STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105717	A. BUILDING _____ B. WING _____	04/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TIMBERRIDGE NURSING & REHABILITATION CENTER	**9848 SW 110TH ST OCALA, FL 34481**

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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 record review, interview, and policy and procedure review, the facility failed to ensure adequate supervision was provided to prevent accidents and/or injury when using a mechanical lift device during a resident transfer for 1 of 3 residents sampled for device-assisted transfers, Resident #1. The facility staff failed to implement proper transfer procedures when using a mechanical lift and failed to follow the facility's policy and procedure for using a mechanical lift with transfers. This had the potential to affect 36 out of total 144 residents in the facility who require mechanical lift transfer assistance. Findings include: Review of Resident #1's medical records revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. enough [MED]gen or has too much carbon [MEDICATION NAME]), status [REDACTED]. Review of the Minimum Data Set Comprehensive Admission assessment dated [DATE] revealed Resident #1 could not complete the Brief Interview for Mental Status (BI[CONDITION]) assessment, and that Resident #1 required two-person physical assistance with total dependence on staff for transfers between surfaces from bed to the chair. Resident #1 was not steady during bed to chair transfers and required human assistance to stabilize during transfers due to functional impairment of upper and lower extremities. Review of the care plan for Resident #1 dated February 4, 2020 revealed the resident required total assistance with Activities of Daily Living (ADL) and full body mechanical lift for all transfers. Review of the Certified Nursing Assistant plan of care revealed Resident #1 required two-person assistance and mechanical lift (A battery-operated lift that safely transfers individuals) use. Review of the nursing progress note authored by the Assistant Director of Nursing dated 3/23/2020 at 9:45 AM read, Called to resident's room to assess for injury s/p (status [REDACTED]. Resident was wearing a gown, brief, left [MEDICAL CONDITION] glove and B/L (bilateral) knee braces. Wound vac and indwelling catheter were in place, G (gastrostomy) tube feeding was disconnected. Therapists and nursing staff had been transferring resident from bed to chair when resident fell forward and onto the floor. Staff removed the mechanical lift and log rolled resident to her back. Her eyes were opened, and she was mumbling incoherent words. resident sustained [REDACTED]. Small abrasion noted to right arm. Cleaned face with normal saline and 4x4 gauze than applied pressure to forehead and nose to stop the bleeding. Wound vac and bilateral braces were removed. 911 called to transfer resident to ER (emergency room) for evaluation and treatment as ordered. Review of a written statement from Staff B, Physical Therapist (PT) dated 3/23/2020, 9:40 AM, read, Patient was assisted for Hoyer transfer room from bed to Broda chair with (Staff C's name) Certified Nursing Assistant (CNA), Staff A, Occupational Therapist (OT) and this writer in pt.'s (patient's) room. Hoyer pad was already placed under patient when this writer arrived in the room. CNA was standing on the right side of bed and put on right top and bottom straps. OT was standing to the left side head of bed and put on left top strap, this writer placed on the left bottom strap as this writer was standing left side foot of bed. As patient was cleared from bed, this writer went to retrieve the Broda chair from window side of the room, began to push Broda chair towards bed, this writer saw patient lost balance, forward falling out of pad face down on floor. Nursing was called immediately. Review of a written statement from Staff A, Occupational Therapist (OT) dated 3/23/2020, 9:40 AM, read, This writer and patient's Physical Therapist (PT) and CNA assisted patient with transfer out of bed. Hoyer pad was already placed under patient when writer arrived to room. CNA was standing on right side of bed and attached top and bottom Hoyer straps on right side. This writer attached top Hoyer strap and PT attached bottom strap. When all 4 straps were secured, CNA started to lift pt. (patient). This writer leaned over bed to reach bed control on right side of bed to lower bed further as CNA proceeded to operate Hoyer away from bed stating: I'm clear when coming back from reaching over bed, this writer observed pt. (patient) suspended on Hoyer pad facing this writer and fully cleared from bed as patient slowly lost balance forward falling out of the Hoyer pad. This writer went to notify nurse supervisor to room immediately. Review of Investigation Notes from the Risk Manager (RM) read, 03/23/2020 at 10:20 AM Risk Manager informed of fall with transfer to hospital. (Staff C's name) interviewed with Director of Nursing present. (Staff C's name) stated she was controlling the Hoyer. She stated she was on the right side of bed and therapist were on the left. Per (Staff C's name) she began to lift resident up and cleared the edge of bed. Per (Staff C's name) she began to turn lift slightly to prepare to get her to chair and suddenly resident slid out of pad. (Staff C's name) questioned regarding who placed pad, she stated she placed pad and also attached the front to lift sling hooks. (Staff C's name) stated (Staff A's name) placed the two leg sling hooks. (Staff C's name) was also given lift and asked to demonstrate how procedure occurred. (Staff C's name) stated she only put on resident shirt and brief and then prepared pad under resident with head cradled midway on pad. Return demonstration shown by (Staff C's name) using lift. 3/23/2020 at 1:00 PM: Risk Manager, DON (Director of Nursing) and Therapy Director present and (Staff A's name) interviewed. (Staff A's name) was asked to demonstrate transfer and show us team where she was positioned. Per (Staff A's name), she was on the left side of the bed, (Staff A's name) states she asked (Staff C's name) about straps and she placed them. (Staff A's name) stated that she also placed catheter tubing and wound vac (portable unit) on resident's lap in sling pad. Per (Staff A's name), (Staff C's name) began to lift resident up from bed and cleared bed and began to turn and resident slid out of sling. (Staff A's name) stated that she saw resident start to slide before she could get around to other side of bed. (Staff A's name) questioned regarding resident's position and stated that resident was facing her, and (Staff C's name) was at an angle toward room door controlling lift. (Staff A's name) was asked to write a statement and she said she would. 03/23/2020 at 1:25 PM: (Staff B's name) was interviewed in main conference room. DON, RM (Risk Manager), and Therapy Director present. (Staff B's name) was asked to explain events as she remembered. (Staff B's name) stated she was standing on left side of bed closer the foot of bed. Per (Staff B's name) she was applying knee braces and checking them. She stated she moved from bed to go retrieve chair which was located in room near window. (Staff B's name) stated that she turned to return chair nearer to bed when resident started to fall from sling, and she could not get to her quick enough. (Staff B's name) stated when asked about taking care of resident previously that she also assisted with transfers on Friday, herself and (Staff A's name) got (Resident #1's name) out of bed and aide was not in room. Aide was providing care to another resident at that time. RM and DON checked lift, lift inspected 2019 by Wings Healthcare. Sling also checked and in good condition. No frayed areas. DON notified Administrator. Administrator informed of events. DON and Administrator phoned significant other. Plan of Care was followed and checked. Assistant Director of Nursing was also interviewed. RM informed DON to err on side of caution, will report. A review of Investigation Review with no date or time, signed by the RM read, Risk Manager spoke with staff involved again. Therapist nor aide could state hands were on resident. All stated lift cleared bed. Identified need for mechanical lift re-education. Spoke with Staff Educator to schedule mandatory lift training for all nursing and therapist. A review of Investigational Review/Findings/Summary/Conclusion (Reasonable Cause) with no date or time, authored by the Risk Manager read, Risk manager spoke with staff present during the fall. Staff provided account of transfer via demonstration using mechanical lift. All involved stated resident had cleared the bed. CNA

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) was operator of lift and demonstrated knowledge of use proficiently. Therapists both stated that they had resident on prior week and performed transfer using lift. Mechanical lifts evaluated and all were inspected December 2019 by Wing healthcare. Vanderpad/sling also inspected with no signs of frays noted. Random reviews of staff using lifts also completed and RM identified need for reeducation of mechanical lift use. Staff involved in fall stated loops used were black on bottom and green on top. This caused the resident to be in a more upright position when in the sling. RM also noted that staff are not always using specific colored loop, identified need to include this in reeducation. RM investigational findings have determined that reasonable cause is attributed to techniques use during mechanical lift transfers. Spoke with DON/Administrator and educator regarding need to schedule mandatory training on sling positioning. Loop application and body positioning during mechanical lift transfers. Staff retraining using lifts has been scheduled. During an interview with Staff C, CNA on 4/2/2020 at 8:50 AM, she stated, I am the CNA who was taking care of Resident #1 the morning that she fell . There were three of us, (Staff A's name) from OT and staff from PT. I was operating the Hoyer lift, (Staff B's name) was on one side and (Staff A's name) on the other side. (Staff B's name) went to get the chair and as I pulled out the machine, she just leaned forward in the sling pad and she was face down on the floor bleeding. I really can't tell you how it happened. I was on one side of the bed, (Staff A's name) was on the other side, no one was touching or guiding the sling when the patient fell . I know that when we use the mechanical lift we should be able to touch the resident or have our hand on the back of the sling or have the residents facing us, it happened so quickly that I didn't have time to turn her toward me and (Staff A's name) was still on the other side of the bed. We always have two people when using the lift. I didn't know everything about the patient, but I did get report and I knew that she was not able to move, and she needed full assistance. I had just cleaned her up and changed her brief and put the lift pad under her, so I knew that she couldn't move almost at all. During an interview with Staff A, Occupational Therapist (OT) on 4/2/2020 at 10:15 AM, she stated, We, PT and OT, were working with Resident #1 giving her passive range of motion while she was supine in bed with the Hoyer lift (Vander) pad already under her. The CNA was on one side of the bed operating the lift, after the hooks were positioned on the lift, I leaned over to get the bed control to lower the bed when the Aid stated I'm clear and pulled the machine out from under the bed. Before I could get to the other side of the bed, I saw the patient lean forward and I couldn't get there soon enough to stop the fall. She ended up on the floor face first and I went to get a nurse. Usually there are two people assisting with mechanical lifts and one person operates the machine and the other person guides the resident into the chair. The resident should not have at any time been hanging in the sling without staff holding the lift/sling pad. Someone should have been holding the sling/lift pad or have the resident facing the person who is operating the controls so they can have hands on the patient's knees/legs. I have worked with this resident before and have used the mechanical lift to get her out of bed without any problems. I do feel comfortable in using that piece of equipment. During an interview with Staff B, Physical Therapist (PT) on 4/2/2020 at 11:42 AM, she stated, When I came to the room (Resident #1's name) was already dressed, with the Hoyer sling pad under her, the CNA was operating the lift machine. I was splinting her extremities and placed the straps on the mechanical lift. I was on the right side of the bed and (Staff A's name) was on the left side. I stepped away to get the resident's chair and when I did the resident fell out of the sling face first onto the floor. The chair was about five feet away near the window in the room. I guess we had a failure to have hands on the resident during the transfer. (Staff A's name) was trying to lower the bed and (Staff C's name) said it's clear and she began moving the machine. I have been working with the resident and know that she has had [MEDICAL CONDITION] hemorrhagic stroke with no arm or leg use, no reflexes, no verbal expression and no trunk control which makes her a high risk for falls. She also has flexor tone in arms and legs. The leadership staff did have the three of us reenact the fall and what we were doing when it happened. It showed me that there was a lack of physical assistance for the resident during the transfer process. We should have had her within reach, holding the back of the sling or had her positioned to be facing whoever was operating the mechanical lift so hands can be on the sling or on the resident's knees to stabilize them. During an interview with the Director of Nursing on 4/2/2020 at 09:05 AM, she stated, Part of our thought was that the resident needed to be less upright during the transfer. There were two staff with (Resident #1's name) when she fell that had worked with her extensively and had just a week prior to the fall did a mechanical lift transfer on the resident. This occurred when staff broke contact with the resident and the sling pad and the resident had a sudden movement that propelled her out of the sling and onto the floor. Someone ideally will position the resident to face them if they are operating the mechanical lift, this will ensure that the knees or legs can be supported until the resident is safely in the chair. Also, if they don't reposition the resident to face them they should maintain hands on the lift pad either the loops on the back of the sling that assist in guiding patients into position or on the sides of the lift sling. These did not happen in this case; the aid did not turn the patient to face her and no one was in position to have hands on contact with the lift pad while the resident was in the air and not over the bed. During an interview with the Risk Manager on 4/2/2020 at 9:35 AM, she stated, I was notified that (Resident #1's name) sustained a fall. I began an immediate investigation and started to get interviews. No staff indicated that they were in contact with the resident or the lift pad sling. We had them demonstrate what they were doing at the time (Resident #1's name) fell . (Staff C's name) was operating the lift machine. (Staff A's name) was on the other side of the bed and (Staff B's name) was getting the residents Broda chair. During the investigation we determined that they had not followed procedure and have hands on the resident. We also found that there was no consistent usage of the loops on the sling that determine how upright residents are when they are being transferred in the sling. Review of the facility's Plan of Correction read, Proper and safe placement of resident on Hoyer lift sling. Follow up: Resident sent to local hospital Date: 3/23/20. Hoyer lift and sling involved immediately removed from unit and were checked by maintenance and housekeeping personnel to ensure lift was in proper working order and sling in good repair. Results of inspection were Hoyer lift and sling were in good working order and repair. PIP (Performance Improvement Plan) initiated 3/23/2000. Dates: 3/23/2020 All current residents requiring use of Hoyer lift were monitored during transfer to ensure safe positioning and contact guard was maintained. 3/24 -29/2020. All Hoyer lifts and slings were inspected by maintenance and housekeeping personnel and found to be in good working order and in good repair. QAPI (Quality Assurance Performance Improvement) meeting held on 3/24/2020 and 4/2/2020 to review, investigate and make changes as necessary to ensure proper and safe placement of residents in slings. Mandatory Hoyer lift skills training with return demonstration conducted for all licensed nursing staff, CNAs and therapy personnel with procedure changes made to use of sling. New audit tool implemented 4/4/2020. Audits tools were done for the immediate time frame for resident safety). The new tool also requires an auditory response as well. They have to tell what they are doing and why. Any nursing personnel or therapy personnel who have not received training will not be allowed to assist with Hoyer transfers until training is completed. Ongoing mechanical lift competency training will continue upon hire and annually for licensed staff, CNAs and therapy personnel. Daily audits will be conducted (to include all shifts) of residents requiring Hoyer lifts. DON/designees to conduct auditing daily and if indicated corrective measures will be taken immediately as concerns are identified. This plan of correction will be brought to the QAPI committee monthly and the committee will decide whether to continue the monitoring period or discontinue based on effectiveness of the plan. Fifty-eight Hoyer/Vander lift transfer audits have been completed to ensure that residents are properly positioned during transfers. Review of the Mechanical Lift Training sign in sheets revealed 89 of 120 staff completed training titled, Lifting and Positioning Training as of 4/2/2020 with repeat demonstration. During an interview with the Director of Nursing on 4/2/2020 at 09:05 AM, she stated, We have started facility wide education with all staff who could use the mechanical lift to transfer residents. These began on 3/30 and will end tomorrow and it is mandatory for all staff. Part of our thought was that the resident needed to be less upright during the transfer, so we are now positioning patients, so they are more cradled as opposed to upright sitting in the mechanical lift sling/pad. We did have the involved staff come to the conference room and demonstrate what they were doing at the time of the fall. We evaluated the Vander lift and determined that it had been serviced and checked in 12/2019 and evaluated the sling/pad for any signs of wear and fraying and it was in good condition. During a follow up interview with the Director of Nursing on 4/3/2020 at 11:46 AM, she stated, I believe there was a failure to follow the procedure due to a lack of knowledge and understanding. We reviewed the Process improvement Plan (PIP), have begun auditing and observing transfers to monitor the mechanical lift training education by observing transfers. I expect that all staff will follow the policy and procedures for mechanical lift use. During an interview with Staff C, CNA on 4/2/2020 at 8:50 AM she stated, I am the CNA who was taking care of (Resident #1's name) the morning that she fell . We have had training on how to use the mechanical lift in our annual competencies and I did go through the mandatory training we just had. I was required to demonstrate the proper use of the mechanical lift with the training I went through. During an interview with Staff G, LPN (Licensed Practical Nurse) on 4/2/20 at 9:01 AM she stated, I have been trained on how to use the mechanical lift and had

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The other person will lower the lift. We make sure the resident is situated in the chair. We should not let go and let the patient free dangle in the air and we should not let go of the Hoyer lift pad. During an interview with Staff I, LPN on 4/2/2020 at 9:32 AM she stated, I have received training on how to use the mechanical lift and I did have to do a repeat demonstration process during the in-service. During an interview with Staff N, CNA on 4/2/20 at 10:16 AM she stated, I have received the recent education and training on mechanical lift use and had to show them I could do it. To transfer a patient using a lift you can't' do it yourself. You have to have someone with you. One person operates the lift and the other person guides the resident to make sure they are safe to prevent falls or skin tears. Sometimes, I would have to hold on to their feet or their knees but usually I guide them by holding the straps until they are seated in the chair. During an interview with Staff J, CNA on 4/2/20 at 10:23 AM she stated, I was at the new training on how to use the mechanical lifts. I was required to repeat demonstrate how to use it properly. First you get a pad, you either have them roll over or roll them over. Tuck the pad under them making sure there are no wrinkles and have it cradling their head. You put the bottom part about the back of the knee. Once they are hooked to the lift, one person will operate the lift the other person will hold the resident. Usually, you hold the straps or the resident's legs. Do not let go of the person until they are securely in the seat. Usually, holding onto the pad this keeps their direction so there is not any swinging when they are in the sling. During an interview with Staff O, CNA on 4/2/20 at 10:40 AM she stated, I did receive education on how to use the mechanical lift and proper resident placement to prevent any falls. Depending on the care plan, we use two or three people. First, we put them on the pad properly, then hook the pad on the second hole from the top. We make sure that the lift is locked. One person operates the lift and another staff holds the pad on both sides guiding the patient. After the resident is in the chair and their bottom is seated then you can let go of the pad. Review of The (Manufacturer's name) Lift policy and procedures read, (Manufacturer's name) lift Effective date 1/2000 Policy: To be used to transfer patents who require high levels of care or are too heavy to handle (Patients up to 350 lbs. of weight). Prior to the use of the (Manufacturer's name) lift, the patient must be evaluated by a licensed nurse to determine the use of the lifter and the need for one or two employees. Procedure: #14. Use the stabilizer handles to guide the patient into the chair. Review of the hospital records for Resident #1 dated 03/23/2020 revealed, Patient presented as a Level 1 trauma alert on 03/23/2020 after she was dropped during patient transport at Timberridge Rehab Center. Per E[CONDITION] (Emergency Medical Services) patient fell with direct impact to her pace. Patient is nonverbal at baseline and has a G (gastrostomy) tube. Per E[CONDITION], patient was GCS 8 (Glasgow Coma Scale - a tool used to assess patients in a coma. The initial score correlates with the severity of [MEDICAL CONDITION] and prognosis. Patients with scores of 3-8 are usually said to be in a coma). Patient was evaluated as per ATLS (Advance Trauma Life Support) guidelines: A (Airway) - not patent; B (Breathing) - no breath sounds heard; C (Circulation) - 2+ pulses throughout; D (Disability) - GCS 5; E (Exposure) - Patient exposed for secondary survey (is performed once a patient has been resuscitated and stabilized. It involves a more thorough head-to-toe examination, and the aim is to detect other significant but not immediately life-threatening injuries.) Secondary survey revealed: 6 cm (centimeter) laceration with hematoma in the R (right) frontal area. 1 cm laceration over nasal bridge - Obvious deformity of nose. Bruising of R knee. Sacral wound with disconnect wound vac. Review of the CT (Computed Tomography) Brain dated 03/23/2020 revealed: Large volume R hemispheric SDH (Subdural hematoma - a type of bleeding in which a collection of blood - usually associated with a [MEDICAL CONDITION] - gathers between the inner layer of the dura mater and the arachnoid mater of the meninges surrounding the brain) (25mm) (millimeters) R frontoparietal and temporal region with compression of the R lateral ventricle and effacement of the sulci throughout the right hemisphere. R-L (right to left) midline shift at least 12 mm. (A shift of the brain past its center line). Injuries/Problems: R sided SDH with midline shift. Surgeries/Procedures: Emergent OR (operating room) with (The physician's name). Neuro (neurology): GCS 3T (deep coma). R sided SDH with midline shift. {Physician's name} consulted: Taken to OR emergently.