STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345167	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YADKIN NURSING CARE CENTER	903 W MAIN STREET YADKINVILLE, NC 27055

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 12/16/24 through 12/19/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #31O011.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 12/16/24 through 12/19/24. Event ID# 31O011.The following intakes were investigated: NC00216514, NC00216469, NC00215920, NC00215252, NC00211078, and NC00209606. 2 of the 19 complaint allegations resulted in deficiencies.	F 000		
F 689 SS=G	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 observation, record review, and staff interviews, the facility failed to safely transfer a resident from a wheelchair to bed when one staff member performed a sit to stand lift transfer (Resident #164) for 1 of 3 residents reviewed. Resident #164 was assisted with a sit to stand lift transfer by a nurse aide and Resident #164 sustained a laceration to the back of her head	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 01/09/2025

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when she fell during the transfer causing pain and requiring sutures.

The findings included:

Resident #164 was admitted to the facility on 04/18/2014. Her current diagnoses included dementia.

A review of Resident #164's Physician Orders revealed no order for an anticoagulant.

Review of an activities of daily living care plan dated 8/13/21 included the following intervention: Transfers- sit-to-stand lift.

Review of the quarterly Minimum Data Set (MDS) dated 10/18/23 indicated that Resident #164 had severely impaired cognition and required one-person physical assistance with transfers.

Review of a document titled "Fall" dated 11/05/23 read in part, "Writer made aware by [nurse aide] that resident had fell from sit to stand, writer entered room to observe resident lying on floor with blood coming from her head. Immediate pressure was applied, writer went to call [medical doctor/responsible person and emergency medical services]. Nurse maintained pressure to laceration and vital signs were obtained. Vital signs were blood pressure139/73, pulse 66, respirations 19, temperature 96.5, oxygen saturation 97% on room air. Resident #164's level of pain was 8 of 10 and she was alert and oriented to person, place, time, and situation. The fall report determined the root cause to be failure of staff to follow the lift policy.

Nurse Aide #1 (NA#1) was interviewed on

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12/19/24 at 4:46 PM. NA #1 stated it was her first shift working alone on the floor and she volunteered to assist the resident to bed. She stated she was not very familiar with Resident #164 and was not aware of her limitations. NA #1 stated it was her first time using the lift by herself. NA #1 stated Resident #164 was sitting in her wheelchair and she put her feet onto the lift and then she just held on to the lift without being strapped on it. She stated Resident #164 told her she did not need the sling around her, that she just held on to the handles of the lift during transfer. NA #1 stated as soon as she moved the lift away from the wheelchair Resident #164 fell. She stated Resident #164 was not standing completely up when she fell backwards and hit her head. NA stated that Resident #164 was bleeding, and she stayed with her and called to the nurse for assistance. She stated the nurse came and assessed the Resident and sent her to the emergency room. NA #1 stated she had received training and completed a check-off prior to using the sit to stand lift. She stated when she talked to the Director of Nursing afterward she realized she should have transferred the Resident as she had been taught. NA #1 stated she received retraining on all lifts prior to returning to work on the floor. She stated since the incident she always used two people when using any lift.

Review of a document titled "Review to Ensure Quality" 11/05/23 revealed an investigation was completed with the root cause analysis identified as "Aide used lift without second person. She did not use lift pad or leg straps. Resident fell to floor due to staff (CNA) failure to follow proper process with use of lifts."

Review of a nurses note by the nurse dated

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11/05/23 at 7:03 PM read in part, "Writer made aware by [nurse aide] that resident had fell from sit to stand, writer entered room to observe resident lying on floor with blood coming from her head. Immediate pressure was applied, writer went to call [medical doctor/responsible person and emergency medical services]. Recommendation to send to emergency department."

Review of the Emergency Department provider note revealed Resident #164 had headache pain 10/10, blood loss was minimal, no anticoagulation, no visual change, no fever, no numbness, no abdominal pain, no nausea, no vomiting, and no loss of consciousness. Resident #164 had a 0.5 centimeter laceration to her scalp which was closed with two absorbable sutures to control bleeding. She received Tylenol 650 milligrams for pain. She was deemed stable and appropriate for discharge back to the facility. Resident #164 was not admitted to the hospital and was discharged back to the facility from the emergency department.

Review of a Radiology Report dated 11/05/23 from the emergency department read in part; radiology report indicated the head CT scan found no evidence of an acute brain bleed or abnormal findings within the skull, but did identify a small to moderate-sized swelling on the left posterior scalp; additionally, a CT scan of the spine showed no signs of recent fractures, misalignment, or bleeding in the surrounding tissues (CT scan is a diagnostic imaging procedure that uses a combination of X-rays and computer technology to produce images of the inside of the body.)

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The Director of Nursing (DON) was interviewed on 12/18/24 at 3:00 PM. The DON stated the former DON and Corporate Nurse Consultant immediately investigated the fall and put a plan of correction in place for the fall involving Resident #164. She stated NA #1 had been trained to use the sit to stand lift during orientation and had been checked off on the competency check list prior to using the lift. She stated the facility used three types of lifts and all staff who use the lifts were trained during orientation and checked off during yearly competencies. She stated after the incident all the resident transfer/statuses were reviewed and updated, and all the staff were reeducated on the lift procedures and the proper way to transfer a resident.

The facility implemented the following Corrective Action Plan with a completion date of 11/9/23.

1. On 11/5/23 The resident was assessed in the facility by the nurse on duty. Bleeding was noted to be coming from the resident's posterior head and the nurse applied pressure to affected area, completed a neurological assessment, obtained vital signs which included: temperature 96.5, pulse 66, blood pressure 139/73, and the On call Provider was called and an order was received to send to the local hospital for evaluation and treatment.

2. On 11/5/23 the Director of Nursing (DON) identified residents that were potentially impacted by this practice by completing a 100% audit on all current working mechanical lifts in the facility. This audit was completed by the maintenance director on 11/6/23. The results revealed 8 of 8 mechanical lifts were in appropriate and safe working order. On 11/6/23 there was no

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corrective action due to no deficient practice found during audits of mechanical lifts.
On 11/6/23 the DON inspected all lift pads for tears, frays, or broken parts. The audit revealed 100 of 100 lift pads were in good repair and working order, there were no frays, tears, or broken parts. On 11/6/23 there was no corrective action due to no deficient practice found during inspection of lift pads.
On 11/6/23 the DON audited careplan/kardexes for all current residents to ensure appropriate mechanical lifts were present on the Kardex to ensure proper transfer status. The results revealed 24 of 98 residents used a mechanical lift and had the type of lift identified on the careplan/kardex correctly. On 11/6/23 there was no corrective action for the current residents due to no deficient practice.
On 11/6/23 the DON audited all nurses (Registered Nurses (RNs) and Licensed Practical Nurses (LPNs)) and nurse aids to ensure lift training with skills checklist had been completed upon hire. This audit completed on 11/6/23. The results concluded 62 of 62 RNs, LPNs, and nurse aids had received lift training upon hire using the mechanical lift transfer safety education and skills checklist completed. On 11/6/23 there was no corrective action for those staff members because there was no deficient practice.

3. On 11/6/23 the DON and Staff Development Clinician (SDC) began inservicing all nursing (RNs and LPNs) and certified nurse assistants including agency on the mechanical lift safety policy. This training included all current staff and agency. This training included:
o When using any mechanical lift two caregivers should be present
o Before transferring a resident have the

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equipment needed re: sling
o If you have a question about any equipment ask the nurse or manager
This education and return skills demonstration will be incorporated into new hire orientation for all RNs, LPNs, and nurse aids (including agency) and will be ongoing.
The DON will ensure that any of the above identified staff who does not complete the in-service training by 11/8/23 will not be allowed to work until the training is complete.

4. The DON or designee will randomly monitor mechanical lift transfers weekly for four weeks and then monthly for two months beginning 11/13/23 to ensure staff are properly transferring residents. The Quality Assurance (QA) tool: ADL Care Provided for Dependent Residents will be used. Reports will be presented to the weekly QA Committee by the Administrator or DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA meeting. The weekly meeting is attended by the Administrator, DON, Minimum Data Set (MDS) Coordinator, Therapy, Health Information Manager (HIM) and the Dietary Manager (DM).

5. The facility's alleged compliance date was 11/9/23.

The Corrective Action plan was validated on 12/19/24 and concluded the facility had implemented an acceptable corrective action plan on 11/09/23. Interviews with current nursing staff including agency staff revealed the facility had provided education and training on mechanical lifts and how to safely transfer a resident using each type of mechanical lift utilized in the facility.

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F 689	Continued From page 7 Staff were observed using proper procedure for transfers using mechanical lifts. Each nursing staff member conducted competency sheets to verify knowledge of how to operate the mechanical lift. The audits conducted starting on 11/05/23 revealed the facility management observed transfers to ensure that proper transfer technique was being utilized by staff. The audits continued weekly through the validation date. The corrective action plan was reviewed with the Quality Assurance committee on 11/05/2023.	F 689		