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F 000	INITIAL COMMENTS A complaint investigation was conducted onsite on 4/19/2024 with additional information obtained remotely on 4/24/2024. Therefore the exit date was 4/24/2024. Event ID # URCO11. The following intakes were investigated NC00215899 and NC00216001. One of the nine complaint allegations resulted in a deficiency. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity of D.	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 record review and staff interview the facility failed to prevent a fall from a mechanical lift for one (Resident #1) of three residents reviewed for supervision to prevent accidents. Findings included: Resident #1 was admitted on 2/13/2020 with multiple diagnoses some of which included a birth defect resulting in a cognitive and developmental disability and spinal stenosis. Documentation in a nutrition note dated	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 04/26/2024

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2/20/2024 revealed Resident #1 was 5 feet tall and weighed 193 pounds.

Documentation in a nursing progress note for Resident #1 dated 2/20/2024 at 3:20 PM revealed, "Writer notified by [Medication Aide] that resident was on floor. The Writer immediately assessed resident for injury. Resident denies pain. No [signs or symptoms] of pain. PACE (Program of All-Inclusive Care for the Elderly) notified, and order received by the Doctor. Transferred to [Emergency Room]. Resident was not moved until EMS (emergency medical services) arrived and EMS transferred resident via [mechanical lift] from floor to stretcher."

An interview was conducted simultaneously with the Nurse Aides (NA) #1 and NA #2 on 4/19/2024 at 11:19 AM. NA #1 explained she was the assigned nurse aide to Resident #1 on 2/20/2024 for the 7:00 AM to 3:00 PM shift. NA #1 further explained she gave Resident #1 a bath and then put a lift pad underneath her so she could be put into her wheelchair via the mechanical lift. NA #1 relayed she then asked NA #2 to come into the room to assist her in moving Resident #1 via the lift into the wheelchair. NA #2 confirmed she came into the room and assisted NA #1 to attach the straps of the lift pad to the wheelchair. NA #2 and NA #1 confirmed they put the same-colored straps on the hooks of the mechanical lift crossing the straps between the legs of Resident #1 to keep her secure. NA #1 recalled that the lift pad underneath Resident #1 was a blue pad, but she could not specifically recall the size pad she used. NA #1 stated she used the lift controls to lift Resident #1 off the bed and into the air. NA #2 stated she was holding onto the hand holds on the lift pad at the side of Resident #1 as she was

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being lifted into the air. NA #1 stated her hands were on the lift machine as Resident #1 was suspended in the air and kept the mechanical lift stationary. NA #2 explained she removed her hands from the hand holds on the lift pad and turned to move the wheelchair into position. NA #1 stated that Resident #1 slid to her side very quickly and slipped out of the top of the lift pad while suspended in the air. NA #1 relayed that she thought Resident #1 slid out of the top of the lift pad because she had a slippery shirt and Resident #1 was top heavy, with most of her weight on the top portion of her body. Both NA #1 and NA #2 confirmed they were retrained on all the steps in using a mechanical lift and specifically that a nurse aide needed to always be holding onto the hand holds while a resident was suspended in the air.

Documentation in an emergency room discharge summary dated 2/20/2024 revealed, "[Resident #1] here with pain after being dropped from lift chair. No apparent major trauma on exam. She is at her mental baseline and moving all extremities. CT (computed tomography) head/[cervical] spine reviewed and are negative. Hip (x-ray) negative. Discussed with [patient's] provider at PACE, will [discharge] with return precautions including any weakness, grip strength changes or signs of occult cord injury despite normal CT. No apparent pain on exam." Resident #1 was diagnosed with a scalp soft tissue injury or a hematoma of the scalp without any underlying skull fracture on the discharge summary.

Documentation in a primary care provider assessment for an emergency room visit dated 2/20/2024 revealed Resident #1 was assessed by her physician in the emergency room after her fall

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from the mechanical lift. An addendum to the assessment was added by her physician on 2/22/2024 revealing Resident #1 was found to have "no evident new arm motor weakness or functional change" out of concern for a neck injury.

Documentation in the Resident #1's care plan, dated as last reviewed on 2/22/2024 revealed the focus area for a risk for falling relative to poor balance, decreased mobility, and weakness. One of the interventions was to ensure proper position of the lift pad prior to transfer.

An interview was conducted with the Director of Nursing (DON) on 4/19/2024 at 12:00 PM. The DON stated on 2/20/2024 she was not the DON at the time, but she participated in the investigation and determination of the root cause analysis of how Resident #1 fell out of the mechanical lift. The DON stated the nurse aides did a recreation of what happened after Resident #1 was assessed and sent to the emergency room. The DON revealed NA #1 and NA #2 recreated their actions using herself in the place of Resident #1. The DON stated NA #1 and NA #2 used the proper size lift pad and used appropriate techniques in using the mechanical lift except for not always keeping hold of the lift pad with the hand holds. The DON revealed NA #1 and NA #2 were reeducated on the entire process of how to transfer a resident using a mechanical lift. The DON further revealed the education was provided to not only NA #1 and NA #2 but to the entire nursing staff to include agency on the use of a mechanical lift. The DON explained the focus of the training was on how to access the resident profile for choosing the correct lift pad, making sure wheelchairs are in

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position before starting the process of moving the resident, obtaining a third nurse aide if needed, and always making sure at least one nurse aide was holding on to the hand holds at all times while the resident was in the air. The DON explained that a return demonstration of the use of a mechanical lift was performed by all the nursing staff after the training. The DON indicated that all the mechanical lifts and the lift pads were checked for functionality by the Maintenance Director on 2/20/2024 in addition to the training and skill demonstrations by the nursing staff by the DON. The DON revealed the staff development coordinator had been doing audits on all the units to confirm the nurse aides were using proper technique in using the mechanical lifts.

An interview was conducted with the Administrator on 4/19/2024 at 12:26 PM. The Administrator stated after the fall of Resident #1 from the mechanical lift she was very concerned for Resident #1 and she spoke with the physician for Resident #1, who called her from the emergency room on 2/20/2024. The Administrator stated Resident #1 had a hematoma on her head but was otherwise not injured or in any pain.

The facility provided the following corrective action plan with a completion date of 2/21/2024.

A Plan of Correction was instituted on 2/20/2024. A root cause analysis was completed by the leadership team at Peak Resources, Alamance. The root cause analysis revealed the lift pad was positioned incorrectly during the transfer and a nurse aide let go of the hand holds on the lift pad while the resident was in the air. Resident was assessed for injury by the nursing staff, and EMS

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(emergency medical services) was notified, and resident was sent to the hospital for further intervention, but no significant injuries were noted. Nursing Unit Managers and SDC (Staff Development Coordinator) performed additional lift training and competency checks with CNAs (Certified Nursing Assistants) involved, signed copy of their competency check was provided by SDC. Nursing Staff Education regarding use of mechanical lift was initiated on 2/20/2024 and SDC and unit managers provided one on one training with lectures and demonstration to all nursing staff regarding proper use of the mechanical lift technique. The Maintenance staff inspected all mechanical lifts. No defects were identified.

All residents that use a mechanical lift are at risk. Unit managers and SDC reviewed those resident's care profile in the electronic medical record to reassure each transfer status and correct sling color were listed. Those resident care plans were reviewed on 2/20/24 to ensure transfer status and sling colors (indicating the size) were listed correctly.

Staff education was provided on a written staff education form and nursing staff meetings. Lift training/ lift safety was 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. Any employee that did not receive the education will be removed from the schedule until education is completed.

SDC will conduct random audits on all three shifts

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weekly for four weeks, monthly for four months, and then quarterly for two quarters. SDC will audit staff using mechanical lifts to ensure staff are transferring residents using proper mechanical lift technique as listed in the care plan.

The findings will be reviewed at the quarterly Quality Assurance/Performance Improvement (QAPI) meetings monthly x 4 months. The QAPI team will also determine if the plan of correction needs to be continued or modified.

Alleged date of compliance February 21, 2024

The Plan of Correction was validated on 4/19/2024 for the alleged date of compliance of 2/21/2024. The Quality Assessment and Performance Improvement Plan was reviewed, each intervention had corresponding documentation to support the actions taken by the facility. The facility nursing staff were educated on how to access the resident profile in the electronic record, selection of appropriate lift pad per recommended height and weight guidelines, positioning residents in the lift, and procedures for safe transfers via the mechanical lift. Nursing staff were interviewed for retention of the information provided in the training on 2/20/2024. The Nursing staff interviewed also confirmed that a return demonstration of use of a mechanical lift with a skill check off was completed in groups of three on 2/20/2024. Review of the documentation revealed mechanical lift competency checks were completed for each nurse aide and dated 2/20/2024. Quality Assurance/Performance Improvement audits were initiated the week of 2/20/2024 with observations of mechanical lift transfers for 5 residents for 4 weeks with no

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F 689	Continued From page 7 concerns identified. The monthly audits were ongoing. Review of Quality Assessment Performance Improvement committee meeting minutes dated 2/29/2024 revealed the audits of the mechanical lift transfers were brought to the committee meeting for review by the interdisciplinary team noting that staff education and monitoring was to continue.	F 689		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators,	F 867		4/26/24

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including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas;

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consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;

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F 867	Continued From page 10 (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility's Quality Assessment Performance Improvement committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the complaint investigation completed 9/19/2023. This was a repeat deficiency in the area of supervision to prevent accidents that was originally cited on 9/19/2023. The continued failure of the facility with a repeat deficiency showed a pattern of the facility's inability to sustain an effective Quality Assessment Performance Improvement program. The findings included: This citation is cross referred to: F689: During the complaint investigation of 4/24/2024 the facility failed to prevent a fall from a mechanical lift for one of three residents reviewed for supervision to prevent accidents. During the complaint investigation of 09/19/2023 the facility failed to provide incontinent care safely for one of three residents reviewed for accidents. The Administrator was interviewed on 4/24/2024 at 11:07 AM. The Administrator stated the Quality Assessment Performance Improvement (QAPI) committee members were made up of the Administrator, Director of Nursing, Medical Director, Dietary Manager, Maintenance Director,	F 867	F867 To correct this deficiency the following items were completed. o The Administrator was reeducated by the Corporate Compliance Manager regarding the purpose of the Quality Assurance and Performance Improvement (QAPI) Program. The education included the objectives of the QAPI program including to identify and review issues from past surveys and evaluate the current plan for its effectiveness and change the plan as needed, the purpose of the QAPI program to provide a means for resident care and safety issues to be resolved, and how the committee monitors issues and follows up with unresolved issues that have been identified. This was completed on 4/25/2024. o Facility QAPI committee members were then be in-serviced by the Administrator on 4/25/2024 on the following: o The purpose of the QAPI Program o QAPI Committee is responsible for identifying and reviewing issues from past surveys and evaluating the current plan for its effectiveness and changing the plan, as necessary. o How the QAPI Committee monitors	

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F 867	Continued From page 11 Social Workers, Activities Director, Housekeeping Manager, Nursing Unit Managers, Infection Preventionist, Staff Development Coordinator, and the Medical Records Manager. The Administrator stated it was mandatory for all department heads to attend the QAPI meetings. The Administrator revealed she was reeducated by the Corporate Compliance Officer on the QAPI process after the fall of Resident #1 from the mechanical lift during care because the corporate office identified non-compliance with the QAPI process for accidents.	F 867	issues and follows up with unresolved issues that have been identified. o QAPI committee members include the Medical Director, Pharmacy Consultant, Administrator, Director of Nursing, Minimum Data Set (MDS) nurses, Admission Coordinator, Social Worker, Business Office Manager, Staff Development Coordinator, Nursing Supervisor, Medical Records Manager, Maintenance Director, Housekeeping Supervisor, Dietary Manager, Treatment Nurse and Activities Director. o A tool will be utilized to assist the QAPI committee. The tool, titled, “QAPI Self-Evaluation”, includes the following: o Does the QAPI committee have a current plan in place? o Does the committee identify who is responsible for overseeing the plan/project? o Is the plan working? o If the plan is not working have changes been put in place to improve? o Is the outcome measurable? o Has the project been successful? o Can the plan be considered resolved? o This tool was developed for a QAPI sub-committee to establish the success of the QAPI projects and make recommendations as necessary. The sub-committee is made up of 3 members of the QAPI general Committee which will include the Director of Nursing, Staff Development Coordinator and the Administrator.	

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F 867	Continued From page 12	F 867	Monitoring: o The Self-Evaluation tool will be completed by the sub-committee at scheduled meetings monthly prior to the next scheduled QAPI monthly meeting which initially noted on 4/25/2024. o Findings of the sub-committee will be addressed at the monthly QAPI meeting when all participants attend. o The Self-Evaluation tool will be utilized for 3 months; ongoing use of the tool will be determined by the recommendations of the QAPI Committee based on results of this tool. QAPI The results of the self-evaluation tool will be brought to the QAPI meeting monthly by the Administrator and reviewed by the QAPI team. The QAPI Team will make recommendations and changes if necessary. Completion date: 4/26/2024.	