STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345330	A. BUILDING _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GRAYBRIER NURS & RETIREMENT CT	116 LANE DRIVE TRINITY, NC 27370

(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 on 06/04/24. Event ID# Z2MQ11. The following intake was investigated: NC00217629. One (1) of the 1 complaint allegation resulted in a deficiency.	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 observations, record reviews, resident and staff interviews, the facility failed to secure Resident #1 in a mechanical lift per manufacturer's instructions and failed to provide a safe transfer which resulted in a fall. This deficient practice was for 1 of 3 residents reviewed for supervision to prevent accidents. The findings included: Manufactures guidelines for the U-Sling or Divided Leg Sling indicated this sling has full coverage along the patient ' s back, with two divided straps that crisscross under the patient ' s legs. The crisscrossed legs ensure that the patient doesn ' t slide out of the sling during transport. Resident #1 was admitted to the facility on	F 689	Preparation and submission of this Plan of Correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted solely because of requirements under state and federal laws. Immediate interventions were implemented for resident #1 prior to the survey. The direct care staff members involved were educated of the importance of appropriately securing the mechanical lift pad under a resident; a return demonstration was completed. On 3/27/2024 it was confirmed that the correct size lift pad was utilized for the	6/18/24

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

Electronically Signed | 06/18/2024

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F 689	Continued From page 1 02/06/15 with the following diagnoses, Dementia, Alzheimer ' s Disease, anxiety, and history of cerebrovascular event (CVA). Resident #1 ' s quarterly Minimum Data Set (MDS) assessment dated 04/22/24 indicated she was cognitively intact. She was dependent on staff for all transfers and had a range of motion (ROM) limitation to both lower extremities. She also had 1 fall with minor injury. Resident #1 ' s care plan, revised on 05/01/24, had a focus that indicated she had impaired physical mobility, and required a mechanical lift for transfers. She was unable to stand or ambulate, causing her to be at risk of injury. She also had decreased ROM to bilateral lower extremities. The interventions included for staff to provide the appropriate level of assistance to promote safety. Another focus read she had the potential for fall related injuries. Resident #1 required assistance with bed mobility and transfers due to diagnoses of Alzheimer ' s Disease, Dementia, CVA, and she was unable to stand. The care plan also indicated she had an assisted fall from the mechanical lift during a transfer. The interventions included that she required staff assistance with transfers by a mechanical lift, and for staff to use appropriate size sling for mechanical lift. Incident report dated 03/27/24 revealed Resident #1 was being transferred from the bed to her chair with the mechanical lift when she slipped through the opening at the bottom of the harness and guided onto the floor by 2 NAs. She did not hit her head. Neuro checks were initiated. The resident ' s cognition was at baseline, she was verbally responsive, and able to make needs	F 689	transfer. As of 5/1/2024, resident #1 care plan was reviewed and revised. On or by 6/18/2024, all direct care nursing staff were provided education regarding safe mechanical lift practices, with proof of understanding. Staff that have not worked since the education began will complete education prior to him/her working their next scheduled shift. On 6/13/2024, the Nursing Administrative team conducted an audit of all residents with orders for mechanical lifts; all orders were confirmed for appropriateness. On 6/13/2024, all other residents without orders for mechanical lifts have been discussed by the interdisciplinary team, to determine if they would benefit from the use of mechanical lifts; no other residents have been identified to need the use of mechanical lifts for safe transfers. The facility discussed the possibility of changing to an alternate style of lift pad. It was determined that the crisscross style pad is the safest option for most residents. Residents requiring full body lift pads already have these devices in place. On or by 6/18/2024, all direct care nursing staff were provided education regarding safe mechanical lift practices, with proof of understanding. Staff that have not worked since the education began will complete education prior to him/her working their next scheduled shift. The facility has developed a monitoring tool, titled “Hoyer Sling Compliance Tool,” to ensure corrective actions are followed.	

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F 689	Continued From page 2 known. An abrasion was noted to the right side/under breast/upper abdominal area with no bleeding or bruising observed at that time. Resident #1 complained of pain in her right leg. An X-ray was ordered of her right femur (thigh bone), right knee, right tibia/fibula (2 bones of the lower leg), or right and left foot. The X-ray was completed, awaiting results. Resident #1 had an active order for tramadol 25mg to be given as needed every 8 hours for complaints of pain. Resident #1 received tramadol for complaints of right leg pain with effective results. Review of X-ray results, dated 03/27/24, revealed no fractures and no soft tissue swelling identified for the right femur, right knee, right tibia/fibula, or right and left foot. An interview was conducted on 06/04/24 at 11:20 AM with Resident #1. She stated she had a fall from the mechanical lift in her room. She stated during the transfer there were 2 Nursing Assistants (NAs) present during the transfer. She further stated she started sliding out of the pad and the NAs guided her to the floor while protecting her head. She also stated she thought the pad had 3 hooks and only 2 were hooked but was not sure how she fell out. She indicated she had a bruised bottom and leg but no other injuries. An interview was conducted on 06/04/24 at 2:15 PM with the Unit Coordinator. She stated she was the first to respond to the fall with Resident #1 on 03/27/24. Upon entering the room, the mechanical lift pad was disconnected from the lift. She stated the Nursing Assistants (NAs) reported that all 6 hooks were fastened and locked in place prior to the transfer. The resident was on	F 689	The facility will monitor at least 3 mechanical lift transfers weekly, and randomly monitor more frequently as needed. Monitoring will be conducted weekly for 2 months, then monthly for 3 months. Monitoring will be conducted by the Director of Nursing designee. Results of the above-mentioned audits will be reviewed in Quality Assurance Meeting monthly for 6 months to ensure regulatory compliance. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. The facility alleges full compliance of this plan of correction, on or before 6/18/2024.	

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F 689	Continued From page 3	F 689		

the floor with the NAs. There were 2 NAs that were in the residents ' room during the transfer. She indicated Resident #1complained of some discomfort to her right leg and she had a small abrasion under her right breast area. The Unit Coordinator assessed the range of motion to extremities and assisted with getting Resident #1 to bed. The Unit Coordinator verified NA #2 had received training during the hiring process and was given check offs for mechanical lift transfers and bed mobility and repositioning.

Review of training and education revealed Nursing Assistant #2 received training for mechanical lift transfers and bed mobility and repositioning.

An interview was conducted on 06/04/24 at 2:30 PM with Nursing Assistant (NA) #1. She verified she was one of the NAs in the room when Resident #1 fell from the sling during a transfer with the mechanical lift. She stated all 6 hooks were connected properly prior to lifting the resident. She also stated she does not know how the resident slid out; it was a freak accident. She further stated she and the other NA assisted the resident to the floor. The sling was the correct size.

Review of a statement written by Nursing Assistant (NA) #2 dated 03/27/24 revealed when preparing Resident #1 for a transfer using the mechanical lift, she hooked all 6 hooks securely in place, however, she forgot to cross the bottom portion of the pad before hooking those straps. When using a half body lift pad, you should cross the bottom of straps of the lift pad.

A phone interview was conducted on 06/04/24 at

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F 689	Continued From page 4	F 689		

4:10 PM with Nursing Assistant (NA) #2 she verified she wrote the statement dated 03/27/24. She stated when preparing Resident #1 for the transfer using the mechanical lift, she forgot to cross the bottom portion of the pad straps before hooking those straps which caused her to slide out the bottom of the lift pad.

In a follow up interview on 06/04/24 at 3:55 PM with the Unit Coordinator she stated she agreed with the statement written by Nursing Assistant (NA) #2. She further stated the reason Resident #1 fell was because the NA forgot to cross the bottom portion of the pad before hooking those straps. Education was done with all nurses and NAs following the incident.

An interview was conducted with the Director of Nursing (DON) on 06/04/24 at 4:16 PM. She was not aware of the incident involving the transfer of Resident #1 as she started her employment on 04/29/24 with the facility. She indicated she expected nursing staff to apply and transfer residents with mechanical lifts per manufactures guidelines.