STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345152	A. BUILDING ______ B. WING ______	C 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY VILLAGE	1265 21 STREET NE HICKORY, NC 28601

(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 An unannounced complaint investigation survey was conducted on 01/19/23. Event ID# 67S011. The following intakes were investigavated NC00196957, NC00196840, NC000196014. 2 of the 6 complaint allegations was substantiated resulting in deficiency (F689).	F 000		
F 689 SS=D	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 staff interviews and record review, the facility failed to ensure a resident's lower extremities were secured in the mechanical lift during incontinence care which resulted in a fall to the floor for 1 of 3 residents reviewed for falls (Resident #1). Findings included: Resident #1 was admitted to the facility on 8/31/18 with diagnoses that included Alzheimer's disease and dementia with behavioral disturbances. A facility policy revised 7/4/19 indicated in addition to orientation training on use of the mechanical lifts, manufacturer manuals would be used to assist in the education and ensure proper usage	F 689	1) Resident was assessed for injury, no injury noted. Hall nurse immediately educated CNA involved about using leg straps although the lift manufacturer information states the safety belts "can" be used. DON reprimanded CNA involved with a final written warning and a 2-day suspension without pay. SDC performed additional lift training with CNA involved, signed copy of this additional training was provided by SDC and attached to reprimand. Staff Education provided to all nursing department staff on 1/20/2023 via point click care bulletin board that included the importance of not removing leg straps from stand-up lift and using the leg straps as indicated. 1/23/2023 written staff education regarding the same was	2/10/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/09/2023

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 689 Continued From page 1

of the lift equipment.

An activity of daily living (ADL) care plan dated 6/30/22 revealed Resident #1 was to be transferred with the standup lift, a yellow medium lift sling, and 1 staff person assistance.

A quarterly Minimum Data Set (MDS) dated 9/1/22 indicated Resident #1 was cognitively impaired, was always incontinent of bowel and bladder, and required extensive assistance of 2 staff for transfers.

A fall care plan dated 9/8/22 revealed Resident #1 was at risk for falls due to confusion and balance problems, and unaware of safety needs.

An incident report dated 11/22/22 indicated Resident #1 was lying in the floor with her head in Nurse Aide (NA) #1's lap when Nurse #1 arrived after being summoned for assistance by an unidentified nurse aide student. The report detailed Resident #1 let go of the handlebars during a transfer and had to be lowered to the floor by NA #1. The incident report indicated Resident #1 was only oriented to person but reported no pain when Nurse #1 arrived.

A disciplinary action report dated 11/22/22 reflected NA #1 was counseled and re-educated on the use of the mechanical lift secondary to a fall encountered by Resident #1 on 11/22/22 due to NA #1 not securing the buckles on the leg straps of the mechanical lift.

Activity of Daily Living (ADL) documentation by NA #1 dated 11/22/22 at 4:07 PM reflected Resident #1 was dependent for transfers.

F 689

placed out for all nursing department staff to sign.

Hall nurse performed immediate physical assessment to check for injuries. DON issued a reprimand and suspension. SDC provided additional lift training for CNA involved. DON placed staff education on point click care bulletin board, did written staff education, and held a staff meeting on 1/26/2023.

Staff Education provided via Point Click Care Bulletin board to all nursing staff, written staff education provided also for all nursing staff, staff meeting held on 1/26/2023.

Resident's care plan reflects color of sling that staff are to use as well as transfer status.

2) Any resident that uses a stand-up lift is at risk.

We will review those resident's care profile on point click care to reassure each transfer status and correct sling color are listed. Those resident care plans were reviewed on 2/2/23 to ensure transfer status and sling colors are listed correctly.

3) Nursing department staff members were educated via point click care bulletin board, written staff education, and via a staff meeting. Maintenance will be asked to secure leg straps to all stand-up lifts by 1/31/23. QAPI meeting held on 1/20/23 resulted in discussion and a Performance

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F 689	Continued From page 2	F 689		

Continued From page 2

A Physical Therapy Evaluation and Plan of Treatment completed by Physical Therapist (PT) #1 dated 11/22/22 reflected Resident #1 was to use the sit to stand mechanical lift with a yellow lift sling for transfers and that staff were educated on proper transfer status to maintain the safety of Resident #1 and staff. The evaluation reflected Resident #1 had a goal of improving lower extremity strength to be able to stand for greater than 10 minutes to improve transfer and sit to stand skills.

An interview with NA #1 on 1/19/23 at 3:27PM revealed she was the NA assigned to provide care for Resident #1 on 11/22/22 from 7 AM to 3 PM. NA #1 indicated shortly before the end of her schedule shift; she placed Resident #1 into the mechanical sit to stand lift in to provide incontinence care. NA #1 stated she got in a hurry and did not retrieve the leg straps and attach them to the lift before attempting to stand Resident #1. NA #1 further elaborated she secured a green lift sling around Resident #1 and lifted her from her wheelchair. NA #1 stated there was a student who was observing her care but was too young to assist in the care of Resident #1 on 11/22/22. NA #1 stated she lifted Resident #1 to a standing position and began providing incontinence care. After about 8-10 minutes, she said Resident #1 started saying she needed to sit down, but NA #1 told Resident #1 she was almost finished with her care and would sit her as soon as the incontinence care was completed. NA #1 stated around 12-15 minutes into care, Resident #1 let go of the handlebars on the lift and had to be caught before she hit the floor from falling out through the lift sling. She could not recall who the student nurse aide present at the time of the fall but indicated she did not recall Resident #1 being

Provider's Plan of Correction (F 689):

Improvement Plan to follow up on lift equipment/sling usage. SDC educated all departments at town hall meeting on 1/31/23, to ensure leg straps are attached to stand-up lifts at all times and what to do when they notice them missing&
Staff who notice missing leg straps should: not use the lift, notify supervisor, complete work order and remove lift from hall and take to the maintenance department.

Staff education was provided on Point Click Care bulletin board, written staff education form, nursing staff meetings, and town hall meeting.

Lift training/ lift safety is also completed by the SDC or designee for all new staff working in the nursing department during new hire orientation. New hires must be checked off on using the lifts correctly before being assigned to the halls.

4) SDC will conduct random audits on all 3 shifts weekly for four weeks, monthly for four months, and quarterly for two quarters. SDC will audit staff using stand-up lifts to ensure leg straps are in place and verify the correct sling is being used according to the care plan. Audits will end 12/31/2023.

All corrective action completed as of 2/10/23.

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F 689	Continued From page 3 injured when the fall occurred. A telephone interview with Nurse #1 on 1/19/23 at 3:42 PM revealed she was the nurse assigned to the unit where Resident #1 resided and was called to the room on 11/22/22 where she found Resident #1 in the floor with her head in NA #1's lap. Nurse #1 indicated she assessed Resident #1 while in the floor to have no visible injuries and she assisted NA #1 to stand her and place her back to her wheelchair with the use of a gait belt. Nurse #1 stated she was not made aware at the time of the fall that NA #1 had performed incontinence care on Resident #1 using the mechanical sit to stand lift without the use of the lower extremity straps to secure her in place. Nurse #1 stated she did not recall any complaints of pain or discomfort by Resident #1 throughout the reminder of her shift on 11/22/22. An interview with PT #1 on 1/19/23 at 4:00 PM revealed she evaluated Resident #1 on 11/22/22 for safe transfer techniques and felt she remained safe to continue use of the sit to stand lift with the use of a yellow medium lift sling for all transfers. An interview with the Director of Nursing (DON) on 1/19/23 at 4:27 PM revealed she was made aware of the fall by Nurse #1 and had reprimanded NA #1 and provided re-education following the fall on 11/22/22. The DON had not discovered during the investigation that Resident #1 was lifted using the mechanical sit to stand lift by NA #1 without the use of lower extremity lift straps being present in the room. The DON stated NA #1 was a very honest employee but did not believe that the lift straps were not attached to the lift during the transfer. She had also not been made aware Resident #1 had remained in the lift	F 689		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 4 for 10-15 minutes while providing incontinence care on 11/22/22.	F 689		