| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34A001 | A. BUILDING _____ B. WING _____ | 06/25/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| BLACK MOUNTAIN NEURO-MEDICAL TREATMENT CENTER | 932 OLD US HIGHWAY 70 BLACK MOUNTAIN, NC 28711 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
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| F 0689<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observations, record review, staff and physician interviews, the facility failed to secure a resident in a mechanical lift for 1 of 3 sampled residents (Resident #1) reviewed for supervision to prevent accidents during transfers. The resident fell from the total mechanical lift, landed on her left side and sustained bruising of the mid-spine and tenderness to the left chest wall. The findings included: Review of the Mechanical Lift Policy, last reviewed 01/09/20 indicated there were to be at least two staff members present to perform all aspects of the mechanical lift procedure. The Mechanical Lift Competency sheet further specified that the transfer process began with the placing of the sling and ended with appropriate positioning on final surface. When attaching a resident to the mechanical lift staff were to recheck the clips and report all clear upon completion. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set ((MDS) dated [DATE] indicated the resident was severely cognitively impaired. She required extensive assistance with bed mobility and was totally dependent on 2+ staff members for transfers. The resident had not experienced any falls since the prior assessment. It was not noted that the resident had any involuntary movements related to her [MEDICAL CONDITION]. The Care Area Assessment (CAA) for falls from the most recent annual MDS dated [DATE] indicated Resident #1 was not ambulatory, she required total assistance from staff with transfers and staff used the mechanical lift for all her transfers. Resident #1's Care Plan initiated 12/29/17, and last reviewed on 02/15/19, indicated Resident #1 was unable to perform Activities of Daily Living (ADL) without limited to extensive assistance from staff.<br>Staff were to assist the resident with ADL to the extend needed as outlined in the resident care tracker profile. Another problem area indicated Resident #1 was at risk for falls and needed assistance with mobility and locomotion. Staff were to safely transfer the resident from one surface to another using the mechanical lift and a medium size sling. The resident care tracker profile last reviewed on 06/05/20 indicated Resident #1 was dependent for transport and required the use of a mechanical lift with medium sling size. The Nursing Summary of Care assessment dated [DATE] was reviewed. This assessment tool outlined all nursing areas of care for the resident for the previous 3 months (January 2020-March 2020). The assessment indicated Resident #1 required two-person assistance and use of a mechanical lift for moving and lifting, it further indicated the resident was non-ambulatory. On 06/03/20 a nursing progress note by Nurse #1 detailed that Resident #1 had fallen from the lift during transfer when the strap that runs between the legs on resident's left side came loose resulting in resident on the floor, on left hip. Review of the facility investigation of the incident indicated that on 06/03/20 at 6:55 pm, Resident #1 fell from the mechanical lift while being transferred from the wheelchair to the bed by Nurse Aide #1 (NA). The incident was witnessed by NA #2. The on-call medical provider was notified of the fall on 06/03/20 at 7:20 PM and an order was written for a left hip x-ray. Review of progress notes by the Medical Doctor (MD) revealed a note dated 06/04/20. The MD assessed Resident #1 and reported the resident had bruising noted to the left of mid spine and a smaller bruise on the right. The resident's bilateral hips moved without apparent pain. It was noted that the resident did react with discomfort with compression of left ribs. X-rays were ordered of the spine, left ribs and bilateral hips. 06/05/20 an additional progress note was documented by the MD and indicated that x-ray imaging showed the resident had fractures of the left 8th, 9th and 10 th ribs and three compression fractures of the spine (at T11, L3 and L4), all fractures were noted to be of indeterminate age. The MD went on to explain that since the resident did not express any discomfort in the spinal area, it was likely that the spinal compression fractures were old. The MD further explained that the rib fractures may have been new since the resident expressed some discomfort with compression of that side of her thorax. Review of the radiology report for Resident #1 dated 06/04/20 displayed mildly displaced fractures of the lateral aspects of the eighth, ninth and tenth left ribs of indeterminate age. A written statement dated 06/03/20 provided by NA #1 who operated the lift at the time of the fall. NA #1 recalled that she had taken the resident and the mechanical lift into the residents room to get her ready for bed. The CNA stated she intended to change the resident's shirt and then planned to go get a second staff member to assist with transfer. The NA reported that while she was in the room with the resident the NA working as hall monitor (NA #2) came into the room and offered assistance with transfer which she accepted. NA #1 reported she hooked the resident up to the mechanical lift (while NA #2 was in the room) and admitted ly did not double check that the clips were secure. NA #1 indicated that one of the clips on the leg portion came unclipped and the resident fell to the floor before it was noticed. NA #1 recalled the incident on 06/03/20 in an interview on 06/23/20 at 11:48 AM and reported she had taken Resident #1 into her room to put her to bed. She was in the room with the resident when NA #2 (who was working as hall monitor at the time) knocked on the door and asked if she needed a spot for transfer. NA #1stated that NA #2 stood back by the door while NA #1 hooked Resident #1's sling to the lift (the sling was already under the resident as it stayed with her in the wheelchair between transfers). NA #1 indicated that she did not double check the security of the clips, nor did NA #2. NA #1 explained she started lifting the resident and watched to make sure she was clearing the wheelchair and did not notice the clip at her leg had come unattached from the lift until the resident was slipping out of the sling onto the floor. According to NA #1, she had been trained to have two staff members present for all parts of the transfer process and that she had failed to double check the security of the sling to the lift. Following the incident, NA #1 stated she was prohibited from using the mechanical lift until she was retrained on proper use of it. She has had 2 trainings on lift use since the incident including return demonstration with therapy services. In a written statement dated 06/03/20 provided by NA #2 it was reported that NA #1 was observed taking Resident #1 and the mechanical lift into the room alone and shut the door. NA #2 knocked on the door and asked if NA #1 needed assistance and NA #1 said well, yeah. NA #2 entered the room and at that time the resident was already hooked up to the lift and NA #1 was attempting to lift Resident #1 using the mechanical lift. NA #2 stated that before she knew what was happening, Resident #1 was falling in the floor. NA #2 instructed NA #1 to stay with the resident while she went to get a nurse. An interview was completed with NA #2 on 06/23/20 at 10:53 AM and reported that at the time of the incident she was working as hall monitor. As hall monitor she was responsible for completing 15 minute checks on all residents, monitoring for any aggressive behaviors, etc. While she was going around and observing residents when she noticed NA #1 had went into Resident #1's room with the resident and the mechanical lift. The NA knew there was no one else in the room to assist with transfer so she went to the room, knocked on the door and upon entry observed NA #1 attempting to lift Resident #1 alone. NA #2 said whoa, do you need a spot to which NA #1 replied well, yeah. The NA stated she got approximately 2 steps into the room and Resident #1 fell from the lift. Per NA #2, NA #1 had already clipped the sling to the lift when she entered the room and she was beginning to lift the resident. She did not have a chance to double check the security of the sling to the lift. It was reported by the NA that she had been trained to have 2 staff members present for the entire transfer process. She stated that NA #1 should have known that she needed a second person in the room while initiating the transfer process, |

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

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| F 0689<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | (continued... from page 1)<br>including when the sling clips were being attached to the mechanical lift. Nurse #1 who was working the night of the incident was interviewed on 06/23/20 at 11:38 AM. He recalled he was notified Resident #1 had fallen from the mechanical lift by NA #2. He went to the residents room and found her on the floor, lying on her left hip and left shoulder between the legs of the lift. He assessed her and did not find any indication of fracture. Her range of motion in her hips was maintained. Her vitals were normal. After he assessed her and felt she was safe to move, he assisted getting her into bed and notified the on-call provider of the fall. The on-call provider ordered an x-ray of the left hip. Nurse #1 spoke with NA #2 who reported she had walked into Resident #1's room and found NA #1 operating the lift alone when a clip holding a strap had come unattached and the resident fell from the sling onto the floor. Nurse #1 did not get a report regarding the incident from NA #1. An interview was completed with the Medical Doctor (MD) on 06/23/20 at 11:30 AM who reported she examined Resident #1 the morning after the fall. The MD stated that the on-call provider had been notified the evening of the incident and ordered an X-ray of the left hip. When the MD evaluated her the next morning she took note of some bruising higher up on the spine and wanted to do more thorough imaging so she ordered additional x-rays. When the x-ray report came back it indicated Resident #1 had indeterminate age compression fractures of the spine. The MD noted the resident displayed no soreness in that area so the MD thought those to be older. The x-ray also showed age indeterminate fractures of the eighth, ninth and tenth left ribs. The MD stated it was impossible to determine if those fractures resulted from the fall but she felt it was a good possibility because Resident #1 winced when the MD put pressure on that area during examination, indicating she had some pain there. The resident also displayed signs of pain when the MD compressed on the left thorax region. On 06/25/20 at 1:24 PM the Director of Nursing (DON) was interviewed and recalled that while the two NAs involved in the incident reported different stories leading up to the incident it was noted that the clips from the sling to the mechanical lift had not been double checked and the resident fell due to a clip coming unbuckled during transfer. The DON assessed the resident the next morning and recounted some bruising above her hip, along her side. The DON recalled the MD noted the resident expressed some pain with pressure on the ribs. The DON reported staff were expected to have at least 2 staff members present in the room at the same time for the entire transfer process and they were to be checking behind one another. Review of the facility investigation into the fall on 06/03/20 concluded NA #1 neglected to provide two-person care as required in the care plan and failed to check the mechanical lift clips a second time. The investigation noted NA #1 stated she did not check the clips a second time and that NA #2 who witnessed the incident had entered the room just as NA #1 was lifting Resident #1, contradicting NA #1's statements. The facility's corrective actions implemented after the incident to prevent a reoccurrence included the following: The corrective action for the alleged deficient practice was accomplished by: The resident was seen by the MD on 06/04/20, the resident was noted to have bruising of the mid-spine and tenderness to the left chest wall. X-ray results revealed indeterminate age compression fractures of the spine (T11, L3, and L4) and fractures of the eighth, ninth, and tenth ribs of indeterminate age. The Physical Therapist and Occupational Therapist re-assessed the resident transfer status and sling lift size fit. NA #1 was prohibited from using the mechanical lift until she was retrained and completed return demonstration of proper use of the mechanical lift. All nurse supervisors, nurses and NAs on Raspberry-2 Unit completed mandatory competency Mechanical Lift training with the Physical therapists (PT) and Occupational Therapists (OT). Residents with potential to be affected by alleged deficient practice: Facility-wide Mechanical Lift return demonstration completed for nurse supervisors, peer mentors and Health Care Tech II's (HCT). Facility wide competency Mechanical Lift competency training for all nursing staff (nurse supervisors, nurses, NA's). The re-education and return demonstration began on 06/09/20 and was completed 06/17/20. Systemic changes: Minimum Data Set employees and Social workers to ensure care plans were updated with transfer information and sling size. PT/OT to ensure Resident Profile and Care Tracker system is current with transfer status and sling size. Restorative Aides will ensure the Quick Reference Tool for Adaptive Equipment is updated at least monthly. Nurse supervisors to be conducting monthly Transfer and Repositioning Audits. Each staff member will have at least 1 audit/quarter. Nurse supervisors would complete Mechanical Lift Competency with all new employees within the first 30 days of employment. Monitoring of performance: The Quality Assurance (QA) Department in conjunction with the nursing department developed Quality Assurance and Performance Improvement (QAPI) plan regarding the nurse supervisor training of new NA's compliance, and NA transfer and repositioning audits. The plan would be reviewed for a minimum of 12 months, dropping off if compliance is greater than 95%. A Safe Resident Handling Task Force was established to examine ongoing strategies, monitoring, and accountability for safe resident handling. The facility's corrective actions were verified on 06/22/20-06/25/20 by observations, record review and staff interviews. As part of the validation process on 06/22/20-06/25/20 the plan of correction was reviewed including the re-education of staff and observations of interventions put into place to ensure correct use of the mechanical lift. All staff signed attendance sheets with in-services addressing proper mechanical lift use and review of the Mechanical Lift Policy, PRO 421. Observations were made of staff transferring dependent residents utilizing the mechanical lift were made. No concerns were identified. Nurses and nursing assistants were interviewed and verified they received in-service on transferring residents with a lift with emphasis on always having two staff present and double-checking security of the sling attachment behind one another. The Nurse Supervisor for the Raspberry-2 Unit reported since 06/03/20 there had been no reports of a nursing assistant transferring a resident independently with a lift. The monitoring tools were reviewed and included audits of staff from all shifts. The monitoring was to be ongoing, in accordance with the policy and discussed at QAPI on a monthly basis for at least 12 months. The facility alleges full compliance with this plan of correction effective 06/17/20. |