STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165324	A. BUILDING _____ B. WING _____	08/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACCURA HEALTHCARE OF PLEASANTVILLE, LLC	909 NORTH STATE STREET PLEASANTVILLE, IA 50225

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 -** Immediate jeopardy **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 clinical record review, staff interviews, and observations, the facility staff failed to safely transfer 1 of 6 sampled (Resident #2). Resident #2 moved while raised in a total mechanical lift and fell from the lift striking her head on the base of the lift. Resident #2 sustained a [MEDICAL CONDITION] which resulted in death. The lift failed to contain safety clips on the hanger bar to prevent the lift sling from detaching from the lift. The facility failed to properly train staff on the proper use of the lift and what to do in the event a resident moves while in the lift. The facility reported 10 residents required a total mechanical lift for transfers. The facility reported a census of 49. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #2 had [DIAGNOSES REDACTED]. Resident #2 had severe cognitive impairments and displayed behavioral symptoms directed towards others (like verbal symptoms or disruptive sounds). Resident #2 did not walk, required the assistance of two staff for transfers and used a wheelchair for mobility. The Care Plan revised [DATE] revealed Resident #2 unable to transfer effectively related to weakness and impaired cognition. The Care Plan instructed staff to assist Resident #2 to transfer with two staff with a total mechanical lift, to offer reassurance and talk with her throughout the transfer to ease fears/anxiety and provide clear instruction in regard to tasks. The Order Summary Report dated [DATE] documented orders to administer [MEDICATION NAME] Bisulfate (or [MEDICATION NAME], an antiplatelet medication) 75 mg (milligrams) once a day. Resident #2's MAR (Medication Administration Record) dated ,[DATE] - [DATE] documented she received [MEDICATION NAME] every morning. The Incident Report dated [DATE] at 7:00 p.m. authored by Staff A (Registered Nurse) documented a Nurse Aide notified her of the need to go to Resident #2's room and the resident fell from the Hoyer. Staff A entered the room and noted the Hoyer sling hung from the lift by the top two loops at the head and one bottom loop at the knee. The fourth loop was unhooked and hanging. Resident #2 lay on her side between the legs of the lift with her head laying partially on the leg of the Hoyer. The Incident Report documented Staff B (Nurse Aide) and Staff C (Nurse Aide) witnessed the fall. The Health Status Note dated [DATE] 8:27 p.m., revealed Staff A (Registered Nurse) noted all lift sling loops were intact. Staff A observed the resident bleeding, moved the lift and assessed the site of bleeding at the resident's right temple. Staff A instructed a Nurse Aide to apply pressure to the wound and summoned 911. Staff A then obtained vital signs and assessed the resident. Resident #2 had an emesis and bowel movement. Medics arrived and started to move Resident #2. Resident #2 had two more emesis and another BM. Medics applied a cervical collar and transferred Resident #2 on a back board and gurney. The note documented Resident #2 had not been lowered to floor. The note also documented Resident #2 received a laceration to the right temple, a hematoma (bruise) to the back right of her head and skin tears to her right shoulder, the sides of her right elbow and right knee and the back of her left hand near the thumb. Staff A documented Resident #2's blood pressure (BP) at ,[DATE], a pulse of 89, respirations at 18 and an oxygen saturation of 93% on room air. The Prehospital Care Report dated [DATE] documented the Fire Department responded following dispatch for a female who fell out of a lift. Staff reported they were transferring the resident with the lift and she fell on her head. The report described the lift as about three to four feet off the floor. Staff also reported the resident was unresponsive for a time prior to Emergency Medical Services (EMS) arrival. The resident did not normally talk or obey commands due to her dementia; she mumbled but did not verbalize any complaints. EMS staff documented a laceration to the resident's forehead that was difficult to access due to copious amounts of blood flowing from the wound. Resident # 2 transported directly to the hospital. During interview on [DATE] at 8:00 a.m., the Emergency Medical Service staff (dispatched on [DATE]) stated she saw the height of the lift when entering Resident #2's room and it must have been three to four feet in the air. The Emergency Department (ED) Physician Notes dated [DATE] at 8:21 p.m. documented Resident #2 presented following a fall just prior to arrival. The fall was described as three feet out of a Hoyer lift at the nursing home. The resident had swelling and bleeding to the head with risk factors of age and anticoagulation and with associated symptoms of nausea and vomiting. The records also documented Resident #2 experienced a hypertensive emergency (BP measurement of ,[DATE]) and she received treatment for [REDACTED]. The notes described Resident #2's condition as critical. A Computed Tomography (CT) scan of Resident #2's head on [DATE] at 8:58 p.m. documented findings of a large subdural hematoma overlying the right cerebral convexity. The hematoma measured 3.3 centimeters (cm) in the maximal dimension. The CT also showed a marked associated mass effect on the adjacent parenchyma (the brain's functional tissue) with an approximate 1.2 cm midline shift. The CT also showed effacement (narrowing) of the right lateral ventricle. The impression of the CT documented an associated mass effect on the adjacent parenchyma and resultant acute [DIAGNOSES REDACTED] (fluid accumulation in the brain). The hospital Discharge Face Sheet dated [DATE] at 3:20 p.m. recorded Resident #2 discharged back to the facility with Hospice and comfort cares. A Health Status Note dated [DATE] at 4:04 p.m. documented Resident #2 returned to the facility. Staff assessed the resident as nonresponsive; she would groan to a firm sternal rub (painful stimuli) but did not attempt to pull away. Resident #2 did not grip or pull (with her hands). Staff contacted Hospice who planned to discontinue the resident's current medications and begin comfort care medications. Observation of Resident #2 on [DATE] at 12:10 p.m. revealed Resident #2 on her left side in bed and with no response to her name. The observation revealed a right frontal/temporal bruised open area, very swollen in appearance and measuring approximately 3 x 5 cm. A Health Status Note dated [DATE] at 10:30 p.m. documented Resident #2 expired at the facility at 6:45 p.m. A Major Injury Determination Form signed by Resident #2's Physician on [DATE] revealed that after reviewing the circumstances, injury and prognosis of Resident #2, the physician believed Resident #2 sustained a major injury. The Certificate of Death dated [DATE] documented Resident #2's immediate cause of death as a traumatic head injury. The manner of death, accidental and a description of the injury as the patient struck head when dropped by nursing home personnel. During a phone interview on [DATE] at 10:57 a.m., Staff A remembered the incident on [DATE]. Staff A stated when she entered Resident #2's room, she saw her laying on the right side with her head partially on the leg of the lift and blood on the floor. Staff A lifted Resident #2's head, observed the laceration was a significant and asked Staff C to apply pressure while she dialed 911. Staff A stated that she asked the aides what happened afterwards. The aides reported the lift sling was not connected correctly. They tried to re-position the sling while the resident sat in the wheelchair, but the resident was positioned badly and fell . Staff A stated it was like they tried to blame positioning on the resident's fall. When asked about the elevation of the lift, Staff A stated the resident's bottom would have been three to four feet in the air. Staff A stated she took a photo right after the fall; the lift had not been lowered but it was moved away so she could care for the resident. Staff A sent the photo via text and asked to speak further. At 11:18 a.m., Staff A stated she is an advocate for patients and did not want to get anyone in trouble. Staff A stated the lift had very pronounced hooks and the sling was intact. Staff A thought the loops were not positioned completely on the lift hooks. When staff lifted Resident #2, her body weight caused the sling to come off the hooks, causing the fall. Staff A stated she sent the

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

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) photo she took on [DATE] to the facility's Director of Nursing (DON). A review of the photograph received from Staff A revealed a total mechanical lift. The photograph revealed one loop hung free from the lift (lower right as the resident sat) and open-ended hooks at the end of the lift arms. The lift seat appeared to hang approximately three feet from the floor. The facility reported Resident #2's fall to the Department of Inspections and Appeals by telephone on [DATE]. The Incident Summary documented Resident #2 moved her lower extremities, which shifted her weight, during the transfer. When the resident's weight shifted, the loop closest to her right knee lifted off the loops of the lift basket. Resident #2 then slid out of the sling onto the floor, hitting her head on the leg of the lift. The User Manual showed illustrations of hooks at the ends of the lift's hanger bar which contained safety clips to close the end of the hooks where the lift sling loops connected. The illustrations showing the safety the clips were present on pages 1, 12, 17, 18 and 21. Page 26 of the manual instructed not to move the patient if the sling was not properly connected to the hooks of the hanger bar. Observation on [DATE] at 10:40 a.m. revealed no safety clips in place on the hooks at the end of the hanger bars on either the facility's total mechanical lifts. During interview on [DATE] at 10:00 a.m., Staff B stated after supper on [DATE], she assisted Resident #2 to her room and put the resident's pajamas on while Staff C obtained the lift. When Staff C arrived with the lift, Staff B noticed the resident positioned crooked in the lift sling, so she straightened her out. Staff B stated she ran the lift. Staff B started to lift the resident while Staff C stood behind the resident's wheelchair. Staff B stated the resident wiggled in the wheelchair before the transfer and in the sling during, so they stopped moving the lift. Resident #2 swung her leg and Staff B thought the right lower hook came out; Resident #2 fell to the floor. During the interview, Staff B stated the lifts are supposed to have safety clips at the top of the hooks to keep the loops in place. Staff B had never seen safety clips on the lifts. Staff B showed the surveyor her phone, which contained photos of the hooks without safety clips at the end of the Invacare hanger bar. Staff B stated she received the photos from another staff member (Staff D). During interview on [DATE] at 3:57 p.m., Staff C (Nurse Aide) stated the night of [DATE], Resident #2 had been kicking her legs over the edge of the chair more than once, beginning at 6 pm. The resident also kept trying to sit forward and she got more fidgety. About 6:30 or 7:00 p.m., she and Staff B assisted Resident #2 to her room. They noticed the resident curled sideways in her chair and the sling appeared crooked; they tried to reposition the sling multiple times. They started the lift; Staff B worked the controls and Staff C pulled the chair away. The next thing she knew, Staff C observed Resident #2 on the floor. It happened fast. Resident #2 turned right in the sling, her right and left legs crossed over each other. Staff C originally thought the loop snapped. Staff C stated she had never seen any safety clips at the hook ends of the lift hanger bar. She also had photos of the lift on her phone which showed no safety clips at the hook ends of the hanger bars. Staff C stated she wished the clips had been on the lift on [DATE]; they might have prevented Resident #2's fall. During interview on [DATE] at 5:15 p.m., Staff D (Certified Medication Aide) stated she had photos of the lift on [DATE] and provided the photos. Staff D stated she had worked at the facility for more than two years and the lifts failed to contain safety clips. Review of the photographs showed no safety clips at the hook ends of the hanger bar of the lift. Observation on [DATE] at 1:50 p.m., revealed the total mechanical lift 600 had safety clips in place to close the hooks at the end of the hanger bar. Observation at 3:00 p.m. revealed the total mechanical lift 450 lift also had safety clips in place to close the hooks at the end of the hanger bar. During observation and interview on [DATE] at 10 a.m., Staff E (Nurse Aide) observed the mechanical lift 600 and stated the safety clips were new. Staff E did not see the safety clips on the lifts the previous week and she thought they were placed on [DATE]. During observation and interview on [DATE] at 10:10 a.m., Staff F (Nurse Aide) observed the total mechanical 450 lift and stated she last worked the floor on [DATE] and did not see safety clips on the Invacare lifts then; today was the first day she'd seen them. On [DATE] at 10:10 a.m., the Maintenance Director stated he had worked at the facility since ,[DATE] and does monthly checks the lifts. He checks the wheels, clips, pulls hair out of the casters and checks the batteries. Observation of the total mechanical lift 600 occurred shortly after the interview. The Maintenance Director stated he did not order or install the safety clips. Review of Mobile Lift Inspection Logbook documentation dated [DATE], [DATE] and [DATE] contained instruction to inspect the boom (where the hanger bar connected) to check its hardware and swivel bar supports and inspect the swivel bar bolts/hooks for damage/wear and the sling hooks for bends or deflection. During an additional interview with the Maintenance Director of [DATE] at 10:00 a.m., he stated the items he mentioned on [DATE] were items he had problems with. He reviewed the Logbook documentation and stated he looked at all listed items. Upon observation of the lifts after the interview, he stated he was pretty sure the safety clips were on the end of the hooks, but not listed on the checklist he maintains. The Maintenance Director then stated he maintained three lifts at another facility and two lifts at this facility and it may be the other facility's lifts he remembered seeing the safety clips in place. During interview on [DATE] at 10:45 am, the Administrator reviewed the photograph taken the night of the fall and stated he had seen the photo before. The Administrator stated he placed the safety clips at the hook ends of the lifts on [DATE]. When asked if the clip's purpose would be to keep the loops on the lift's hooks, he stated he did not really know but it's not unreasonable to think so. An invoice from the facility's equipment supplier identified a purchase order for clips for the Invacare Spreader Bar as ordered on [DATE] and delivered on [DATE]. On [DATE] at 11:30 a.m., the Director of Nurses provided a list of residents who required mechanical lifts for transfers; the list contained the names of nine current residents and did not include Resident #2. The DON stated the facility had no bariatric residents and all nine residents could transfer in either the total mechanical lift 450 or the total mechanical lift 600. 2. During interview on [DATE] at 10:00 a.m., Staff B (Nurse Aide) stated she was [AGE] years old when she trained as A Nurse Aide and did not complete lift transfers during that training. Staff B stated that facility staff must be [AGE] years or older to use the mechanical lifts. Staff B stated the Director of Nurses knew she had observed transfers but she had no physical training on use of the mechanical lifts. Staff B turned 18 in June, 2020 and she thought everyone knew this because other staff told her she could use the lifts now. During further interview on [DATE] at 7:25 pm, Staff B stated she had been using both total mechanical lifts for all residents who required lift transfers since she turned 18 in June, 2020. She likely had transferred Resident #2 50 to 100 times. She stated Resident #2 could be fidgety with transfers but that night was really bad. During interview on [DATE] at 5:00 p.m., the Director of Nurses stated it is corporate policy that staff must be [AGE] years old or older to use the facility's mechanical lifts. At 3:30 pm, the Director of Nurses and the Administrator stated the facility had no policy regarding staff under the age 18 being prohibited from using mechanical lifts; it is the facility's practice though. On [DATE] at 11:10 a.m., the Director of Nurses provided Staff B's Staff Orientation Checklist - Transfer and Lifting Equipment, dated [DATE]. The Director of Nurses reported this was the most recent training Staff B had on mechanical lift transfers. Staff B had no additional training aside from watching other staff use the lift. 3. Staff B and Staff C both stated that Resident #2 fidgeted, moved her legs and attempted to turn sideways during the transfer on [DATE]. During an interview on [DATE] at 9:50 a.m., Staff G (Nurse Aide/Medication Aide) stated she had not received training regarding resident movement during a lift transfer. Staff G stated she worked in long-term care for a long time and if a resident moved during a mechanical lift transfer, she would stop the transfer and tell her charge nurse and try again later. On [DATE] at 10:20 a.m., Staff H (Nurse Aide) stated she received training on using the total mechanical lifts from another Nurse Aide. If a resident moved their legs or tried to roll during a transfer, she would not transfer the resident, would let them calm and try again later. The Nurse Aide who trained her told her that. She had not received an audit on safe use of the mechanical lifts prior to Resident #2's fall on [DATE]. During an interview on [DATE] at 10:40 a.m., Staff I (Nurse Aide) stated if a resident tried to move their legs or turn during a lift transfer, she would wait and try again later. It wouldn't be safe to move the resident. Staff I knew this based on her own experience, not from training at the facility. Page 7 of the Mechanical Lift 450 User Manual instructed to use common sense in all lifts. Special care must be taken with people with disabilities who cannot cooperate while being lifted. Review of the Staff Education for ,[DATE] document, with training beginning on [DATE], identified the following training items: a. User manuals for each lift are attached to the lifts themselves. Please utilize this as a user's guide to operation. Shower slings should be utilized for showers only b. In the event that any equipment fails, it needs to be removed from operation. A sign should be securely affixed to the equipment identifying it is out of operation. The equipment should be place in the vending machine area until it can be addressed. c. When assisting residents with Activities of Daily Living, reference the Pocket Care Plans to provide care as appropriate. The Pocket Care Plans are located at the designated nurse's station. The Staff Education for ,[DATE] also contained staff audits on safe use of the mechanical lifts. During interview on [DATE] at 10:45 a.m., the Assistant Director of Nurses (ADON) stated she conducted the staff education for ,[DATE]. The ADON stated she went through each item as documented and also went through the User Manual (pages ,[DATE], ,[DATE] and 31). She stated she watched as staff read the manual and use the lifts. The ADON stated the training did not specifically address what to do if a resident moved or squirmed during a

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) lift transfer, but it did address the safety and comfort of the resident. On [DATE] at 2:45 p.m. the State Agency informed the facility of the Immediate Jeopardy. The facility abated the Immediate Jeopardy on [DATE] by educating staff on the proper use of lifts according to the manufacturer's instructions with return demonstration, educating staff on what to do in the event a resident moves while in the lift, installing clips to the lift hanger bar and implementing checks to ensure the clips are in place prior to use of the lifts. After corrective actions the scope lowered from a J to D.