STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525653	A. BUILDING _____ B. WING _____	08/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VIRGINIA HIGHLANDS HLTH AND REHAB	W173 N10915 BERNIES WAY GERMANTOWN, WI 53022

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 -** Some	**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 interview and record review, the facility did not ensure that 1 of 6 (R3) residents reviewed remained free of accident hazards as is possible during a Hoyer lift transfer of R3. * Facility staff did not attach the sling strap correctly to the Hoyer lift and did not wait for a second staff member to assist with R3's transfer. As a result of these actions, R3 fell from the Hoyer sling and sustained a laceration to her face requiring stitches and fractures to both her legs. R3 died that evening. * Additionally, and more systemically, at the time of R3's fall, the facility was using universal straps not designed specifically for the Hoyer lift, had not numbered the slings per facility policy, and was not routinely inspecting the slings to ensure appropriate and safe use for residents. This deficient practice was determined to affect 18 residents who used the sling and mechanical lift for their transfer needs. The failure to use the correct sling, to use an additional person while transferring R3, and the failure to routinely inspect slings and to use straps designed specifically for the Hoyer lift created a finding of Immediate Jeopardy that began on [DATE]. The Nursing Home Administrator (Administrator-A) and Director of Nursing (DON-B) were notified of the immediate jeopardy on [DATE] at 12:25 p.m. The immediate jeopardy was determined to be past non-compliance and was found to be removed and corrected on [DATE]. Findings include: The facility's policy with no listed date and titled, Sava SeniorCare Quicklist: Transfer with a Mechanical Lift documents, Review the patient's medical record for conditions that may affect mechanical lift use and ensure the patient's weight doesn't exceed the mechanical lift's weight limitation; Introduce yourself and state the purpose of your visit; Ask about recent changes in the patient's health status; Explain the procedure; Determine the patients ability to cooperate and follow directions; Survey the patient care environment ; Inspect the mechanical lift and test the lift controls; Inspect the sling and the straps ; Ensure that both the bed and the chair or wheelchair are stable: if any of the wheels are present ensure they are locked; Position the patient supine and then roll the patient onto the side away from you; Place the center of the sling under the patient spine and fanfold the material of the far side of the sling; Roll the patient onto the back so that the patient is centered on the sling; Position the mechanical lift so that its arm is perpendicular to the bed, directly over the patient. Ensure the arm doesn't hit the patient; Attach the straps on the sling to the hooks on the arm of the mechanical lift according to the manufacturer's instructions. Face the hooks away from the patient. Ensure the straps are securely attached to the hooks and aren't twisted ; Instruct the patient to keep the arms inside the sling straps during transfer; If the patient has an IV line or urinary drainage bag, move it first; Tell the patient when you are going to the activate the mechanical lift. R3 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R3's Quarterly MDS (Minimum Data Set) dated [DATE] documented a BIMS (Brief Interview for Mental Status) score of 14, indicating that R3 was cognitively intact. Section G (Functional Status) documents that R3 had total dependence on facility staff and required a two person physical assist for her transfer needs. R3's ADL (Activities of Daily Living) care plan dated as revised on [DATE] documents under the Interventions section, TRANSFER: Full body lift with 2. On [DATE], the Southeastern Regional Office received a facility self-report that documented R3 had fallen from a Hoyer lift and sustained injuries. R3's nursing note dated [DATE] at 7:30 a.m. documents, SBAR (Situation, Background, Assessment, Recommendation) Summary: Vital Signs: BP (Blood Pressure) ,[DATE], P (Pulse) 85, R (Respirations) 20, T (Temperature) 97.6 (degrees Fahrenheit) .LPN (Licensed Practical Nurse) Appearance of resident - What I think is going on with the resident is: Resident fell from Hoyer lift when transferred to wheelchair per 2 RC's (CNAs- Certified Nursing Assistants). Writer was down the hall passing medications when called to the room to assist with patient. Legs bent at the knee's laying position. Resident was alert and able to answer questions. Pressure and ice pack applied to left side of forehead. Called DON (Director of Nursing) who was on call at the time and updated. 911 called and arrived to resident's room. Additional Nursing Notes as applicable: Family/Health Care Agent Notified: [DATE] 7:55 AM. Primary Care Clinician Notified: [DATE] 7:50 AM. R3's Fall Incident Report dated [DATE] documents, Incident Description: Nursing Description- Resident fell out of Hoyer when transferring from bed to wheelchair; Resident Description- I was up in the air in the thing and I fell . Under the Immediate Action Taken section it documents, Writer ran to resident's room when CNAs (Certified Nursing Assistants) called out to staff. Seen resident laying on the floor under the hoyer. Cold pack and pressure to left side of head. Legs bent at the knee. Call to RN (Registered Nurse) on call and updated. 911 called and updated. Came to resident's room for transport. Under the Mental Status section it documents, Resident had abrasion to left side of face, temple area. Cold pack and pressure applied. Resident had pain when ambulance tech's (technicians) tried to position. Medicated by ambulance techs (technicians). R3's Hospital Admission documentation dated [DATE] at 3:16 PM documents, ER (emergency room) Joint Care Attestation: Patient presented after a fall from Hoyer lift and extensive work for traumatic injuries revealed right femur fracture and left tib-fib (tibia-fibula) fracture. She has what almost appeared to be incidental [MEDICATION NAME] by CT (Computerized Tomography) belly which was really done for trauma and while in the ED (emergency department) has transient and very labile blood pressures with intermittent [MEDICAL CONDITION] and I did reexamine her thigh multiple times and do not see large hematoma to suggest she is in hemorrhagic shock and blood pressure rebounds quickly. Independent of her blood pressure fluctuations she also developed some [MEDICAL CONDITION] or waxing and waning mental status in the ED .Case was discussed with the intensivist who evaluated the patient at the bedside and agrees to admit her to ICU (Intensive Care Unit). Case was also discussed with multiple specialists including surgery, IR ([MEDICATION NAME] Radiology) and orthopedic surgery. Procedures: Wound Repair The 0.5 cm (centimeter) long puncture wound with necrotic edges on the left face was anesthetized with 2 cc (cubic centimeter) of 1% [MEDICATION NAME] .and closed using a single layer closure with #2 ,[DATE] [MEDICATION NAME] simple interrupted sutures. Impression and Plan: R3 is an 80 y female who presented to the ED (Emergency Department) with fall. Multiple [DIAGNOSES REDACTED].were considered in the care and evaluation of this patient. Patient was seen immediately upon arrival and examined. Past medical history, medications and allergies [REDACTED]. She was placed on nasal cannula. I called my supervising physician who came and evaluated patient. Her initial blood pressure was also 77 systolic. She was mentating. Able to answer questions. She had no chest wall tenderness or tracheal deviation to suggest tension pneumothorax, chest x-ray was immediately ordered and imaging was called. As fall was less than ground level, I discussed with my supervising physician regarding as a trauma alert and it was determined that this was not a trauma alert level .Patient remained hypotensive throughout her stay in the ER (emergency room) with occasional episodes of normotensive. She was found to have a right femur fracture and left tib-fib (tibia-fibula) fractures. Her CT (Computerized Tomography) of the chest abdomen pelvis revealed acute [MEDICATION NAME], worsening pancreatic mass. I spoke with orthopedics who recommended knee immobilizer on the right, long leg posterior splint from mid-thigh to ankle on the left. Given the fact that she is a quadriplegic, this is likely inoperable . Patient was given IV (Intravenous) fluid bolus here in the ER (emergency room). She had minimal improvement with her

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

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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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) blood pressure. I discussed with the hospitalist who initially accepted patient for admission however with the persistent [MEDICAL CONDITION], I discussed at length with the intensivist who accepted patient for admission. Diagnosis: [REDACTED]. Death Summary: R3 was pronounced dead at 2156, [DATE]; Hospital Course: Brief Narrative: R3 is a(n) 80 yo female with incomplete [MEDICAL CONDITION] secondary to cervical tumor .She presented to ER (emergency room) today after falling from the hoyer lift at her care facility. She landed with her legs underneath her and hit her head. She did not lose LOC (level of consciousness). EMS (Emergency Medical Services) called . Upon arrival, she reported right leg pain and had hypertension. Trauma work up showed bilateral leg fractures .Seen in ER (emergency room) for intermittent [MEDICAL CONDITION]. She had already been given 1 liters NS (normal saline). Additional 2 liter given over an hour. Exam difficult due to [MEDICAL CONDITION]. ER (emergency room) RN (Registered Nurse) report bowel incontinence on arrival and foley. Foley was replaced. Admit to ICU. At 1500 (3PM), BP (blood pressure) noted to be ,[DATE]. 1 liter of LR ([MEDICATION NAME] Ringers) bolus given with good response but then BP (blood pressure) dropped to ,[DATE]. Additional liter of LR ([MEDICATION NAME] Ringer) given. In total including ED (emergency department), 4 liters fluid given .Decision made to not escalate therapies including, central line and pressors. Over the course of several hours patient became lethargic and then obtunded. EICU (electronic intensive care unit) discussed transition to full comfort care with family, and orders placed. She converted to asystole at 2156; Complications in the hospital: Cardiogenic shock; Body disposition: Body released to the morgue. The facility's self-report and investigation regarding R3's fall on [DATE] documents, On [DATE] at approx. (approximately) 7:10 a.m. R3 was assisted by CNA (Certified Nursing Assistant)-H with morning ADL's (activities of daily living). The CNA placed a mechanical lift sling under resident, brought in Hoyer lift and hooked resident up to lift. CNA-H went into the hallway to get a second CNA to assist with the lift. The second CNA (CNA-I) entered room and was putting on gloves and getting into position as CNA-H lifted resident from bed, pulled lift back, and began to pivot resident over to her power wheelchair. During the turn a snapping noise was heard and the resident slid out of the sling and landed on the floor at the base of the Hoyer lift. The second CNA (CNA-I) yelled for help and a nurse responded to room immediately and assessed the situation. Emergency response personnel were called and resident was sent to the hospital for evaluation. DON (Director of Nursing) obtained statement from the second CNA, CNA-I. This CNA reported she was asked to come to room to assist with the mechanical transfer. She stated she was still getting her gloves on as the transfer started and did not actually see what happened. She stated she did hear a snap sound just prior to the resident falling from the lift. Statement obtained from CNA-H. CNA-H reported she got the resident ready, placed the sling under resident, hooked the resident to the lift, and got a second CNA. She reported hearing a snap sound just prior to resident falling. At approx. (approximately) 8:45 AM Administrator-A went to the resident's room and obtained the sling used for the transfer. Upon inspection the lower left sling strap appeared to be broken. Outside of the broken strap, the sling appeared to be in good working condition with fraying or holes. The assistant housekeeping manager was interviewed about the laundering process. Proper laundering instructions were clearing posted in laundry room and inspection log was verified to be in use when sling are laundered. Approx. (approximately) 10 AM both CNA's involved in the incident were re-educated on proper lifting procedures. The lift used in the transfer was inspected by maintenance director. All safety devices on lift were present and functioning properly. Approx. (approximately) 2 PM CNA-J stated while the resident was on the ground waiting for the ambulance to arrive she knelt on ground to comfort the resident while they waited. She stated at the time she did this the sling was still hanging on the lift which the resident was under. She reported she looked at the sling strap hanging down and noted it was not broken. She further stated she told CNA-H You must not have had this hooked up right. This was witnessed by CNA-K who was orientating with CNA-J. DON (Director of Nursing) called CNA-H and informed her she was suspended pending the outcome of the investigation. The DON requested CNA-H return to the facility so she could be questioned about this new information. CNA-H stated she couldn't today, but would come in on Tuesday morning. On Tuesday [DATE] Administrator-A called CNA-H to find out when she was coming in. CNA-H reported she couldn't come in today, but would come in tomorrow at 8:30 AM to give her statement. Around 15 minutes after this conversation CNA-H sent a text message to the facility's scheduler and stated she would not be coming in and would instead be terminating her employment to save herself the embarrassment of being fired. Administrator-A called her again and left a voicemail with no call back. Administrator-A attempted to contact again on ,[DATE] with no response. CNA-H has been a nursing assistant for nearly [AGE] years. She began orientation at this facility on [DATE]. CNA-L verified she did orient CNA-H to the proper Hoyer lift process. On [DATE] a conference call was held with Administrator-A, DON-B, corporate Operational Safety Director and division regional team. Pictures of the sling and lift were shared to debrief this incident. It was the opinion of the Operational Safety Director that the break in the sling strap was not a failure in the equipment but most likely cut. This opinion was based on the fact the break was clean with no fraying. The lift was further examined. There is a spring loaded washer which keeps the sling straps in place. When the straps are removed, the washer slaps against the mental of the spreader bar and causes a snapping noise. Interventions put into place: Training was conducted with administrator and nurse management staff by Hoyer representative. Training was also conducted with all CNAs and nurses on proper transfers with mechanical lifts. Root Cause Summary: The root cause of the fall was the use of an incorrect sling that was not completely hooked into all 4 of the clips of the lift. As the lift was executed the lower strap became dislodged which caused the washer to make the snapping noise, and caused the resident to fall to the ground. The facility is able to come to a reasonable conclusion that an isolated incident involving a staff member no longer employed at Virginia Highlands using a mechanical lift and sling improperly resulted in the resident fall. Correcting action has been taken and ongoing. Surveyor noted that staff statements included in the investigation and self-report from CNA-H & CNA-I verified the above findings. Surveyor noted that per the facility's investigation and staff statements, CNA-H did not attach the sling strap correctly to the Hoyer lift and did not wait for a second staff member to assist with R3's transfer per R3's plan of care. On [DATE] at 11:39 a.m., Surveyor informed DON (Director of Nursing)-B of the above findings. Surveyor asked DON-B to confirm that the facility's self-report and fall investigation for R3's fall on [DATE] as documented above was accurate. DON-B informed Surveyor that the facility's self-report and fall investigation for R3's fall on [DATE] as documented above was accurate. Surveyor asked DON-B if CNA-H should have ensured that the strap for the sling was correctly attached prior to transferring R3 with the Hoyer and if CNA-H should have waited for a second staff member to be in position to assist with R3's transfer per R3's plan of care. DON-B informed Surveyor that CNA-H should have ensured that the strap for the sling was correctly attached prior to transferring R3 with the Hoyer. DON-B also informed Surveyor that CNA-H should have waited for a second staff member to be in position to assist with R3's transfer per R3's plan of care. On [DATE] at 11:35 a.m., Administrator-A provided Surveyor with the sling that CNA-H used on R3 when R3 fell on [DATE]. Surveyor observed the sling to be torn, as if it was cut by a sharp edge, and not frayed or worn condition. Surveyor noted that the sling did not have a manufacturer name and was not numbered. Surveyor was unable to find any documentation that the facility was inspecting the conditions of the sling being used at the time when R3 fell on [DATE]. Surveyor asked Administrator-A what type of lift was used by CNA-H when R3 fell on [DATE] and if he (Administrator-A) could provide Surveyor with the manufacturer recommendations for the lifts used by the facility. Administrator-A informed Surveyor that all the lifts at the facility were manufactured by Hoyer and that he would provide the manufacturer recommendations for the lifts used by the facility. On [DATE] at 11:20 a.m., Administrator-A provided Surveyor with the manufacturer recommendations for the Hoyer lifts used by the facility. The manufacturer recommendations titled Hoyer Full Back Sling documents, HOYER RECOMMENDS THE USE OF [MEDICATION NAME] HOYER PARTS. Hoyer slings and lifters are not designed to be interchangeable with other manufacturer's products. Using other manufacturer's products on Hoyer products is potentially unsafe and could result in serious injury to patient and/or caregiver. For the safety of the patient and carer; before using a sling a full risk assessment must be conducted to ensure that the correct sling choice, method of positioning in the sling and procedure for transfer has been determined for the patient. Check sling and stitching before each use. Using bleached, torn, cut, frayed or broken sling is unsafe and could result in serious injury or death to the patient. Destroy and discard worn slings. Do not-alter slings. Never leave a patient unattended. Surveyor noted that per the facility's investigation and the lift's manufacturer's recommendations, CNA-H was using universal sling that was not designed specifically for the Hoyer lift when R3 fell on [DATE]. Surveyor also noted that at the time of R3's fall, the slings being used by CNAs for resident transfers were not routinely inspected by the facility to ensure their condition and safety of each sling used by residents. On [DATE] at 11:22 a.m., Surveyor informed Administrator-A of the above findings. Surveyor asked if at the time of R3's fall on [DATE], the facility had a system in place to routinely inspect the lift slings to ensure their condition and safety. Administrator-A informed Surveyor that at the time of R3's fall on [DATE], the facility was not routinely inspecting the lift slings. Administrator-A informed Surveyor that the previous system of sling inspection was to have all the lift slings

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) numbered and inspected when washed. Administrator-A informed Surveyor that at the time of R3's fall on [DATE], not all the lift slings were numbered and that at the time, not all lift sling were being routinely inspected. Administrator-A informed Surveyor that in addition to not having all the lift slings numbered, the lift slings that were in use at the time of R3's fall were not all made for use with a Hoyer lift and that some lift slings, like the one that was used on R3 when R3 fell , were considered to be universal fit lift slings. Administrator-A informed Surveyor that after R3's fall, all the slings were inspected and replaced with Hoyer brand slings to ensure proper fit with the Hoyer lifts. On [DATE] at 12:25 p.m., Surveyor informed Administrator-A and DON-B of the above findings. The failure to use the correct sling and an additional person for the transfer and the failure to ensure slings were routinely inspected and were designed specifically for the Hoyer lift, created a finding of Immediate Jeopardy because of the serious outcome that can occur when an older person falls. According to For Elderly, Even Short Falls Can Be Deadly: Adults 70-Plus Three Times as Likely to Die Following Low-Level Falls (Science Daily [DATE]), .ground level falls, essentially falls from a standing position, with feet touching the ground prior to the fall, have traditionally been considered minor injuries. But, the new study found elderly adults - [AGE] years of older - who experience ground-level falls are much more likely to be severely injured and less likely to survive their injuries compared to adults younger than [AGE] years. Elderly patients are three times as likely to die following a ground-level fall compared to their under-70 counterparts .approximately 4.5 percent of elderly patients ([AGE] years and above) died following a ground-level fall, compared to 1.5 percent of non-elderly patients. Elderly patients remained in the hospital and the intensive care unit longer and only 22 percent were able to function on their own after they left the hospital, compared to 41 percent of non-elderly patients. The facility removed the jeopardy on [DATE], when it had completed the following: - Education was provided to all nursing staff (RN, LPN and CNA) regarding the proper transfer techniques with Hoyer lifts which was completed on [DATE]. - All lift slings were replaced with Hoyer branded slings per the Hoyer lift manufacturer recommendations. All the lift slings are now numbered and are color coded by patient weight to ensure proper fit and use. - The facility conducted lift audits and a QAPI (Quality Assurance and Performance Improvement) plan has been put in place for ongoing review regarding the proper use of lift slings.