STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	08/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

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)
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interviews, and medical transport interviews the facility failed to provide two person transfer assistance while using the sit to stand mechanical lift for a resident (Resident #1) who was at risk for falls which resulted in the resident being lowered to the floor for 1 of 3 residents (Resident #1) reviewed for falls. Findings included: Resident #1 was admitted to the facility on [DATE] and readmitted from a recent hospitalization on [DATE]. Her active [DIAGNOSES REDACTED]. The most recent Minimum (MDS) data set [DATE] indicated Resident #1 had severely impaired cognition with acute onset mental status change, and altered level of consciousness, she required extensive two-person assistance with transfers, and was not steady for surface to surface transfers. The care plan dated 11/6/19 documented Resident #1 was at increased risk for falls related to gait and balance problems. Her goals included; the risk for falls would be minimized through current interventions with a target date of 10/28/20. The interventions included; to anticipate needs, assist to bed when tired or drowsy, frequent checks throughout shift, educate on safety reminders, encourage non skid socks, keep frequently used objects within reach, monitor and document for 72 hours post fall for signs and symptoms of pain, bruising, mental status change, new onset confusion, sleepiness, inability to maintain posture, agitation, and report these symptoms to the physician. A nursing progress note dated 8/14/20 at 8:42 AM documented; the nurse (Nurse #1) was notified by the medication aide (medication aide #1) that she was transferring the resident (Resident #1) from her wheelchair back to her bed because transport was there to get her for [MEDICAL TREATMENT] using a stretcher which was why she was transferred back to the bed. The medication aide (#1) stated at the time she was transferring Resident #1 back to bed she would not fully cooperate with her getting her back into the bed. The medication aide (#1) stated she got Resident #1 onto the side of the bed and she began slipping down the edge and the medication aide (#1) grabbed her to prevent her from falling and she assisted the resident to the floor. The bed was in low position. (Nurse #1) checked Resident #1's range of motion in all extremities and she showed no signs or symptoms of pain or discomfort when moving any of them. When asked if she was hurting anywhere, she shook her head no. The nurse (Nurse #1) and the transport staff (two [MEDICAL TREATMENT] transport staff) assisted Resident #1 onto the bed and in a lying position. Resident #1 was shivering cold, and per policy vital signs were obtained, she had a low-grade temperature of 100.0 F, (pulse) 87, (respirations) 20, (blood pressure) 158/63, and (oxygen saturation) 98% on room air. Nurse #1 asked the medication aide (#1) to give Tylenol, her clothes were removed, and her skin was checked which had no new skin tears or open areas and no new bruises. The medication aide (#1) was informed to take Resident #1's skid free socks off and put a gown and sheet over her to bring her temperature down which is what she was doing when the nurse (Nurse #1) left the room. The physician and Resident #1's emergency contact was notified. The oncoming nurse and the assistant DON (Director of Nursing) was notified. A review of the Admission Risk assessment dated [DATE] at 8:13 PM documented Resident #1's orientation was forgetful with short attention. Her degree of physical activity was documented as being chairfast due to her ability to walk was severely limited or non-existent. She could not bear own weight and/or must be assisted into chair or wheelchair. A Nursing Admission/Readmission Review dated 8/13/20 at 8:15 PM documented Resident #1 was alert with confusion, and was able to voice her needs and wants. She had bilateral upper and lower extremity weakness and required assistance with transfers using a stand assist device. During a phone interview on 8/26/20 at 1:29 PM with Medication Aide #1 she stated at the beginning of her shift around 7:00 PM on 8/13/20, Resident #1 was not herself, she had just returned from the hospital that evening, she was whiny, yelling out, calling out names, and crying a lot. She reported that around 4:30 AM on 8/14/20 she and the nurse aide (Nurse aide #1) transferred Resident #1 from her bed into her wheelchair for [MEDICAL TREATMENT] transport. The nurse aide (Nurse aide #1) left the residents room after she was settled in her wheelchair. Transport came with a stretcher and the medication aide (#1) transferred Resident #1 back to bed in order to transfer her to the stretcher. She stated she transferred Resident #1 back to bed using the easy stand without using two-person assistance because she thought she could do it on her own. She reported the bed was in low position, she got her back to bed, Resident #1 was acting very weak, the bed sheets were slippery, and she slid to the floor. The Medication aide (#1) stated she grabbed Resident #1 and lowered her to the floor. She stated she was alone with Resident #1 in the room when she slid to the floor. She indicated Resident #1 was alert and oriented to her situation. She stated she was a two person assist with transfers and required the use of the sit to stand lift. She reported after Resident #1 was lowered to the floor, she left the resident unattended for 3-5 minutes to go get the nurse. She obtained the residents vital signs which were within normal limits, and the nurse (Nurse #1) completed the fall assessment. She reported the nurse along with the two [MEDICAL TREATMENT] transport staff transferred Resident #1 back to the bed. She reported there were no injuries from the fall. In a written statement regarding the incident dated 8/14/20 Medication Aide #1 documented; at 5:00 AM she was attempting to put Resident #1 back to bed from her wheelchair as transport was there to take her to [MEDICAL TREATMENT], at that point Resident #1 would not fully cooperate. Having got her to the bed, she was slipping to the edge, and she grabbed her to prevent her from being on the floor. The bed was in the lowest position. She lowered her to the floor, there were no injuries. Resident #1 had not been cooperating in any way with transferring. Nurse #1 and the transport staff assisted Resident #1 back to bed. Vital signs were recorded as; temperature 100.0 F, blood pressure 158/63, pulse 87, oxygen saturation 98%. During a phone interview with Nurse #1 on 8/26/20 at 12:47 PM she stated, Medication aide #1 reported to her that Resident #1 had a fall. Nurse #1 went into the room and Resident #1 was observed sitting on the floor beside her bed. Nurse #1 stated that Medication aide #1 reported to her that Resident #1 was sitting on side of the bed and she slid her to the floor. Nurse #1 stated she completed a fall assessment, she asked Resident #1 if she had any pain, Resident #1 stated no. Nurse #1 reported the assessment revealed no signs or symptoms of pain with range of motion and no injuries. Nurse #1 stated the two [MEDICAL TREATMENT] transport staff assisted her in transferring Resident #1 from the floor back to bed. She stated Resident #1 required sit to stand lift for transfers. She stated Resident #1 was alert, she would look at the nurse and would nod her head appropriately to questions. During a phone interview with Nurse aide #1 on 8/26/20 at 3:31 PM she reported that she and Medication aide #1 transferred Resident #1 from her bed to her wheelchair using the sit to stand lift at approximately 4:15 - 4:30 AM on 8/14/20 to ger her ready for [MEDICAL TREATMENT]. Nurse aide #1 stated once she was in her wheelchair, she left the residents room and went to the 500 hallway. She reported later the Medication aide (#1) came and told her Resident #1 was on the floor. When she (nurse aide #1) arrived in the room Resident #1 was on the floor with her IV (intravenous catheter) hooked up. Nurse aide #1 stated she told the medication aide (#1) to go get the nurse to assess her. Nurse aide #1 reported the sit to stand was out of the room at that time, and she asked the medication aide (#1) why she tried transferring Resident #1 alone because she required the sit to stand lift. She reported the Medication aide (#1) stated she could do it herself. A phone interview was conducted on 8/27/20 at 11:45 AM with one of the

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

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) two [MEDICAL TREATMENT] transport staff members. She confirmed that Resident #1 was observed on the floor in her room when they arrived at the facility around 5:00 AM on 8/14/20. She stated they assisted the nurse (Nurse #1) with transferring Resident #1 from the floor and into her bed. A follow up phone interview was conducted on 8/27/20 at 12:52 PM with Medication Aide #1, she stated Resident #1 required the use of the sit to stand lift for transfers. She reported Resident #1 was able to hold on to the lift handles for transferring. She stated she transferred Resident #1 with the sit to stand lift to the bed without having two person assistance. She reported the facility policy was to have a second person to assist with all mechanical lifts which included the sit to stand. She stated she was assigned the 700 hallway that night and was overwhelmed with her assignment. During a phone interview with the Director of Nursing on 8/27/20 at 4:03 PM she stated two people were required for transfers with mechanical lifts, one person to operate the lift and one person to spot the resident. She reported staff were trained to use two person assistance when using the sit to stand lift.