned to Resident #1. She brought him to the shower room before lunch for shower via a shower chair. She gave him a shower and then dressed him up with his pants, shoes and shirt. Then she hooked him to the stand-up lift and called NA #2 to help her. She raised the lift up when his legs collapsed. NA #2 came, asked the resident but the resident did not respond so NA #2 left the room to get the nurse. NA #1 noticed the resident was pale but not blue, and his shirt was not on his neck. The Nurses came in and the resident was placed on the floor. NA #1 stated that she knew that 2 persons were needed during transfer using the stand-up lift and she had called NA #2 to help. NA #1 confirmed	F 689		

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that NA #2 came in the room when the resident was already hooked and raised. NA #1 would not comment as to why she didn't call for help before securing and raising the resident on the lift. NA #1 stated that she strapped the resident on his chest and legs prior to raising him up on the stand-up lift.

An interview with Nurse #2 was conducted on 1/28/19 at 3:04 PM. Nurse #2 stated that she was the Nurse Supervisor on 10/12/18 when the incident happened. She stated that she was at the nurse's station when she heard something on the walkie talkie but could not understand what was said. NA #2 came at the nurse's station and said that she was needed in the shower room now, it was an emergency. She immediately went to the shower room and found Resident #1 on the stand-up lift, with his head down, unresponsive but was breathing. His color was pale. Nurse #1 was in the room with the resident. His shirt was around his chest/neck area, and his abdominal area was bare. She assisted transferring him down to the floor and stimulated him. He started coming around but was still lethargic. The physician was called and he ordered to send him to the ER for evaluation.

An interview with NA #2 was conducted on 1/28/19 at 3:23 PM. NA #2 stated that NA #1 had called her using the walkie talkie to come to the shower room. When she got to the shower room, she found Resident #1 hooked up to the stand-up lift and was up in the air. His legs were not strapped onto the lift. His legs were elevated off the lift. His shirt was lifted up with the lift pad and his lips were blue. She immediately ran out of the shower room to get the nurse. Nurse #1 was the first nurse who came to the shower room and

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Nurse #2 and Nurse #3 followed. NA #2 stated that Resident #1 was a big man and he needed 2 persons assist with transfers.

An interview with the Director of Nursing (DON) was conducted on 1/28/19 at 3:50 PM. The DON stated that it was not a written facility policy nor a manufacturer's instruction to use 2 persons on all transfers using the lift. She stated that it was just her expectations that nursing staff to always use 2 persons on all transfers using the mechanical lift for safety. The DON also stated that the Staff Development Coordinator (SDC) had been educating new staff during orientation to use 2 persons for all transfers using the lift. The DON further stated that she expected the nursing staff to follow the manufacturer's user's guide with regards to securing the resident's legs/calf prior to using the lift.

An interview with the Administrator was conducted on 1/29/19 at 9:25 AM. The Administrator stated that she had investigated the incident that happened on 10/12/18 with Resident #1. She indicated that the resident had a syncopal episode while in the shower room due to the room temperature being too hot per interview with NA #1. The Administrator stated that she had requested written statements from Nurse #1 and Nurse #2 but the statements were provided on 1/23/19 and 1/24/19. She added that she was made aware by NA #2 that the leg straps were not applied during the transfer by NA #1 but she failed to investigate whether the resident's legs were strapped or not in the stand-up lift during transfer. She stated that per interview with NA #1, it was verified that she had called NA #2 for help when Resident #1 was already on the lift and NA #1 was re-educated on the need for 2 persons

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assist on all transfers using the lift. The Administrator further stated that the SDC had started in-servicing the nursing staff on 10/15/18 on the use of the lift and the need for 2 persons assist during transfer. She also stated that the monitoring was conducted by observing transfer techniques.

A timeline was provided by the Administrator. The timeline revealed that on 10/12/18 at 1:10 PM:
>NA #1 had given Resident #1 a shower. The resident had a syncopal episode while on the lift. Resident's legs went limp and the resident was not able to support self on stand-up lift. NA #2 was assisting with shower. NA #2 noted Resident #1 being non responsive and left the room to get assistance. Nurse #1 was the first nurse to assist with resident being unresponsive and was able to get the resident to respond. Nurse #2 and Nurse #3 also responded to resident's episode of being unresponsive.
>Written statements were requested from both NA #1 and NA #2 as well as Nurse #1.
>The DON was notified by Nurse #2 that Resident #1 had unresponsiveness during shower.
>DON instructed nursing staff to contact the Medical Director.
>A message was left to the Resident #1's family member.
>Resident #1 was sent to the hospital for evaluation.
>Resident #1's lift status was changed due to resident having syncopal episode while on stand-up lift.
>The DON had met with NA #1 and coached her on lift transfer.
On 10/15/18 (no time),

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>The Administrator had met with NA #1. NA #1 stated that Resident #1 went unresponsive during care in shower room while on lift and she called for NA #2 to come for assistance.
>The Administrator reviewed the statements of NAs and the incident report of Nurse #3
On 10/15/18 at 9:30 AM: In daily clinical meeting, the Medical Records Director discussed the incident report written on 10/12/18 by Nurse #3 and the nurse ' s note 10/12/18 on Resident #1. The note and the incident report were reviewed by the Administrator, DON, SDC, Registered Nurse (RN) and the Medical Records Director. The nurse's note did not include enough information regarding the event that occurred in the shower room. The clinical team requested Nurse #2 who was the supervisor during the event to complete a more thorough nurse ' s note.
>The incident report was reviewed and the incident policy discussed. The committee after reviewing the incident report viewed the event as a syncope episode.
> In-service began on lifts for nursing staff by the SDC

A return demonstration was conducted on 1/29/19 at 2:20 PM with NA #3 and the DON. NA #3 was hooked onto the stand-up lift using the sling around her chest and both legs were buckled up using the leg straps. NA #3 was unable to move her legs nor bend her knees to the floor with the leg straps in place.

An interview with the Physician of Resident #1 was conducted on 1/30/19 at 10:35 AM. The Physician stated that he recalled being called about Resident #1 having an episode in the shower room and he ordered to send him out to the ER for evaluation. The Physician further

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F 689	Continued From page 16 stated that he was not informed though of the exact details of the incident and he was not informed that Resident #1 was found blue. The Physician also stated that his medical opinion was Resident #1 was strangulated by the shirt on his neck when he was on the stand-up lift and that impaired his circulation which caused him to become blue. An interview with Nurse #3 (assigned to Resident #1) was conducted on 1/30/19 at 1:05 PM. Nurse #3 stated that she was called to the shower room by NA #2 and she went in the room with Nurse #2. She found Resident #1 with his head on the side and was on his knees. Nurse #1 was in the room with the resident and she was informed by Nurse #1 that Resident #1 was blue and purple when she got to the shower room. Reenactment videos provided by the facility were watched and staff written statement dated 2/5/19 was reviewed on 2/8/19 at 2:05 PM. The resident did not participate in the reenactment, a staff member was transferred by the lift instead. The videos verified that NA #1 was raising the resident on the lift while calling NA #2 for help. When NA #2 came to help, Resident #1 was already up on the lift. The video also verified that NA #1 failed to fasten the resident ' s calf/leg straps before using the lift. · Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #1 was sent to the emergency room (ER) for evaluation on 10/12/18 after the incident and returned back to the facility on same day.	F 689		

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Resident #1 lift status was changed to total mechanical lift and his care plan was updated by the MDS Nurse on 10/12/18. The certified nursing assistant (CNA) assignment sheets and the kiosk were also updated by the charge nurse on 10/12/18 to include the type of lift (total lift) and the need for 2 persons assist during transfers. The charge nurse is responsible for making the assignment sheets available to the NA. The NAs depend on the assignment sheets. The assignment sheets are updated by medical records staff during the daily clinical meeting as needed and the kiosk is a part of the electronic medical record so it is updated as the electronic record is updated.

The CNA assignment sheet is used to ensure resident needs are communicated to staff and that residents are transferred safely. The CNA assignment sheet has detailed information about bathing/shower, continence/toileting, transfers, meals, vitals, diets, adaptive equipment, pressure ulcers, and fall care plan interventions. Also, this information can be accessed on the electronic medical record kiosk. This assignment sheet and the kiosk provides information about resident needs.

The charge nurse provided one-on-one education to the NA #1 following the incident on 10/12/18. The education included having 2 staff members to use lifts, reading CNA assignment sheets, and how to keep residents safe. Before Nurse Aide (NA) #1 returned to work after the incident on 10/12/18, she received in-servicing from the staff development coordinator (SDC) on 10/15/18. The NA did not work on 10/13/18 and 10/14/18. The in-servicing on 10/15/18 included education on the following:

· No resident is to be transferred in the shower room, this includes transferring from

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shower chair to wheelchair, broda chair, etc

- No resident is to stand in shower room for dressing, this includes standing a resident to pull up their pants, apply a brief, etc
- All mechanical lifts require that 2 staff members are present in the room at the time of the transfer and are assisting with the transfer
- Mechanical lifts should always be used with all safety devices in place -this includes using the - leg straps on the sit to stand lifts.
- All NAs including NA #1 are trained by working side by side with another NA at which time they are instructed on the use of the lift per manufacturer's instruction with return demonstration.

Lowering the resident to the floor is appropriate protocol during an emergency. The manufacture instructions do not address a syncopal episode. Per NA #2 interview, it was noted that the resident's legs were not secured using the leg straps on the stand-up lift. However, resident remained in standing position on lift in upright position until lowered to the floor.

As resident was going unresponsive and slumping in stand up lift the shirt rose under his armpit begin to move closer to neckline. The discoloration in his facial area was secondary to the syncopal episode.

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

All lift incidents are investigated after the occurrence. The investigation was initiated 10/12/18 by the charge nurse. The logs have been reviewed for all resident incidents from

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7/12/18 through 10/12/18, including discharged residents. The director of nursing verified that incidents were investigated and education provided as determined necessary. There were no other incidents related to lift transfers

· Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

The SDC in-serviced all nursing staff on 10/15/18, 10/22/18, and 10/24/18. The information is reviewed during orientation, annually and at all nurses' meetings.
Nursing staff have been in-serviced by the SDC regarding the following bullet points. Trainings were held on 10/15/18 for all nursing staff in the building. All nursing staff that were not in the building on 10/15/18 were trained when they returned to work on 10/22/18 and 10/24/18.
· No resident is to be transferred in the shower room, this includes transferring from shower chair to wheelchair, broda chair, etc
· No resident is to stand in shower room for dressing, this includes standing a resident to pull up their pants, apply a brief, etc
· All mechanical lifts require that 2 staff members are present in the room at the time of the transfer and are assisting with the transfer
· Mechanical lifts should always be used with all safety devices in place -this includes using the leg straps on the sit to stand lifts

Staff training began on 10/12/18 with instructions on how to use the lift per manufacturer ' s recommendations. The charge nurse began completing audits and monitoring return demonstration on 11/30/18. This monitoring

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continues monthly.
The Nurse Aides (NAs) receive this information during orientation and they are required to complete and sign a checklist on their understanding during orientation. The NAs get info on the charting kiosk for each resident and on their printed assignment sheets. During new hire orientation, nursing staff are required to demonstrate competency by observation and the team nurses monitor by reviewing the electronic medical record activities of daily living coding.

· Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State.

The administrator is responsible for auditing the audit tool and transfer observations. The audit tool will be completed by the charge nurse beginning 10/12/18. The audit include lift transfers, proper user of lifts, ensuring safety features in place, and ensuring the proper number of people are present during transfer is being observed. At least eight residents per month are being audited by the charge nurse, and this will continue through February 1, 2019 and will continue as needed. The administrator will report on the results monthly during QAPI starting November 2018.

The facility alleges full compliance with this plan of correction effective 11/30/18.

As part of the validation process on 1/30/19, the plan of correction was reviewed including review of the in-service records of nursing staff and

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F 689	Continued From page 21 observation of staff during transfer using the total and stand-up lift. The records revealed that 100% of the nursing staff had been in-serviced on resident transfer using the mechanical lift. Staff interview was also conducted and confirmed that they received in-service regarding the use of lifts. The audit tool and the transfer observation forms were also reviewed. The validation process verified the facility's compliance effective 11/30/18.	F 689		