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	17E589	A. BUILDING _____ B. WING _____	C 12/01/2021

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #167397 and #167412. This 2567 was electronically sent to the facility on 12/08/21.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 38 residents with three residents reviewed for accident hazards. Based on record review, observation, and interview, the facility failed to ensure staff transferred one of the three residents as care planned, with a mechanical lift (a device used to assist with transfers for a person who is unable to stand on their own, or can bear minimal weight when standing) for Resident (R)1, when staff directed the resident to stand holding on to a grab bar in the shower room which resulted in the staff assisting her to the floor and staff also failed to use the mechanical lift to move the resident off of the floor. R1 sustained bilateral distal femur fractures (a break in the thigh bone above the knee) that required surgical intervention. Findings included:	F 689		

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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- The "Physician Orders," dated 08/02/21, for Resident (R)1, included diagnoses of low back pain, chronic pain, and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain).

The "Admission Minimum Data Set" (MDS), dated 04/05/21, assessed R1 with a "Brief Interview of Mental Status" score of 13, indicating intact cognition, and she did not reject cares. She was totally dependent on two or more staff for transfers and ambulation did not occur. The staff did not move her from sitting to standing to assess balance during transitions. She had no functional limitations in range of motion (ROM) to her bilateral lower extremities but had functional limitations to her bilateral upper extremities. R1 used a wheelchair for mobility, had no falls or fractures in the six months prior to admission, and had no falls since admission. R1 received active ROM per a restorative nursing program for three days of the assessment period and did not require Physical Therapy or Occupational Therapy services.

The "Activities of Daily Living [ADL] Care Area Assessment" (CAA), dated 04/06/21, indicated R1 was obese (overweight) and had no complaints of pain with use of her scheduled pain medication. The CAA lacked a summary note regarding her ADL assistance needed.

The "Quarterly MDS," dated 09/20/21, assessed R1 with a BIMS score of 14, indicating intact cognition. There was no change in the assessment for her transfers, ambulation, balance during transitions, ROM, and mobility devices used. She had no falls since the prior assessment. R1 did not require Physical Therapy

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or Occupational Therapy services and did not receive any restorative nursing services.

The "Care Plan," located in the care plan binder, dated 04/09/21, indicated under the ADL problem the staff were to transfer R1 with total assistance of two staff using the Hoyer (a brand of mechanical lifts) lift and she was non-ambulatory. The fall portion of the care plan revealed she required use of a Hoyer lift with two staff assistance for all transfers.

The "Physician Orders," dated 08/02/21, included R1's ambulation status was non-ambulatory, wheelchair bound, and she required a Hoyer lift with assistance of two for transfers.

The "Progress Note," located in the EMR, dated 11/19/21 at 09:47 PM, revealed R1 was in the shower room in the shower chair and a staff member asked a co-worker to reposition the sling behind her in the shower chair. As the staff assisted R1 to her feet to stand at the handicap bar, her legs gave out and she was lowered to the floor by two staff members. Licensed Nurse G did not observe any obvious evidence of injury and the resident had passive ROM to all extremities. R1 was alert, oriented, and verbal, she made comments that indicated the presence of pain during the assessment. R1 had scars to both knees from past knee replacement surgeries. Three staff assisted R1 to her wheelchair. The note lacked a description of how the staff transferred her off of the floor.

The "Progress Note" on 11/20/21 at 12:12 AM, revealed fall follow up indicated no pain or discomfort voiced or difficulty with repositioning. R1 rested comfortably in bed.

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The "Progress Note," dated 11/20/21 at 04:18 AM, revealed staff administered Tylenol (medication used for pain) 325 mg (milligrams) two tabs by mouth for complaint of bilateral knee pain rated as a seven (indicating severe pain) per the PAINAD scale (a pain tool used for patients with advanced dementia [progressive mental disorder characterized by failing memory, confusion]).

The "Progress Note," dated 11/20/21 at 05:21 AM, revealed R1's follow up pain scale was a one (indicating mild pain), and the medication was effective.

The "Medication Administration Record," for 11/2021, revealed R1 did not require administration of Tylenol, as needed, at any other time during 11/2021.

The "Progress Note," dated 11/20/21 at 08:29 AM, revealed R1 was "not herself this AM" and staff notified the nurse at 07:30 AM that she was "pale and not acting herself" and vital signs were stable. The staff dressed her and transferred her to her wheelchair via the Hoyer lift. R1 sat in the day room and continued to be pale in color and had moments of "unresponsiveness." The staff paged the on-call doctor at 07:58 AM with a return call received at 08:05 AM. The doctor gave orders to transfer R1 to the hospital.

The "Emergency Department Provider Documentation Report," dated 11/20/21, indicated the chief complaint was lethargy and a mental status change. She had changes to her heart rhythm pattern on an EKG (electrocardiogram-records the electrical signal of

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the heart) that morning and R1 would be transferred via helicopter due to unavailable services that included but was not limited to cardiology.

The "Hospitalist History and Physical," dated 11/20/21 at 02:36 PM, indicated R1 presented to an outside hospital after being found confused in the nursing home. An initial concern for STEMI (ST segment elevation myocardial infarction [most severe type of heart attack]), and septic shock (a widespread infection causing organ failure and dangerously low blood pressure) secondary to a urinary tract infection. She was not felt to be having an active STEMI here [hospital]. R1 admitted to the hospital, she appeared tired, but was resting quietly in the bed. She denied pain, physical exam revealed no edema, and she could move all extremities.

The hospital "Progress Note," dated 11/21/21 at 08:13 AM, revealed R1's shins hurt when palpated and she had no edema. R1 was lethargic and not oriented.

The hospital "Enterostomal Therapy [specialize field of nursing involving care of patients with stomas incontinence, dermal ulcers, and other select skin conditions or those needing wound care] Note," dated 11/22/21 at 10:20 AM, revealed every time R1 turned from side to side for assessment or moved she would verbalize the presence of pain.

The "X-ray Femur Right" and "X-ray Femur Left," dated 11/22/21, indicated the reason for the exam was "Pain," and findings revealed an oblique fracture (when the bone breaks at an angle) of the distal femur just above the prosthetic device

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[hardware from knee replacement] of the left knee and the right knee had a distal right femur fracture just above the knee prosthesis.

The "Orthopedic Consultation," dated 11/22/21 at 02:13 PM, revealed the reason for the consultation was bilateral periprosthetic (close relation to an implant) femur fractures. R1 had a history of bilateral knee replacements and per the family she did not ambulate or bear weight, and the last week she had an episode with a Hoyer lift while getting a shower where she had to be lowered to the ground. No other known possible cause for the trauma was determined. R1 had ecchymosis (bruising) to the left knee and bilateral knee swelling. She denied pain to knee, but would not attempt ROM. The plan was for ORIF (open reduction internal fixation) surgery of the fractures the next day, and placement of bilateral lower extremity knee immobilizers to prevent displacement an reduce risk of fat emboli (disruption of blood supply caused by fat globules in a blood vessel most commonly associated with a trauma, such as a bone fracture).

The "Witness Statement," dated 11/29/21, from Certified Medication Aide (CMA) R, revealed he was giving R1 a shower and called Certified Nurse Aide (CNA) M to the bath house to help reposition the sling. It was then realized R1 was having a bowel movement and at that time CNA N came in the bath house. R1 was standing at the bar in the bathhouse with CMA R and CNA N on each side trying to clean her and CNA R was behind trying to reposition the sling in the chair. During a time span of 15-20 seconds R1 could no longer stand at the wall and CNA N and CMA R lowered her "slowly and safely as possible to the ground" on her bottom then laying on her back.

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CNA N then left to go get Licensed Nurse (LN) G.

The "Witness Statement," dated 11/29/21, from CNA N, revealed he entered the bath house and CMA R asked if he would help him adjust the sling under R1 and noted that she had bowel movement on her. Then, CNA N and CMA R, with extensive assistance, stood R1 at the bar in the bath house while CNA M adjusted the sling. While standing, R1 continued to have a bowel movement, CMA R was cleaning her and within 15-20 seconds of standing, R1's legs gave out and CNA N and CMA R reacted quickly to put her into a "fireman position" and "slowly lowered her to the ground" her feet never left the ground. CNA N then left to go get LN G.

The "Witness Statement," dated 11/29/21, from CNA M, revealed she responded to the call light in the bath house to get R1 out of the shower. CMA R and CNA M attempted to adjust the sling since there was bowel movement on it but could not. Then, CNA N walked in and CMA R asked for CNA N to help. CMA R and CNA N with extensive assistance of two, transferred R1 and helped her stand at the bar so CNA M could adjust the sling. While adjusting the sling, CMA R was cleaning the resident. R1 stood for 15-25 seconds then her legs gave out, and CNA N and CMA R "lowered her to the ground quickly by her back and legs" her feet never leaving the ground. CNA N left to go get LN G.

On 12/01/21 at 02:21 PM, R1 rested in bed with her eyes open. She was unable to recall falling or being lowered to the floor in the shower or being transferred to the hospital. When asked, she did not know what happened that caused the fractures.

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On 11/30/21 at 09:18 AM, an unidentified family member stated the facility contacted her on the night of 11/19/21 and said they stood R1 up and then had to lower her with no injury at that time. I was told nothing about her knees hitting the wall until a teleconference with Administrative Staff A on 11/26/21.

On 11/30/21 at 11:10 AM, CMA R stated on 11/19/21 he assisted with R1's shower. There was bowel movement present and he had to reposition the sling but could not clean under her thighs properly and thought he could clean her more if the resident stood. R1 stood holding the bar for 15-20 seconds, her legs were not totally straight while standing, her legs started giving out and CNA N and CMA R "lowered her to the ground." CMA R stated her knees were touching the wall when they first started to bend, but they lowered her away from the wall and extended her legs flat once they had her sitting on the floor. After LN G assessed her CMA R stated they could not get the lift sling fully under her, so the wheelchair was behind her with CNA M behind the chair to keep it steady. CMA N was to R1's right side, CMA R was on the left, LN G was in front to make sure R1's feet were not going to slide, and CNA N and CMA R did a "fireman transfer." We lifted under her knees and picked her up for two to three seconds to get her bottom to the chair, then we moved her back in the chair. CMA R stated R1 was to have the Hoyer lift for transfers per her care plan.

On 11/30/21 at 02:09 PM, CNA M stated she responded to the pager from the bath house, CMA R finished bathing R1, and there was bowel movement on the sling. CNA M and CMA R tried

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to stand her, and she would not stand so CMA R asked CNA N to assist to stand her while CMA M repositioned the sling. R1 stood for 15-20 seconds and her legs gave out and they "lowered her to the ground." When lowered to the floor, CNA N and CMA R had one arm to her back and the other arm "catching her legs" as they went down. R1 went down so quickly they did the best they could from stopping her from hitting the ground "super hard" and they were able to slow the movement down. CNA M stated after LN G assessed her, they tried to put the sling under R1 but she would not cooperate, she would not move her legs or sit up when asked. CNA N and CMA R partially stood her up to get her to the chair from the floor and neither had a hold of her under her legs when getting her up off the floor. CNA M stated that R1 was to have the Hoyer lift and assistance of two for transfers.

On 11/30/21 at 02:28 PM, LN G stated that CNA N, CMA R, and CNA M were all in the bath house, and one of them came and got me. When entering the bath house, R1 was on the floor on her buttocks and her feet were one to two feet away from the wall. When questioning R1 if she was hurting or having pain and she indicated she was in pain. LN G asked R1 to move her legs up to her chest and she could not, they barely moved, so passive ROM assistance provided and did not observe any obvious deformities or pain in either leg, but indicated she had pain after I finished. LN G questioned R1 what happened, but she would not say anything. LN G stated the staff told her that they transferred her from the chair to the grab bar because the sling was coming out from under her and R1 was going to slide to the floor which I understood to be on her knees, but they said she was never on her knees,

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that they assisted her to her bottom. LN G stated she talked with the staff about how to get her off of the floor and she suggested to call Emergency Medical Services because she was a "big lady" and CNA N and CMA R said "no we can get her." LN G stated she did not observe staff moving her up and off of the floor and did not know if they attempted to put the sling under her to use the lift to get her off of the floor. LN G stated that R1 had in her care plan to be transferred with assistance of two staff using the Hoyer lift.

On 11/30/21 at 03:02 PM, Administrative Nurse D stated she was not aware of how CNA N and CMA R got R1 off of the floor, but they should have used the lift and she has seen instances where a lift could not be used. Administrative Nurse D stated she was not at the facility or notified at the time staff lowered R1 to the floor and moved her up and off of the floor. Administrative Staff A had been involved in the investigation.

On 11/30/21 at 03:18 PM, CNA N stated he entered the bath house and CMA R and CNA M were in there with R1 and CMA R asked for help. CMA R said the sling was high up on her back and they needed to stand R1 to lower the sling. CNA N stated R1 was standing at the bar and CNA N's arms were under her to help support her. Within 15 seconds her arms and legs went limp and we "lowered her to the ground" with my left hand behind her back and right arm at her knees. CNA N was not aware how CMA R supported the during the movement. CNA N stated R1's feet were on the ground the entire time, "it was like we caught her and laid her on her back." When LN G came in the bath house, we sat R1 up. CNA N stated that he and CMA R

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used the "fireman lift" to get her up and off of the floor and did not attempt to use the sling to get her off of the floor because the floor had bowel movement and urine on it. CNA N stated that they might have been able to clean the urine and the bowel movement off the floor before applying a sling, but did not think about it as he just wanted to get R1 up and off of the cold hard floor. CNA N stated her feet were close to the wall and he was not sure if they could have got the lift in there anyways. CNA N stated that R1 was to transfer with the Hoyer lift at all times.

On 11/30/21 at 03:40 PM, Administrative Staff A stated she expected the staff to use a lift to get her up and off of the floor. Administrative Staff A stated she was a CNA and an RN (registered nurse) and with R1 having a bowel movement and the sling not in place she would have "done the same thing." The staff reported to me that R1 went down quickly, she had some bowel movement on her, they stood her, and her knees gave away, and that CMA R had "stood her up like that before."

On 12/01/21 at 01:02 PM, CMA S stated that R1 does not stand and required the use of a Hoyer lift for transfers.

On 12/01/21 at 01:03 PM, LN H stated that the staff were to use a Hoyer lift with R1 for transfers and to her knowledge it was always that way.

On 12/02/21 at 01:03 PM, an unidentified family member stated on 11/26/21 at the facility during a conference, one of the three aides were reached by phone (could not remember the aide's name). The unidentified aide said they stood R1 and had her hold on to the grab bar, he turned to

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reposition the sling, heard a loud "thud," and she hit her knees on the wall as she was going down to the floor.

On 12/02/21 at 02:08 PM, an attempt to contact the orthopedic physician was unsuccessful.

On 12/02/21 at 02:50 PM CNA M stated on 11/19/21, R1 was sitting upright in the shower chair at 90 degrees and she was not sliding out of the chair. CNA N and CMA R stood her while she was behind CNA N holding on to the shower chair, which was straight behind R1, and had her foot behind one of the wheels. When R1's legs gave out, she went straight back at first, then at an angle to straighten her legs, and denied hearing a "thud" during the process. CNA M did not see her knees hit the wall and said she would have been able to if they did. When R1 was standing her legs were bent some, but not touching the wall, and after she was lowered, she sat on her bottom with her knees bent. CNA N and CMA R attempted to put the sling under her and were trying to get R1 to bend her knees and she finally did. CNA N and CMA R picked her up under her arms and her bottom while CNA M scooted the wheelchair under her.

On 12/03/21 at 09:40 AM, Consultant GG stated R1 had a DEXA scan (imaging test that measures bone density [strength]) in November in 2019 and showed osteopenia, which increased risk for fracture, but not like osteoporosis would. It would be unlikely that the fractures occurred if just lowered to the floor. Bruising and swelling can take 2-3 days to show up after an injury. It was not appropriate for the facility to stand her and they definitely should have used the lift to get her off of the floor.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 12	F 689		

On 12/03/21 at 03:17 PM, Consultant Staff HH stated that on admission to the hospital, R1 was very confused, but once she started feeling a little better she reported aching knee pain on 11/22/21 and her pain was at a level "8/10" every time then x-rays were done. There were no events before that time, and she was not up/out of bed between her fall on 11/20/21 and 11/22/21.

The facility policy "Hoyer Lift Use," dated 09/27/2017, revealed the residents of the facility who had been assessed as unable to transfer independently or with minimum assistance who are unable to bear any weight will be transferred safely with use of a full body Hoyer lift. The policy included instructions on positioning the sling under the resident from the lying down position (bed or the floor).

The facility policy "Restorative Transfer Training," dated 02/18/16, revealed safety considerations for transfers included to always follow individualized comprehensive care plan related to the type of transfer and to request extra help or a nursing assessment if resident's behavior or other circumstances creates an unsafe transfer condition.

The facility policy "Mechanical Lift Transfer," dated 09/12/09, revealed the facility was a "no-lift" facility in order to provide maximum safety for both the residents residing in the facility and the staff working with the residents. Residents who were unable to transfer themselves independently or with minimum assistance or unable to bear any weight would be transferred safely with the mechanical lift device.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E589	A. BUILDING _____ B. WING _____	C 12/01/2021

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F 689	Continued From page 13 The facility failed to ensure staff transferred the resident appropriately, with a mechanical lift, when standing her at a grab bar in the shower room which resulted in the staff assisting her to the floor and failed to use the mechanical lift to move the resident off of the floor, who later was diagnosed with bilateral distal femur fractures that required surgical intervention.	F 689		