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

PRINTED: 10/12/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 10/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(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	F 000		

An unannounced Medicare/Medicaid abbreviated standard survey was conducted 10/3/17 through 10/4/17. One complaint was investigated during the survey. Significant corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements.

The census in this 120 certified bed facility was 101 at the time of the survey. The survey sample consisted of 2 current Resident reviews (Residents #1 and #2).

F 309 SS=D 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING — F 309

483.24 Quality of life
Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:

(k) Pain Management.
The facility must ensure that pain management is

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dominic O'Sullivan — TITLE: Administrator — (X6) DATE: 10/20/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

(I) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on observations, staff interview and clinical record review the facility staff failed to provide the necessary care and services to attain the highest practicable physical well-being by failing to follow the physician orders for one of two residents in the survey sample, Resident #1.

During a transfer on 9/19/17 Resident #1 sustained a fracture to the right shoulder. The orthopedic physician's plan of care for the resident included the order for the use of a sling to the right arm. The facility staff failed to follow the order for the sling.

The findings included:

Resident #1 was admitted to the facility on 8/5/13 with diagnoses to include, but not limited to history of a stroke with right sided hemiplegia (paralysis on one side of the body) and displaced right humeral neck fracture (shoulder).

The current MDS (Minimum Data Set) at the time of the incident was an annual with an assessment reference date of 7/10/17. The resident scored a 13 out of a possible 15 on the Brief Interview for

F309
1
Corrective Action for resident found to have been affected by the deficient practice:
Resident #1

1. Physician Order: Sling was placed as ordered.
2. Care Plan, Kardex and TAR reflect Order.
3. All physicians orders, for last 45 days, for this individual resident reviewed to confirm all orders were accurately transcribed, actioned and documented.
4. Clinical Staff educated on Order for Sling and the application of sling by the Clinical Manger.

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Mental Status, indicating the resident's cognition was intact.

The State Survey Agency received an initial Facility Reported Incident (FRI) on 9/20/17. The report stated that on 9/19/17 two of two Hoyer lifts in the facility (total mechanical lifts) were not working. The CNA used a sit to stand mechanical lift to assist the resident. When assisting the resident with the sit to stand device the device stopped working. The CNA called out for assistance and the nurse came into the room as well as another CNA. During this process the resident was suspended by the lift straps, resulting in a displaced humeral neck fracture and non-displaced fracture of the olecranon process. The resident was lowered to the bed and the straps were disconnected. The resident was assessed and complained of pain to the right shoulder, therapeutic medication was administered. The physician and the family were notified. An order for an X-ray was obtained. The resident was sent to the ED (emergency department) for evaluation. An investigation was started and equipment was evaluated.

The X-ray reports dated 9/20/17 read:
1. Shoulder- Acute minimally displaced right humeral neck fracture.
2. Elbow Right-Questionable non-displaced fracture of the olecranon process.

The resident was evaluated at the ED on 9/20/17 and returned back to the facility that same day. The ED discharge diagnosis was nondisplaced fracture of proximal end of right humerus.

The Orthopedic follow up dated 9/22/17 read, in part:

F 309

II Other Residents Affected:

All residents were identified as potentially afffected by deficient practice

-Audit Medical Records to identify all Physicians Orders and/or consults for limb positioning or support devices (orthortic) during last 45 days.

III Measures and Systemic Changes:

-Therapy to complete screen on all orthortic devices to confirm correct application and use on initiation, annually and as needed.
Care Plan and Kardex will reflect orthotic Order.
-Education: 100% Clinical Staff education on application of the orthotic device/s.
-Doumentation: Licensed Staff will confirm orthotic device placement each shift and acknowledge on Medication Administration Record.
-Clinical Managers will review all new Consult Orders and/or Orthotic orders to confirm correct transcription and careplanning. This audit will be evidenced by the Clinical Manager/s signature on the Consult/Order .

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F 309	Continued From page 3 "...positive Right humeral neck fracture with minimal displacement. Plan: Sling to right UE (upper extremity). See orders. No use (R) UE, caution when transferring. F/U (follow up) 3 weeks." On 10/3/17 at 12:25 p.m., the resident was in bed attempting to eat lunch. The resident's speech was slurred. The right arm was not in a sling, the right hand was contracted. At 2:15 p.m., and 5:00 p.m., the resident was observed in bed. The right arm sling was still not on as ordered by the physician. On 10/3/17 at 5:15 p.m., the Nansmond unit manager was made aware of the observations of the sling not being on the resident as ordered. The unit manager then went into the resident's room. The sling was then placed on the resident. The unit manager then left the room and stated to this inspector, "I will educate the staff (on the use of the sling)". The findings was shared with the Administrator, the Corporate Nurse, the Interim Director of Nursing, and the Nansmond Unit Manager at the pre-exit meeting conducted on 10/4/17. The Nansmond unit manager stated the sling was used "to maintain a 90 degree angle and comfort".	F 309	-Documentation: All orthotic devices will be require shift documentation by the licensed nurse that device is placed per order (M.A.R) -Clinical Managers or designee will complete a witten audit of 100% of all orthotic devices once per month . IV: Performance Monitoring: 1. Nursing and Therapy will report outcomes of audit and oversight of orthotic devices to the facility Quality Assurance and Process Improvement Comittee. 2. Process Improvement for Orthotic Devices will be ongoing with QAPI Team for 12 months. After 12 months the PI will be re-evaluated for contination. Completion Date: 11-17-17	
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and	F 323		

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(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.

(1) Assess the resident for risk of entrapment from bed rails prior to installation.

(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.

(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interviews, clinical record reviews, facility document reviews and in the course of a complaint investigation the facility staff failed to ensure that the appropriate lift device and or lift was provided during transfers according to the residents comprehensive person-centered care plan to prevent accidents for 2 of 2 residents in the survey sample, Resident #1 and #2.

1. Based on physical functional limitations Resident #1 required the utilization of a total mechanical lift for all transfers. On 9/19/17 the facility's total lift equipment was not maintained in safe operating condition; therefore, the staff (Certified Nurse Aide/CNA #2) elected to use a sil lo stand mechanical lift to transfer the resident

I: Corrective Action for those Residents (2) found to have been affected by deficient practice.

-Physical Therapy Evaluation to confirm correct Transfer Procedure for each resident.
-Care Plan and Kardex updated to reflect Transfer Procedures for each resident.

II: How Facility will identify resident/s affected by deficient practice:

All residents are a risk of deficient practice:

1. Physician's Orders will be reviewed to identify all resident/s utilizing any mechanical lifting device.
2. 100% of Care Plans and Kardex will be reviewed to confirm that correct transfer process is identified for each individual resident.

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from the wheelchair to the bed. The resident did not meet the criteria for the use of the sit to stand lift due to non-weight bearing status and inability to fully grasp both handle bars due to right sided weakness from a stroke. During the transfer, the sit to stand lift malfunctioned. The resident was suspended by the lift straps. The resident's weight pulled her down causing the lift belt to rise under the resident's neck and the right shoulder, as a result the resident sustained a fracture to the right shoulder (proximal right humerus) and possible fracture of the right elbow (olecranon).

2. Based on physical functional limitations Resident #2 required a pivot transfer with one staff or use of a total mechanical lift for transfers. The resident did not meet the criteria for a sit to stand mechanical lift due to inability to fully grasp both handle bars due to right arm contracture and weakness from a stroke. On 10/4/17 CNA#3 transferred the resident from the bed to a wheelchair using a sit to stand mechanical lift.

The findings included:

1. Resident #1 was admitted to the facility on 8/5/13 with diagnoses to include, but not limited to history of a stroke with right sided hemiplegia (paralysis on one side of the body).

The current MDS (Minimum Data Set) at the time of the incident was an annual with an assessment reference date of 7/10/17. The resident scored a 13 out of a possible 15 on the Brief Interview for Mental Status, indicating the resident's cognition was intact. The resident required extensive assistance of two staff for bed mobility and transfers. The resident was not steady and was only able to stabilize with staff assistance during

III: Measures/Interventions/Systemic Changes.

1.Therapy evaluation to confirm correct mechanical lifting device for each individual resident or order initiation, annually and as needed.

2. Care Plan and Kardex will reflect correct transfer procedure for each resident.
3. Staff will refer to the Kardex or Care Plan prior to transfering any resident. A mechanical lift will not be used on any residents who does not have an order for the mchanical lift reflected on the Kardex and CarePlan.
3. All Clinical Staff will complete Competency Training with Mechanical Lifts at Orientation and then annaully. This competency will include the FDA Patient Lift Safety Guide and will include how to evaluate the resident and the lift prior to begining lift with a mechanical device.
4. Agency Clinical Staff will be required to evidence competency before using Facility Mechanical Lifts without staff supervision.
5. Staff Educator will maintain list of completed Mechanical Lift Competency Evaulations.
6. Policy: Two Staff in attendance for all Mechanical Lifts regardless of type
7. "RED TAG" Procedure: All Staff Eduction on how to use the Red Tag Out process for mechanical lifting devices that evidence an actual or suspected mechanical failure.

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transitions from surface to surface (transfer between bed and chair or wheelchair). Functional limitation of range of motion was identified due to impairment on both upper and lower extremities on one side. The resident's weight was 187 pounds.

The comprehensive person-centered care plan initiated on 9/23/13 identified the resident had ADL (activities of daily living) self care performance deficit due to diagnosis of right hemiparesis. The goal was the resident would maintain current level of functioning. Several of the interventions listed was for the resident to wear a right hand orthotic at bedtime for contracture management, a right half lap tray for upper extremity support while seated in a wheelchair, bed mobility extensive of assistance of two, and for transfers the resident required extensive to total and two assist.

The CNA Kardex Report/ care plan at the time of the incident identified for transfers Resident #1 required, "extensive to total and two assist with Hoyer lift (total mechanical lift). One staff member during transfer with Hoyer is to support/monitor right side paresis to ensure resident's safety."

The State Survey Agency received an initial Facility Reported Incident (FRI) on 9/20/17. The report stated that on 9/19/17 two of two Hoyer lifts in the facility (total mechanical lifts) were not working. The CNA used a sit to stand mechanical lift to assist the resident. When assisting the resident with the sit to stand device, the device stopped working. The CNA called out for assistance and the nurse came into the room as well as another CNA. During this process the resident was suspended by the lift straps.

8. Equipment: Two new Hoyer (Total Lift Devices) have been purchased.
9. Clinical Staff will receive training on new Hoyer Lifts before new lifts are placed into use.
10 Night Shift Nursing Supervisor will perform a written audit of mechanical lifts to include charging status.
11 Rehab will complete three random unannounced observation audits of resident transfer with mechanical lift per month.
12 Clinical Managers will complete 100% audit on all Resident/s with physicians orders for mechanical lifting device monthly
13. Environmental Services will complete monthly Mechanical Lift equipment checks and Maintain a Log of "Red Tag" events, equipement malfunction and/or repair.
14. Kardex and Care Plan will be reviewed Quarterly to ensure that correct transfer process is reflected.

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resulting in a displaced humoral neck fracture and non-displaced fracture of the olecranon process. The resident was lowered to the bed and the straps were disconnected. The resident was assessed and complained of pain to the right shoulder, therapeutic medication was administered. The physician and the family were notified. An order for an X-ray was obtained. The resident was sent to the ED (emergency department) for evaluation. An investigation was started and equipment was evaluated.

The X-ray reports dated 9/20/17 read:
1. Shoulder- Acute minimally displaced right humeral neck fracture.
2. Elbow Right-Questionable non-displaced fracture of the olecranon process.

The resident was evaluated at the ED on 9/20/17 and returned back to the facility that same day. The ED discharge diagnosis was nondisplaced fracture of proximal end of right humerus.

The Orthopedic follow up dated 9/22/17 read, in part:
"...positive Right humeral neck fracture with minimal displacement.
Plan: Sling to right UE (upper extremity). See orders. No use (R) UE, caution when transferring. F/U (follow up) 3 weeks."

The final facility internal investigation report dated 9/25/17 concluded the following:
1. Equipment evaluation was completed and there were no malfunctions. The batteries had not been properly charged on the mechanical lifts resulting in the 2 Hoyer lifts not working and the sit to stand which did not have an adequately charged battery to manage the transfer.

F 323 1V Performance Monitoring:

1. Nursing, Education, Therapy & Enviromental Services Departments will form the QAPI Team: Mechanical Lifts and Patient Safety. The team will report on the Department Audits and Continuous Process Improvement Plan at the Facility Quality Assurance and Process Improvement (QAPI) meeting.
2. The QAPI Team: Mechanical Lifts and Patient Safety will remain in affect for 12 months and then be re-evaluated.

Completion Date: 11-17-17

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2. Choice of the sit to stand lift for this transfer was incorrect based on resident functional status.
Corrective measures implemented to prevent recurrence were:
1. In-service staff on properly charging mechanical lifts between use.
2. In-service staff on alternative measure for transferring a resident if lift is not functioning.
3. One to one in-service and disciplinary action taken with CNA who initiated the transfer with the incorrect type of lift.

On 10/3/17 at 1:50 p.m., CNA#1 assigned to care for Resident #1 was interviewed. She was asked how do you determine the transfer status of your resident, she stated, "the care plan inside the closet door, if the resident is not a one person assist you get someone to help". She stated Resident #1 was a total lift resident who required the Hoyer lift. When asked, when and where are mechanical lifts charged, she stated, "for myself, I put it on the charger in the clean supply room, sometimes I come in and they are not charged". She stated that this past Saturday (9/30/17) when she went to get the sit to stand to use on a resident it was "beeping", indicating that it was not fully charged. She stated each lift has 2 batteries. CNA #1 was asked if she had been inserviced recently on mechanical lifts, sit to stand lifts and manual lifting that was provided by the facility on 9/28/17 and 9/29/17 as part of the corrective measure, she stated, "No".

The care plan located inside Resident #1's closet dated 8/29/17 indicated the resident required a mechanical Hoyer lift for transfers.

On 10/3/17 at 8:41 p.m., an interview was conducted via telephone with CNA #2 who

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transferred Resident #1 with the incorrect lift on 9/19/17. Per the interview and CNA #2's written statement she stated that at approximately 8:30 p.m., the resident was sitting up in a wheelchair in her room. The resident requested to be placed back into bed. The CNA obtained the total lift from the shower room, took it into the residents room and at that time discovered it was not working. She then went to the other unit to obtain the other total lift. This lift was not working either, she stated,"the battery was not working". She then went back to the unit and asked a coworker how was she was supposed to transfer the resident to bed if the both total lifts were not working, the coworker stated to transfer the resident using the sit to stand as they had used this lift on the resident before and "everything went well". She then went to get the sit to stand lift. After applying the waist guard she began to lift the resident. The lift "kept going in and out-stopping and starting back up." She stated once she realized the lift was beginning to go out she quickly tried to proceed, the resident asked to be put down, stating, "Put me down". At that time she saw the nurse across the hall and alerted her that she needed help. The nurse came in to assist. They both attempted to lift the resident up but could not. The nurse left the room to get more assistance. While waiting the waist guard "had quickly went up causing her stroke arm to lift as well". She stated, "during the whole transfer (name of resident) was calm but was saying her arm was hurting". When asked what was the root cause of the resident obtaining a fracture from the transfer, she stated, " The machines, if they had been working properly I would have used the appropriate equipment...I did what I thought was best".

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(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
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The written statement dated 9/20/17 from the nurse involved with the incident read, in part:"...I entered the room and noted (Resident #1's name) with a lift belt under her neck and around her R shoulder. I rushed to help but the (Resident name) was too heavy and I had to run and scream for someelse (sic) to come help. Then I ran back into the room to help (CNA#2) support (Resident name) till helped arrived so she would not choke on the belt. The patients weight was pulling her down and the belt was under her chin... If I had released the belt around her neck, she would have fallen to the floor and possibly sustained more injury, and her shoulder was still caught in the belt as well... (name of CNA#2) stated that the patient should have been moved with a different type of lift but she had tried the two we have and they were not working at all. So the lift used in the incident was the only one she had available to use to get this non weight bearing, non ambulatory bariatric patient from wheelchair to her bed and the lift just stopped working mid transfer".

On 10/3/17 at 12:25 p.m., the resident was in bed attempting to eat lunch. The resident's speech was slurred. The right arm was not in a sling, the right hand was contracted. At 2:15 p.m., and 5:00 p.m., the resident was observed in bed. The right arm sling was still not on as ordered by the physician.

On 10/3/17 at 4:00 p.m., an interview was conducted with the Administrator. When asked what was the root cause of the incident that resulted in the resident's fracture, she stated, "The CNA used poor judgement in selecting the sit to stand".

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	495206	A. BUILDING _____ B. WING	C 10/04/2017

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The findings was shared with the Administrator, the Corporate Nurse, the Interim Director of Nursing, and the Nansmond Unit Manager at the pre-exit meeting conducted on 10/4/17.

The facility policy titled "Lift Machine Using", undated, read in part:
"Purpose:
The purpose of this procedure is to help lift residents using a manual lifting device.
Preparation:
1. Review the resident's care plan to assess for any special needs of the resident.
2. Assemble the equipment and supplies as needed.
General Guidelines:
The portable lift can be used by one nursing assistant if the resident can participate in the lifting procedures. If not, two (2) nursing assistants will be required to perform the procedure."

The following information was obtained from Interior Health Patient Handling Procedure Stand Assist-Sit Stand Lift Criteria provided by the facility, in part, but not limited to:
The Patient Must:
2. Be able to hold onto both handles on the machine. Reason-Sling will place too much pressure in patient's armpits.
3. Be able to keep both feet flat on the footplate of the lift throughout the transfer. Reason-Patient could fall off the lift. This position is painful for patients who have stiff of contracted knees or hips.

Patient lifts are designed to lift and transfer patients from one place to another (e.g., from bed to bath, chair to stretcher). The powered models

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generally require the use of a rechargeable battery and the manual models are operated using hydraulics. These medical devices provide many benefits, including reduced risk of injury to patients and caregivers when properly used. However, improper use of patient lifts can pose significant public health risks. Patient falls from these devices have resulted in severe patient injuries including head traumas, fractures, and deaths. Source www.fda.gov

The FDA (U.S. Food & Drug Administration) Patient Lift Safety Guide read, in part;
"3. Check Patient's Condition-Before using a patient lift, check: to see if patient can assist with transfer, make sure you have correct lift and sling for patient's condition, ensure lift will not make patient's condition worse.
9. Perform Safety Check-Before lifting the patient, perform safety checks: For electric lifts, make sure batteries are always charged."

2. Based on physical functional limitations Resident #2 required a pivot transfer with one staff or use of a total mechanical lift. The resident did not meet the criteria for a sit to stand mechanical lift due to the inability to fully grasp both handle bars due to right arm contracture and weakness from a stroke. On 10/4/17 CNA #3 transferred the resident from the bed to a wheelchair using a sit to stand mechanical lift.

Resident #2 was readmitted to the facility on 11/23/16 with diagnoses to include, but not limited to, history of a stroke, right sided weakness with right arm contracture.

The current MDS a quarterly with an assessment reference date of 9/4/17 assessed the resident as

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having unclear speech. The resident was coded as having both long and short term memory deficits and moderately impaired cognitive skills for daily decision making. The resident's self performance during transfers required extensive assistance and support of two staff. Under Balance During Transitions and Walking the resident was not steady and only able to stabilize with staff for moving from seated to standing position and surface-to-surface transfer (transfer between bed and chair or wheelchair). The resident had functional limitation of range of motion to one side of the body effecting both upper and lower extremity.

The comprehensive person centered care plan dated 11/7/13 identified the resident had ADL performance deficit related to diagnosis of a stroke with right hemiparesis. The goal was that the resident will maintain current level of ADL function. Under Transfers the approach the resident required extensive assistance of 2 staff members.

The CNA kardex/ care plan under 'transfer' indicated the resident required extensive assistance of 2 staff members.

On 10/4/17 at approximately 10:30 a.m., this inspector along with the Administrator and Nansmond unit manager were inside the Nansmond unit shower room inspecting the mechanical lifts. CNA #3 (an agency staff) entered the shower room to place the sit to stand lift back inside for storage and then left the room. The CNA was followed out by this inspector and asked what resident was this sit to stand lift used for, she stated (resident #2's name). The CNA was asked if this lift was appropriate for this

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resident, she stated, "This is the second time I've worked with him, I had a problem getting him up... they (other staff) were busy...". When asked if she had asked for help as the resident is a two person assist she stated, "No. I didn't see anyone at that time". The closet door kardex was reviewed and indicated the resident was a two person lift. The CNA stated, "the sit to stand is a one person lift as long as the resident is able to sit and hold on to the bar to stand".

The Nansmond unit manager was interviewed immediately following the interview with CNA #3. The above finding of Resident #2 being transferred with a sit to stand lift was shared. She was asked how is Resident #2 supposed to be transferred. She stated when she gets him up he can pivot transfer with two staff. When asked if a sit to stand lift was an appropriate lift for this resident, she stated, "I don't know if anyone uses a lift with him...I don't know". When asked does Resident #2 meet the criteria for the sit to stand, she stated, "No, due to his weakness". When asked if it was okay to use a sit to stand with one staff, she stated, "No, not if you don't have a second person...a second person is there to prevent possible injury." The unit manager was asked are agency staff trained on the facility's lift policy, she stated, "It's pretty standard in most facilities that you use two people...". The unit manager stated she would have therapy screen the resident for transfers.

Following this interview the rehab therapy department conducted a screening on the resident for safe transfers. The Screening Form dated 10/4/17 concluded the resident does not require a lift for transfers, however, if a lift is used for safety, it must be a Hoyer (total lift) with assist

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F 323	Continued From page 15 of 2 staff. On 10/4/17 at 2:30 p.m., the rehab manager was interviewed. She stated the resident was not appropriate for the sit to stand lift due to the resident's right hand contracture that hinders him from grabbing onto the hand bar. The following information was obtained from Interior Health Patient Handling Procedure Stand Assist-Sit Stand Lift Criteria provided by the facility, in part, but not limited to: "The Patient Must: 2. Be able to hold onto both handles on the machine. Reason-Sling will place too much pressure in patient's armpits." The findings was shared with the Administrator, the Corporate Nurse, the Interim Director of Nursing, and the Nansmond Unit Manager at the pre-exit meeting conducted on 10/4/17.	F 323		
F 465 SS=E	COMPLAINT DEFICIENCY 483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents.	F 465	F465 I: Corrective Action for those resident/s found to have been affected by deficient practice: 1. Lifts Inspected by Environmental Services. 2. Education: 100% Clinical Staff education on A. evaluating mechanical lifts	

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This REQUIREMENT is not met as evidenced by:
Based on staff interviews, clinical record review, facility document review and in the course of a complaint investigation the facility staff failed to ensure resident equipment was maintained in safe operating order.

The mechanical lifts were not maintained in safe operating order. The lift batteries were not maintained charged. As a result a CNA used an alternate lift that was inappropriate for Resident #1, a sit to stand lift. The sit to stand lift battery also was not fully charged and stopped functioning during the transfer, as a result Resident #1 sustained a fracture to the right shoulder.

The findings included:

Resident #1 was admitted to the facility on 8/5/13 with diagnoses to include, but not limited to history of a stroke with right sided hemiplegia (paralysis on one side of the body).

The current MDS (Minimum Data Set) at the time of the incident was an annual with an assessment reference date of 7/10/17. The resident scored a 13 out of a possible 15 on the Brief Interview for Mental Status, indicating the resident's cognition was intact. The resident required extensive assistance of two staff for bed mobility and transfers. The resident was not steady and was only able to stabilize with staff assistance during [redacted] between bed and chair or wheelchair). Functional limitation of range of motion was identified due to impairment on both upper and lower extremities on one side. The resident's weight was 187

F 465 prior to begining a lift.
B. Placing the lift back on charge after using a Mechanical Lift.
C. "Red Tag" Procedure for any mechanical equipment suspected of not being in full functional order.
D. Care Plan and kardex to reflect process of evaluation of resident and mechanical lift prior to initiating a transfer (FDA Patient Lift Safety Guide).

II. How Facility Will identify other residents affected by deficient pratice:

All residents using mechanical lifts are at risk of deficient practice.

Orders will be reviewed to identify all residents with current orders for mechanical lift transfers.

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pounds.

The comprehensive person-centered care plan initiated on 9/23/13 identified the resident had ADL (activities of daily living) self care performance deficit due to diagnosis of right hemiparesis. The goal was the resident would maintain current level of functioning. Several of the interventions listed were for the resident to wear a right hand orthotic at bedtime for contracture management, a right half lap tray for upper extremity support while seated in a wheelchair, bed mobility extensive of assistance of two, and for transfers the resident required extensive to total and two assist.

The CNA Kardex Report/ care plan at the time of the incident identified for transfers Resident #1 required, "extensive to total and two assist with Hoyer lift (total mechanical lift). One staff member during transfer with Hoyer is to support/monitor right side paresis to ensure resident's safety."

The State Survey Agency received an initial Facility Reported Incident (FRI) on 9/20/17. The report stated that on 9/19/17 two of two Hoyer lifts in the facility (total mechanical lifts) were not working. The CNA used a sit to stand mechanical lift to assist the resident. When assisting the resident with the sit to stand device the device stopped working. The CNA called out for assistance and the nurse came into the room as well as another CNA. During this process the resident was suspended by the lift straps, resulting in a displaced humeral neck fracture and non-displaced fracture of the olecranon process. The resident was lowered to the bed and the straps were disconnected. The resident was assessed and complained of pain to the right

F 465

III Measures and Systemic changes:

1. Environmental Services will inspect all Mechanical Lifts Monthly.
2. Environmental Services will maintain a Maintence Log.
3. All Clinical Staff will complete a competency on using Mechanical Lifts on orientation and annually thereafter (including agency). This will include evaluating the device to ensure it is fully functional prior to begining any mechanical lift.
4. All Clinical Staff will be trained in the RED Tag Procedure for marking any mechanical device evidencing a malfunction or suspected malfunction.
5. Night Shift Supervisor will complete a written audit of mechanical lifts including battery status (every night)
6. Two aging Hoyer lifts have been retired. Two New Hoyer lifts are being placed into use.

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shoulder, therapeutic medication was administered. The physician and the family were notified. An order for an X-ray was obtained. The resident was sent to the ED (emergency department) for evaluation. An investigation was started and equipment was evaluated.

The X-ray reports dated 9/20/17 read:
1. Shoulder- Acute minimally displaced right humeral neck fracture.
2. Elbow Right-Questionable non-displaced fracture of the olecranon process.

The resident was evaluated at the ED on 9/20/17 and returned back to the facility that same day. The ED discharge diagnosis was nondisplaced fracture of proximal end of right humerus.

The final facility internal investigation report dated 9/25/17 concluded the following:
1. Equipment evaluation was completed and there were no malfunctions. The batteries had not been properly charged on the mechanical lifts resulting in the 2 Hoyer lifts not working and the sit to stand which did not have an adequately charged battery to manage the transfer.
2. Choice of the sit to stand lift for this transfer was incorrect based on resident functional status.
Corrective measures implemented to prevent recurrence were:
1. In-service staff on properly charging mechanical lifts between use.
2. In-service staff on alternative measure for transferring a resident if lift is not functioning.
3. One to one in-service and disciplinary action taken with CNA who initiated the transfer with the incorrect type of lift.

On 10/4/17 at 11:30 p.m., the Maintenance

F 465 IV Performance Monitoring:

Nursing, Therapy, Education & Enviromental Services Departments will form the QAPI Team: Mechanical Lifts and Patient Safety.

The team will report on the Audits and Continuous Process Improvement Plan at the Facility Quality Assurance and Process Improvement (QAPI) meeting.
2. The QAPI Team: Mechanical Lifts and Patient Safety will remain in affect for 12 months and then be re-evaluated.

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Coordinator was interviewed. He stated that following the incident for Resident #1 all the lifts were checked out by the biomedical company and all found to be in good operating order. It was found that the batteries had not been charged. He also stated, it had been bought to maintenance department's attention around July of this year by nursing that the lift batteries were not maintaining their charge. In response to this, the facility ordered back-up batteries for all the lifts. He stated that frequently since then he has found that the staff have not been consistent with ensuring the sit to stand batteries are in the chargers and charging up. He also stated that he has found the total lift batteries on the charger but the surge protectors were not turned on; therefore, the battery was not charging.

The findings were shared with the Administrator, the Corporate Nurse, the Interim Director of Nursing, and the Nansmond Unit Manager at the pre-exit meeting conducted on 10/4/17.

The FDA (U.S. Food & Drug Administration) Patient Lift Safety Guide provided to the inspector by the facility read, in part:
9. Perform Safety Check:
Before lifting the patient, perform safety checks. For electric lifts, make sure batteries are always charged.

COMPLAINT DEFICIENCY