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	345301	A. BUILDING _____ B. WING _____	C 06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS The survey team entered the facility on 6/05/24 to conduct a complaint investigation survey and exited on 6/06/24. Additional information was obtained on 6/07/24. Therefore, the exit date was changed to 6/07/24. The following intakes were investigated NC00217568 and NC00217474. Four (4) of the 7 complaint allegations resulted in deficiency. Intakes NC00217568 and NC00217474 resulted in immediate jeopardy. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 05/16/24 and was removed on 06/07/24. A partial extended survey was conducted.	F 000		
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, and staff, Nurse Practitioner, and Physician interviews, the facility failed to prevent injury when Resident #1 was transferred to bed with the mechanical lift by	F 689	White Oak Manor - Burlington ensures residents remain as free of accidents as is possible and each resident receives adequate supervision and assistive device	6/28/24

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

Electronically Signed | 06/27/2024

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F 689	Continued From page 1 Nurse Aide #2 and the Maintenance Director on 5/16/24. Resident #1 was non-ambulatory, dependent on staff for transfers, and was at increased risk for bleeding related to blood thinning medication. On 5/17/24 the resident was identified with discoloration to the top of the right thigh area with edema (swelling caused by fluid trapped in the body's tissues) to the entire thigh. The resident reported to staff she believed the injury occurred from the mechanical lift sling during a transfer and the Interdisciplinary Team determined the injury was caused from the lift "pinching" the edematous areas (areas affected by edema) of Resident #1's leg. On 5/18/24 Resident #1 was transferred to the emergency department (ED) and an ultrasound was performed and Resident #1 was diagnosed with a large hematoma (a collection of blood that occurs when blood leaks from vessels and pools in nearby tissue) of the right thigh which measured 12.5 centimeters (cm) x 10.6 cm x 17.6 cm. Resident #1 was admitted to the intensive care unit with acute blood loss and hemorrhagic shock (a life-threatening condition that occurs when the body loses too much blood in a short period of time) secondary to traumatic right leg hematoma and required seven units of packed red blood cells transfused during the hospitalization. Resident #1 returned to the facility on 5/31/24 and was transferred to the hospital on 6/03/24 related to active bleeding from the hematoma site on the right thigh. This deficient practice was for 1 of 3 residents reviewed for accidents (Resident #1). Immediate jeopardy began on 5/16/24 when the facility failed to prevent injury for Resident #1. The immediate jeopardy was removed on 6/7/24 when the facility implemented an acceptable credible allegation of immediate jeopardy	F 689	to prevent accidents. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #1's new interventions that were put in place in order to prevent further accidents from recurring. The interventions include a 4-person assist when transferring Resident #1 in the Mechanical Lift and pad resident's right leg with towels while using the lift. The Corporate Consultant researched the manufacturer's information which revealed no contradicting information regarding the use of the barrier towel. The new interventions are listed in the resident's summary. The facility's Administrator ordered a special sling just for Resident #1 that has extra padding and extended leg coverage. Resident #1 will see therapy when she returns back to the facility to ensure that the transfer is safe. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. In order to protect residents in similar situations, the following was completed. On 6/5/24, an audit was completed by the facility's Safety Nurse who identified the current residents with a transfer status of a Mechanical Lift through their lift transfer assessment form. On 6/6/24, the facility's Administrative staff conducted interviews	

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removal. The facility remains out of compliance at a lower level and severity of "D" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put in place are effective.

The findings included:

Resident #1 was admitted to the facility on 10/05/21 with diagnoses which included diabetes and atrial fibrillation.

Resident #1 had an active physician order dated 10/05/21 for apixaban (an anticoagulant medication) 5 milligrams (mg) twice a day for atrial fibrillation.

Resident #1's care plan last reviewed on 4/09/24 revealed a care plan was in place for risk of bleeding related to anticoagulant (blood thinner to prevent blood clots from forming in the bloodstream) medication with interventions which included to monitor skin during routine care and report and bruising or bleeding at once.

The Minimum Data Set (MDS) quarterly assessment dated 4/09/24 revealed Resident #1 was cognitively intact, was dependent on staff for transfers, and utilized a motorized wheelchair for mobility throughout the facility. Resident #1's weight was coded as 342 pounds.

Review of the resident care summary (document to notify NA staff what level of care was needed) no date, revealed Resident #1 required a mechanical lift for transfers.

An interview was conducted on 6/05/24 at 1:45

with residents that are interviewable by asking them if they feel safe during transfers on the mechanical lift. The Administrative nursing staff completed body audits on 6/7/24 for residents that are not interviewable. This is to ensure there are no other residents affected.

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

On 6/5/24 to6/6/24, the facility's Director of Nursing and Staff Development Coordinator conducted the education with the facility staff to prevent serious adverse outcomes from occurring or recurring again. The Nursing staff were educated on the following. All total lifts are a 2-person assist at all times. The nursing staff must use the correct lift sling pad that the resident is color coded for, and it will be on the outside of the resident's door and be trained before using the mechanical lifts. The Nursing staff need to be cautious and careful when transferring residents that are at high risk for injury, such as anticoagulants.

Newly hired facility staff members, and if any staff on vacation or employed as needed when they return to work prior to working on the floor will receive this education during their job specific orientation by the Staff Development Coordinator.

4. Indicate how the facility plans to

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F 689	Continued From page 3 pm with the Activity Assistant who revealed that during the late afternoon on 5/16/24, while in the hall outside Resident #1's room, she observed the Maintenance Director operate the mechanical lift to put Resident #1 in bed. She reported she was not sure if another staff member was present with the Maintenance Director at the time of the observation because the privacy curtain was pulled. The Activity Assistant stated Resident #1's normal routine was to spend the day in her wheelchair for activities and then go back to bed after the scheduled afternoon activities. An interview with the Maintenance Director on 6/05/24 at 3:13 pm revealed she was completing maintenance on a wheelchair in the hall in the afternoon on 5/16/24, after 3:00 pm but not sure of the exact time, when NA #2 asked her to assist with the Resident #1's transfer back to bed with the mechanical lift. The Maintenance Director stated she was only present in Resident #1's room during the transfer to bed and Resident #1 did not report any pain while she was in the room. A telephone interview was conducted on 6/05/24 at 2:49 pm with Nurse Aide (NA) #2 who reported she was assigned to Resident #1 on 5/16/24 during the 7:00 am-3:00 pm shift. NA #2 stated she looked in the hall to find a staff member to assist with Resident #1's transfer with the mechanical lift but she was unable to remember what time. NA #2 reported the Maintenance Director was in the hall and offered to assist with Resident #1's transfer. NA #2 stated the Maintenance Director operated the mechanical lift to assist with the transfer under her direction while she positioned Resident #1 on the bed. NA #2 stated Resident #1 did not report any pain or discomfort at the time of the transfer, and she did	F 689	monitor its performance to make sure that solutions are sustained. The facility's Nursing Administration staff will monitor current and newly admitted residents that use a mechanical lift by observing 5 random residents per week for 24 weeks being transferred with a mechanical lift to ensure the lift is being properly conducted and the lift is being performed by trained nursing staff members. The identified trends or issues from the monitoring will be presented by the DON or designee and discussed with the team weekly during the Morning Quality Improvement meetings for 24 weeks, and then discussions with the Quality Assurance Committee meeting monthly for 6 months for further recommendations and indicated. The Director of Nursing is responsible for the continued compliance for F689. Compliance Date is 6/28/24	

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not observe any discoloration or edema. NA #2 reported her normal care routine for Resident #1 was after she ate breakfast, she would get bathed, and then Resident #1 would then be lifted into the wheelchair. NA #2 stated Resident #1 would remain in the wheelchair for the rest of the shift and would ask to go back to bed at the end of her shift (3:00 pm) or she would stay up and go back to bed during the 3:00 pm-11:00 pm shift.

Review of NA #2's written statement provided to the facility (no date) revealed that on 5/16/24 on the 7:00 am-3:00 pm shift she completed a head-to-toe bath and prepared Resident #1 for transfer with the mechanical lift. NA #2 stated she popped her head out into the hall for assistance and the Maintenance Director asked if she needed assistance. NA #2 stated Resident #1 did not report pain or discomfort. NA #2 stated that later in the day, approximately 2:30 pm she had another nurse aide that she could not remember assist her to get Resident #1 back to bed. NA #2 stated she again gave Resident #1 a full head-to-toe bath and did not observe any injury.

A follow-up telephone interview was conducted with NA #2 on 6/06/24 at 10:32 am to clarify the timeframe of the mechanical lift transfer that was completed on 5/16/24 with the Maintenance Director after review of the written statement provided by the facility. NA #2 stated she only worked the 7:00 am-3:00 pm shift on 5/16/24 and she thought the Maintenance Director assisted during the morning transfer because Resident #1 did not normally go back to bed before she left at 3:00 pm. NA #2 was notified by this surveyor that she was assigned to Resident #1 on 5/16/24 from 7:00 am until 11:00 pm based on the

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schedule provided by the facility. NA #2 stated she did not recall working a double shift on 5/16/24 but may have. NA #2 stated she thought the Maintenance Director assisted her with Resident #1's transfer in the morning to the wheelchair but now she stated it may have been the afternoon transfer back to bed. NA #2 stated she just did not know, but maybe she gave Resident #1 the bath in the morning, and she got help from someone else to get Resident #1 out of bed in the morning and the Maintenance Director helped get Resident #1 back to bed later in the afternoon.

A telephone interview was conducted on 6/06/24 at 9:43 am with NA #3 who was assigned to Resident #1 on the 11:00 pm-7:00 am shift on 5/16/24. NA #3 revealed she did not transfer Resident #1 out of bed during the shift but would have offered toileting to Resident #1 throughout her shift. NA #3 was unable to recall if Resident #1 required care, but NA #3 stated she did not recall any discoloration to Resident #1's right thigh if care was performed and no pain was reported.

An interview with NA #1 on 6/06/24 at 9:45 am revealed she was assigned to Resident #1 during the 7:00 am-3:00 pm shift on 5/17/24. NA #1 reported Resident #1 was "acting odd" (not herself, sleeping more) that morning and was more difficult to wake up on that morning. NA #1 stated she returned to Resident #1's room around noon and Resident #1 was awake and asked to be assisted out of bed to participate in a planned activity at the facility. NA #1 stated she noticed before she transferred Resident #1 out of bed that Resident #1's right leg was swollen more than her other leg and she stated Resident #1

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reported she had pain, but she was not sure if she could recall seeing bruising. NA #1 stated Resident #1 stated her leg was okay and she wanted to get out of bed for the planned activity, so NA #1 got Resident #1 out of bed with the assistance of NA #7 by the mechanical lift. NA #1 stated she told Resident #1 she would look at her leg more after the activity and Resident #1 left for the activity. NA #1 reported that Resident #1 was assisted back to bed by NA #4 and NA #7 after the activity. NA #1 stated after Resident #1 was back in bed she felt Resident #1's right leg and it was warm and felt like a ball was on her leg, so she notified Nurse #2 and Nurse #3.

Review of NA #1's written statement provided to the facility on 5/20/24 revealed NA #1 reported on 5/17/24 at 11:30 am Resident #1 was placed in the wheelchair and stated it felt like they (Resident #1) were sitting on something. NA #1 stated she made sure the pad was not bunched under Resident #1 and Resident #1 stated she was okay and wanted to go to the party. After the activity Resident #1 was placed back to bed by another nurse aide and when NA #1 went to check on Resident #1, Resident #1 reported her leg was hurting and she wanted pain medication. NA #1 stated she notified the nurse when Resident #1's told her the leg hurt.

A follow-up interview was conducted with NA #1 on 6/06/24 at 5:35 pm to clarify statements provided during the initial interview after reviewing the statement NA #1 provided to the facility which did not mention the observation of swelling or reported pain. NA #1 stated when she prepared to get Resident #1 out of bed around noon on 5/17/24 she observed Resident #1's right thigh to be swollen more than the left leg and recalled a

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light bluish/greenish discoloration to the middle of the right thigh area. NA #1 stated Resident #1 did not report pain prior to getting out of bed, but when Resident #1 was placed in her motorized wheelchair she stated it felt like she was sitting on a ball. NA #1 stated she made sure the pad under Resident #1 was flat and Resident #1 left for the activity.

An interview was conducted on 6/05/24 at 1:45 pm with NA # 4 who revealed she assisted Resident #1 back to bed after the facility activity on 5/17/24 with NA #7. NA #4 stated Resident #1 did not report pain during or after the transfer with the mechanical lift.

An attempt to interview NA #7 on 6/06/24 at 12:00 pm was unsuccessful.

On 6/07/24 the Administrator provided a written statement dated 6/07/24 by NA #8 who reported she assisted NA #1 with Resident #1's transfer out of bed in the morning on 5/17/24. NA #8 noted that Resident #1 did not report any pain and went to the activity. NA #8 reported NA #4 and NA #7 assisted Resident #1 back to bed after the activity. NA #8 reported Resident # 1 reported her leg hurt later in the evening and she notified the nurse.

Review of the staff assignment schedule provided by the facility for the dates of 5/16/24 through 5/18/24 revealed NA #8 was not listed on the schedule. NA #8 was not identified in previous interviews as the NA that assisted NA #1 with Resident #1's transfer out of bed on 5/17/24.

An interview was conducted on 6/05/24 at 3:54 pm with Nurse #3 who revealed she was notified

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by NA #1 in the afternoon on 5/17/24 about Resident #1's report of pain to the right thigh. Nurse #3 stated she assessed Resident #1 in bed and when she touched the right thigh it was warm to touch and felt like "a knot" was there. She stated she asked Nurse #2 to come and assess Resident #1 because she (Nurse #3) was a new nurse, and she was concerned that Resident #1 could have a blood clot. Nurse #3 stated a video call was performed with the NP and Nurse #2 to assess Resident #1. Nurse #3 stated she was not aware of the concern with Resident #1's right thigh prior to NA #1 reporting her concerns. Nurse #3 reported she did not see Resident #1 in her wheelchair that morning (5/17/24) which was not normal for her. Nurse #3 explained that normally Resident #1 was in the motorized wheelchair going past the nursing station on her way to activities. She revealed she did not see Resident #1 out of bed prior to attending the facility activity on 5/17/24 in the afternoon.

The nursing progress note dated 5/17/24 at 5:01 pm by Nurse #2 revealed Resident #1 complained of discoloration to the right thigh area. Nurse #2 observed bluish/purple discoloration to the top of the right thigh area with edema to the entire thigh. Resident #1 reported pain when assessed and the Nurse Practitioner (NP) was notified. Orders were obtained for an antibiotic twice a day for 7 days for possible cellulitis of the right lower extremity and a venous doppler (ultrasound to measure blood flow through blood vessels) of the right lower extremity to rule out deep vein thrombosis (DVT or blood clot).

The Occurrence Report with date of occurrence noted as 5/17/24 revealed Nurse #2 noted that on

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5/17/24 at 2:30 pm Resident #1 was noted to have severe pain of the right thigh, the skin was warm, and discoloration (bluish/purple) was noted. The NP was notified, and new orders were obtained. The supervisor comments provided by the facility with the report revealed that the interdisciplinary team determined the area of injury was caused from the lift "pinching" edematous areas of Resident #1's leg.

The Medication Administration Record (MAR) revealed Resident #1 was administered 650 mg of acetaminophen for a reported pain level of 10 out of 10 on 5/17/24 at 5:40 pm.

Resident #1 had a physician order dated 5/17/24 for venous doppler to right lower extremity due to edema, discoloration, and warmth to rule out DVT.

Resident #1 had a physician order dated 5/17/24 for cephalexin (antibiotic) 500 mg 1 capsule every 12 hours for possible cellulitis of the right lower extremity.

A telephone interview with Nurse #2 on 6/05/24 at 4:00 pm revealed she was notified by Nurse #3 in the afternoon on 5/17/24 that Resident #1 was observed to have edema and discoloration to the right thigh. Nurse #2 stated she observed Resident #1 in bed with discoloration (purple, green, and blue) in an irregular shape on the right thigh from the top left of center of the thigh towards the groin area. Nurse #2 stated the right thigh was swollen when compared to the left thigh. Nurse #2 reported Resident #1 did not initially report pain, but when Nurse #2 pressed on the bottom of the right foot towards the ankle to assess for a possible blood clot Resident #1

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yelled out in pain. Nurse #2 stated Resident #1 reported she believed the injury occurred from the sling during a transfer with the mechanical lift, but she did not say when she thought it occurred. Nurse #2 stated that NA #1 reported to her that Resident #1 was kind of different that morning (5/17/24) because she usually would ring the call bell for the bedpan, but she had not asked for the bedpan and slept more than normal. Nurse #2 reported when she returned to work on 5/20/24 she was notified that Resident #1 was admitted to the hospital, so she completed the occurrence report related to the discoloration and notified Nurse #3 and NA #1 to write their statements.

The nursing progress note dated 5/18/24 at 4:29 pm by Nurse #1 revealed Resident #1 reported pain to the right upper thigh with moderate amount of edema and discoloration as noted last evening. The NP was notified of increased pain and edema and obtained orders for an x-ray of the right hip and right femur (thigh bone), and hydrocodone (a narcotic pain medication) 5 milligrams (mg)/acetaminophen 325 mg every 6 hours as needed for pain.

Resident #1 had a physician order dated 5/18/24 for hydrocodone 5 milligrams (mg)/acetaminophen 325 mg every 6 hours as needed for pain.

A physician order dated 5/18/24 was in place for an x-ray of the right hip and femur.

Review of the MAR revealed Resident #1 was administered hydrocodone/acetaminophen on 5/18/24 at 1:30 pm for pain. No pain level was listed on the MAR.

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A telephone interview was conducted on 6/06/24 at 8:16 am with the NP who revealed she participated in a video call on 5/17/24 to assess Resident #1's right thigh. The NP stated Resident #1's right thigh was much larger than the left thigh with a more pronounced skin fold approximately 8 inches below the groin that had erythema (an abnormal redness of the skin due to the accumulation of blood in capillaries) and was reported by Nurse #2 to be warm to the touch. The NP reported ecchymosis (bruising) was noted horizontally across the right thigh and her initial concern was a possible blood clot or cellulitis (skin infection). The NP stated she ordered the antibiotic and venous doppler, but the next day with increased pain and swelling she ordered the hip and femur x-ray to rule out an injury. The NP stated Resident #1 denied any known injury or fall during the video call on 5/17/24. The NP stated the location of the ecchymosis was similar to the location the mechanical lift sling would be located on Resident #1's leg when in use. The NP stated with Resident #1's obesity, the size of the thigh, and the amount of soft tissue in the thigh, the bruising could have been delayed. She also stated the increased edema present on Resident #1's right thigh would have made the leg heavier which could also delay the observation of the bruising. The NP stated Resident #1's use of blood thinners increased her risk for bleeding and made her more susceptible to this type of injury.

A nursing progress note dated 5/18/24 at 4:31 pm by Nurse #1 revealed Resident #1 was unable to complete the mobile x-ray due to weight limits of the x-ray machine and was transferred to the emergency department (ED) for further evaluation of the right upper thigh.

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Review of Nurse #1's written statement provided to the facility on 5/18/24 revealed she assessed Resident #1's right thigh in bed and the front and back of the thigh was swollen, discolored with blue/purple, and a reported 6 out of 10 pain rating. Nurse #1 stated that Resident #1 reported she believed it was the mechanical lift sling that hurt her leg.

An interview with Nurse #1 on 6/05/24 at 1:26 pm revealed on 5/18/24 sometime after breakfast, she was notified by NA #6 that Resident #1's right thigh was swollen and discolored. Nurse #1 stated Resident #1 reported pain to the right thigh which increased when she was turned and repositioned to have care provided. Nurse #1 stated Resident #1's skin was intact, the right thigh was swollen, and had bluish/purple discoloration on the thigh. Nurse #1 stated she asked Resident #1 if this was a new incident or previous injury and Resident #1 reported she unsure of what exactly happened, but she felt the injury occurred from the strap of the sling used for the mechanical lift and that it may have happened when she was put back to bed. Nurse #1 stated she asked Resident #1 if the injury occurred yesterday (5/17/24) or the day before (5/16/24) and Resident #1 stated she was not sure if it was yesterday or day before. Nurse #1 reported Resident #1 stated it was not her NA who put her to bed, but Resident #1 would not tell her who it was. Nurse #1 stated she believed Resident #1 did not feel comfortable reporting who performed the transfer. Nurse #1 stated on 5/18/24 she notified the Director of Nursing and the Administrator about Resident #1's report that she believed the injury was caused by the mechanical lift. Nurse #1 stated Resident #1 refused the

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recommended ED evaluation initially, but stated later in the day the right thigh was noted to have increased edema and the x-ray was unable to be completed at the facility, Resident #1 consented to be transferred to the ED for evaluation.

The hospital record with an admission date of 5/18/24 revealed Resident #1 presented to the ED for right leg swelling, mild discomfort, and bruising following a suspected injury from mechanical lift. An ultrasound of the right lower extremity was performed on 5/18/24 and confirmed a large hematoma (a collection of blood that occurs when blood leaks from vessels and pools in nearby tissue) of the right thigh which measured 12.5 centimeters (cm) x 10.6 cm x 17.6 cm. Resident #1's hemoglobin (protein in the red blood cells) level dropped from 13 grams/deciliter (g/dL) to 7.7 g/dL (the normal hemoglobin level for women is 12-16 g/dL) and the medication prothrombin complex concentrate (an anticoagulant reversal agent) was administered, and 2 units of packed red blood cells were transfused. Resident #1 was admitted to the intensive care unit with acute blood loss and hemorrhagic shock (a life-threatening condition that occurs when the body loses too much blood in a short period of time) secondary to traumatic right leg hematoma. A repeat ultrasound of the right lower extremity was performed on 5/19/24 with the findings of large 29 cm complex fluid collection consistent with a hematoma that may be on the basis of pseudoaneurysm (localized hematoma that occurs outside of an artery when the vessel wall is damaged) distal medial thigh on the right. On 5/20/24 a right lower extremity ultrasound was performed to evaluate the lower extremity arteries with the following findings: a large right medial

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thigh hematoma not significantly changed in size since the prior examination with a region of flow within the hematoma measured at 1.2 cm was noted as suspicious for a pseudoaneurysm or arteriovenous (AV) fistula (an abnormal connection between an artery and vein). A consultation was initiated with vascular surgery related to the ultrasound findings concerning pseudoaneurysm and a right lower extremity arteriogram (an imaging test with dye to determine if blood vessels are blocked, narrowed, enlarged, or malformed) with coil embolization (a small soft metal coil placed inside aneurysm to block blood flow) was performed to Resident #1 on 5/21/24 by the vascular surgeon. Resident #1 required seven units of packed red blood cells transfused during the hospitalization and was transferred back to the facility on 5/31/24.

An interview was conducted on 6/05/24 at 2:29 pm with the Physician who revealed she did not observe Resident #1's injury prior to the hospitalization, but she stated Resident #1 was alert and oriented and had reported at the hospital that the injury was caused by the mechanical lift. The Physician stated Resident #1 was non-ambulatory and used a power wheelchair so she would not be able to say exactly how the injury occurred, but it was possible the mechanical lift sling caused the injury. The Physician stated that due to Resident #1's obesity and immobility she would have expected the bruising to be more prominent on the back of the right thigh which Resident #1 would not have been able to visualize and may have been more difficult for staff to observe. The Physician stated it was possible that the bruising could have taken an extended period of time to develop due to Resident #1's size and how deep

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the injury was, but she was not able to say for sure.

The nursing progress note dated 5/31/24 at 6:55 pm by Nurse #5 revealed Resident #1 was re-admitted to the facility from the hospital and presented with swelling and a hematoma to the right thigh which was hard to touch and purple in color.

The nursing progress note dated 6/03/24 at 4:56 pm by Nurse #2 revealed she was called to Resident #1's room for a bleeding hematoma. A moderate amount of blood was present, and the center area of right thigh hematoma was noted to be oozing blood. Nurse #2 placed a pressure dressing with 6 gauzes folded and applied with tape to secure to the right thigh. Nurse #2 notified the dialysis clinic to report to the charge nurse the resident's recent bleeding and was notified that dialysis would notify the nephrologist and may send to the ED due to the bleeding.

A progress note dated 6/03/24 at 4:24 pm by the Social Service Assistant revealed Resident #1 was transferred to the hospital from dialysis for a change in condition.

During a follow-up interview with Nurse #2 on 6/06/24 at 3:15 pm she revealed she was called to Resident #1's room on 6/03/24 because it was reported that the hematoma was bleeding. Nurse #2 stated she observed blood coming from the center of the hematoma on the right thigh which looked like a fistula (abnormal connection between two parts of the body that don't normally connect and can form tunnels that allow bodily substances like blood to travel where they shouldn't). Nurse #2 stated she applied a

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pressure dressing to Resident #1's right thigh and called the dialysis center nurse to report Resident #1's bleeding that had occurred before Resident #1 left the facility for dialysis. Nurse #2 stated Resident #1 went to the dialysis center as scheduled and was transferred from the dialysis center to the hospital related to the bleeding hematoma.

A follow-up telephone interview was conducted on 6/06/24 at 1:00 pm with the Physician who reported she did not have the opportunity to see Resident #1 since her return from the hospital on 5/31/24 and before being transferred back to the hospital on 6/03/24. The Physician reported she was aware Resident #1's hematoma was bleeding on 6/03/24 and stated if Resident #1 was bleeding in the location of the hematoma and she required hospitalization it was associated with the initial hematoma injury.

An interview with the Director of Nursing (DON) on 6/05/24 at 2:43 pm revealed she did not speak to Resident #1 prior to her transfer to the hospital so she was unable to say exactly what happened, but she stated Resident #1 reported she believed it was from the lift sling when she got back to bed.

The Administrator was notified of immediate jeopardy on 6/5/24 at 5:55 pm.

The facility provided the following credible allegation of immediate jeopardy removal:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

On 5/16/24, the Maintenance Director was asked

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by Nurse Aide #2 to assist with the controls on the Mechanical Lift while she transferred the resident on the sling from the motorized wheelchair to her bed. Resident #1 had no complaints or signs of pain with the transfer.

Per the Certified Nurse Assistant's statement on 5/17/24 at around 11:30AM, Resident #1 reported she felt like she was sitting on something in her wheelchair, and the Certified Nurse Assistant made sure the lift sling pad was not bunched up under her and the resident said she was ok and went on to an activity. The Certified Nurse Assistant checked on Resident #1 later that day and the resident reported that her leg was hurting, and she wanted pain medication. Resident #1 reported a discoloration to the right thigh that was assessed in her bed by the Licensed Nurse to have a bluish/purple discoloration to right thigh with edema present. The Nurse Practitioner was contacted by the Licensed Nurse and orders were obtained to administer pain and antibiotic medications, x-ray and doppler.

On 5/18/24, the Licensed Nurse was informed by the Certified Nurse Assistant regarding the resident's swollen right thigh, and she assessed the resident's right inner, front and back of thigh that appeared swollen and discolored blue/purple. Resident #1 reported pain of 6 out of 10. Resident #1 reported to the Licensed Nurse that she had gotten up yesterday, 5/17/24 for an activity and she was uncomfortable in her motorized wheelchair and believed the lift sling had hurt her leg. Resident #1 was transferred to the emergency department when the ordered x-ray could not be performed in the facility.

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As a result of the 5/17/24 Occurrence Report also known as an incident report, which is a document that provides the details of an incident, new interventions for Resident #1 were put in place in order to prevent further serious adverse outcome from recuring. The interventions included a 4-person assist when transferring Resident #1 in the Mechanical Lift and pad resident's right leg with towels while using the lift. The manufacturer's information for the mechanical lift was reviewed and there was nothing in there contradicting the use of a towel. The Administrator has ordered a special sling just for the resident that has extra padding and extended leg coverage. The resident will be seen by therapy when she returns back to the facility to ensure that the transfer is safe, which is normal practice upon readmission of a resident. The 4-person transfer is so two people can operate the lift and 2 people can support each leg to relieve pressure. The decision to see therapy was made before 6/6/24 as it is standard practice for a readmit to see therapy when they return.
The new interventions are listed in the Resident's Summary also known as their Care Guide by the Safety Nurse and updated on Resident #1's Activities of Daily Living care plan by the Resident Assessment Coordinator also known as the Minimum Data Set Nurse.

On 6/5/24, the facility's Safety Nurse identified the current residents with a transfer status of a Mechanical Lift through their lift transfer assessment form. On 6/6/24, the facility's Administrative staff are conducting interviews with residents that are interviewable and asking them if they feel safe during transfers on the mechanical lift. The Administrative nursing staff are completing body audits for residents that are

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not interviewable. This is to ensure there are no other residents affected.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

On 6/5/24 to 6/6/24, the facility's Director of Nursing and Staff Development Coordinator conducted the education with the facility staff to prevent serious adverse outcomes from occurring or recurring again. The Nursing staff were educated on the following. All total lifts are a 2-person assist at all times. The nursing staff must use the correct lift sling pad that the resident is color coded for, and it will be on the outside of the resident's door. The Nursing staff need to be cautious and careful when transferring residents that are at high risk for injury, such as on anticoagulants.

The Staff Development Coordinator will educate staff members, if any, on vacation or employed as needed when they return to work prior to working on the floor. The Staff Development Coordinator will also educate the new employees upon hire.

Alleged immediate jeopardy removal date: 6/7/24.

The credible allegation of Immediate Jeopardy Removal was validated by onsite verification on 6/06/24 as evidence by interviews with direct care staff, alert and oriented residents, record review, and observations.

Record review of Resident #1's care guide revealed Resident #1's mechanical lift needs were updated to include a 4-person assist team

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with a towel placed under Resident #1's right leg when being transferred.

Interviews were conducted with direct care staff assigned and confirmed education was provided regarding Resident #1's specific mechanical lift transfer requirements with no concerns identified.

Interviews were conducted with alert and oriented residents who required the use of a mechanical lift for transfers reported they felt safe when staff transferred them with the mechanical lift. Body audits were reviewed with no newly identified concerns.

Nursing staff were interviewed and reported education was provided which included that all residents that required a total lift transfer with a mechanical lift required a minimum of two (2) nursing staff members at all times. The education included that each resident was assigned a specific color-coded lift sling which was to be used for the mechanical lift transfer, and that the resident specific color-coded sling information was posted on the door of each resident's room. The staff were to be careful when transferring residents that were at high risk for injury including residents that were on blood thinner medications.

The education forms were reviewed, and they indicated the topics reviewed, who provided the education, and staff signatures for those staff educated in person. The staff education was dated 6/05/24 and 6/06/24.

Observations were conducted on 6/06/24 of all residents that were identified by the facility that required a total mechanical lift for the color-coded

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F 689	Continued From page 21 lift sling information posted on the door of each resident room with no concerns identified. Observations of total mechanical lift transfers confirmed two staff members were present and the color-coded lift sling matched the information on the resident door. The facility's Immediate Jeopardy removal date of 6/07/24 was validated.	F 689		
F 728 SS=D	Facility Hiring and Use of Nurse Aide CFR(s): 483.35(d)(1)-(3) §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency	F 728		6/28/24

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F 728	Continued From page 22 A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure staff who performed a job responsibility of a nurse aide (NA) had completed a training and competency evaluation program and was competent to provide nursing and nursing related services when the Maintenance Director assisted NA #2 with transferring Resident #1 from her wheelchair to bed utilizing a mechanical lift on 5/16/24. This deficient practice was for 1 of 7 staff reviewed who performed nursing related services. The findings included: Resident #1 was admitted to the facility on 10/05/21. An interview was conducted on 6/05/24 at 1:45 pm with the Activity Assistant who revealed that during the late afternoon on 5/16/24 she observed the Maintenance Director operate the mechanical lift to put Resident #1 in bed. She reported she was not sure if another staff member was present with the Maintenance Director at the time of the observation because the privacy curtain was pulled. The Activity	F 728	White Oak Manor - Burlington ensures staff are competent to provide nursing and nursing related services. 1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 5/30/24, The Maintenance Director received disciplinary action for assisting with the mechanical lift and received education on 6/5/24 on not using or assisting nursing staff with mechanical lifts. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. An audit was completed on 6/5/24 by the Safety Nurse. The Safety Nurse identified the current residents with a transfer status of a Mechanical Lift through their lift transfer form. On 6/6/24, the facility's Social Services Department and Safety	

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F 728	Continued From page 23 Assistant stated she also worked as a NA at the facility, and she reported that she had to complete mechanical lift training and take a test before she could begin working with the residents. An interview with the Maintenance Director on 6/05/24 at 3:13 pm revealed she was completing maintenance on a wheelchair in the hall in the afternoon on 5/16/24 when NA #2 asked her to assist with the Resident #1's transfer back to bed with the mechanical lift. The Maintenance Director stated she did not tell NA #2 she was not trained to operate the mechanical lift because she did not know she needed to be trained. The Maintenance Director confirmed she had not received training in the use of the mechanical lift, and she was not trained to work as a nurse aide. Review of NA #2's written statement provided to the facility (no date) revealed that on 5/16/24 on the 7:00 am-3:00 pm shift she completed a head-to-toe bath and prepared Resident #1 for transfer with the mechanical lift. NA #2 stated she popped her head out into the hall for assistance and the Maintenance Director asked if she needed assistance. NA #2 stated she was very unaware of the fact that the Maintenance Director was not "officially" lift trained so she accepted her offer to assist. NA #2 stated the Maintenance Director used the remote of the mechanical lift to raise Resident #1 and place her in the wheelchair. A telephone interview was conducted on 6/05/24 at 2:49 pm with Nurse Aide (NA) #2 who reported she was assigned to Resident #1 on 5/16/24 during the 7:00 am-3:00 pm shift. NA #2 stated on 5/16/24 she was ready to transfer Resident #1	F 728	Nurse conducted interviews with residents that are interviewable and asked them if anyone other than a nurse or a certified nursing assistant transferred or assisted them in a lift. The Social Services Department and Safety Nurse also interviewed staff members for residents that are not interviewable were conducted on 6/6/24 and asked them if they witnessed anyone or were involved other than a nurse or certified nursing assistant transferring the residents in a mechanical lift. This is to ensure there were no other residents affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 6/5/24 to 6/6/24, the facility's Director of Nursing and Staff Development Coordinator continued education with the facility staff to prevent serious adverse outcomes from occurring or recurring again. The Nursing staff were educated on the following. The nursing staff must be fully trained and signed off by the Staff Development Coordinator before using any lift in the facility. The other staff are aware of who is trained on using the mechanical lift because the nursing staff do not work on the floor until they complete this training. The staff member assisting another staff member with the lift must be the clinical nursing staff or another Certified Nursing Assistant that is fully trained. Housekeeping, dietary, laundry, and department heads, unless	

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	345301	A. BUILDING _____ B. WING _____	C 06/07/2024

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F 728	Continued From page 24 with the mechanical lift when she looked in the hall for another staff member to assist and the Maintenance Director was in the hall outside the room. NA #2 stated she told the Maintenance Director she was ready to transfer Resident #1 with the mechanical lift and was looking for someone to assist. NA #2 stated the Maintenance Director offered to assist with Resident #1's transfer so NA #2 accepted the Maintenance Director's assistance since Resident #1 was ready to be transferred. NA #2 stated she was not aware the Maintenance Director was not trained to operate the mechanical lift and the Maintenance Director did not report she was not trained when she offered to assist with Resident #1's mechanical lift transfer. NA #2 stated the Maintenance Director operated the mechanical lift to assist with the transfer under her direction while she positioned Resident #1 on the bed. An interview was conducted on 6/06/24 at 9:53 am with the Safety Nurse who revealed she was responsible along with the Staff Development Coordinator to train staff on the use of the mechanical lift. The Safety Nurse reported she had not trained the Maintenance Director on the use of the mechanical lift, and she stated staff were not to operate the lifts until trained. During an interview on 6/06/24 at 5:30 pm the Staff Development Coordinator reported she trained staff on the use of mechanical lifts with the Safety Nurse during orientation. The Staff Development Coordinator stated once the training was completed, staff were competent to use the mechanical lifts. She stated she had not provided training to the Maintenance Director for use of the mechanical lifts. The Staff Development Coordinator stated mechanical lift training was	F 728	they are a licensed nurse, are not to assist with any type of transfer or repositioning. Ant nursing or Certified Nursing Assistant students are not to use the lift. The non-clinical staff were educated by the Director of Nursing and Staff Development Coordinator. The education included to not use any lift device or provide care in the facility, and if asked to assist with care or the lift, they must get a nursing staff member and immediately tell Administration. Newly hired facility staff members, and if any staff on vacation or employed as needed when they return to work prior to working on the floor will received this education during their job specific orientation by the Staff Development Coordinator. 4. Indicate how the facility plans to monitor its performance to make sure solutions are sustained. The facility's Nursing Administration staff will monitor current and newly admitted residents that use a mechanical lift by observing 5 random residents per week for 24 weeks that are being transferred with a mechanical lift ensure the lift is being properly conducted and the lift is being performed by trained nursing staff members. The identified trends or issues from the monitoring will be presented by the DON or designee and discussed with the team weekly during the Morning Quality	

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F 728	Continued From page 25 important to ensure that residents and staff were safe and avoid injury when using the mechanical lift. An interview with the Director of Nursing (DON) on 6/05/24 at 2:43 pm revealed she was notified by staff that the Maintenance Director assisted NA #2 to get Resident #1 back to bed on 5/16/24 with a mechanical lift. The DON stated the Maintenance Director was not trained to use the mechanical lifts, she was not trained to work as a nurse aide, and she was not allowed to assist NA #2 with Resident #1's transfer. An interview was conducted on 6/06/24 at 11:19 am with the Administrator who revealed the Maintenance Director was competent to use the lift because she understood how to use the mechanical lift and maintained the lifts, but she should not have assisted NA #2 with Resident #1's mechanical lift transfer. The Administrator reported he spoke with the Maintenance Director and reviewed the scope of her job description, and she was notified that involvement with nursing services was out of her scope.	F 728	Improvement meetings for 24 weeks, and then discussions with the Quality Assurance Committee meeting monthly for 6 months for further recommendations as indicated. The Director of Nursing is responsible for continued compliance for F728. Compliance Date is 6/28/24.	