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	165294	A. BUILDING _____ B. WING _____	C 10/11/2017

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AVOCA SPECIALTY CARE	**610 EAST YORK STREET AVOCA, IA 51521**

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F 000	INITIAL COMMENTS Correction date _____ Complaint # 71340-C was substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff	F 323		

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

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interview, the facility failed to ensure that the resident environment remained as free from accident hazards as possible; and each resident received adequate supervision to prevent accidents for 1 of 5 residents reviewed that used mechanical lifts. Resident #1 fell from an EZ lift when agency staff improperly hooked the sling to the bar and started the transfer without a second staff present. There was no evidence the facility provided the agency staff with orientation before working with the resident. The facility census was forty-four (44) residents.

Findings include:

1. A Minimum Data Set (MDS) with assessment reference date of 7/13/17, assessed Resident #1 with short and long term memory problems and severely impaired decision making. The resident had the following indicators of delirium that were continually present: inattention and disorganized thinking. The resident did not have behavior symptoms. The resident was totally dependent on two staff for transfers, locomotion on unit, dressing, toileting personal hygiene and bathing. The resident required extensive staff assistance for eating and bed mobility. The resident had functional range of motion limitations of both upper and lower extremities. The resident did not ambulate and used a wheelchair for mobility. The resident had diagnoses that included Alzheimer's disease. The resident had no prior falls identified since the previous assessment. The MDS revealed Resident #1 weight at 192 pounds and his height at 6 feet tall.

A fall risk evaluation dated 7/10/17 identified the resident with a fall risk score of "8". A score of "10" or above represented high risk.

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A care plan dated 2/26/16 that identified the resident at risk for falls due to impaired balance and non-weight bearing due to advanced dementia. The care plan directed staff to transfer the resident with 2 staff via EZ lift (mechanical lift). An addendum to the care plan dated 8/18/17 directed staff to ensure they correctly placed straps on EZ lift prior to transfer.

A nurses note entry dated 8/18/17 at 1 p.m. and documented by Staff A RN (registered nurse), revealed the resident laid on the floor underneath the mechanical lift. The resident appeared in pain with red face, grunting and moaning loudly. The resident's vital signs were: blood pressure 112/52, pulse 125, temperature 95.7 degrees. The resident's right leg appeared shortened. A CNA (certified nurse aide) reported the resident did not hit his/her head. The facility notified the physician and the resident transported to the ER (emergency room) for evaluation. On the same date at 5:10 p.m., the resident returned from ER. On the same date, an entry at 5:20 p.m. identified the resident's activity level as complete bed rest for 8 weeks.

An ER report dated 8/18/17, revealed the 87 year old non-verbal resident with advanced dementia presented to the ER after being dropped from a mechanical lift. The resident was elevated on a mechanical lift when the strap broke loose, dropping the resident to the floor and the resident landed on the right side. The resident moaned with pain but could not tell anyone the location of the pain due to the resident's nonverbal status. The resident's right hip appeared shortened. The x-ray revealed no evidence of an acute hip, pelvis and or ankle fracture/s.The report indicated the

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resident had rib fractures which placed him/her at risk for pneumonia. The report documented the resident had prior hip fracture after a fall at the nursing home approximately a year ago.

A radiology report dated 8/18/17 revealed the resident had mildly displaced fractures of the right 4th, 5th, 6th and 7th ribs without apparent complication.

On 8/23/17 at 7 p.m. the physician identified the injury as NOT a major injury.

An incident/accident/unusual occurrences form dated 8/18/17 at 1:45 p.m. revealed the resident fell during a transfer from wheelchair to bed. The medical device involved in the incident was a mechanical lift. The fall investigation for nurses dated 8/18/17 revealed the staff did not use the mechanical lift correctly. The mechanical lift strap came loose and the resident slid out of the sling. The resident fell out of the lift when staff transferred the resident from wheelchair to bed. The internal quality investigation form identified the staff responsible for care at the time as Staff B CNA. In the area "preventive measures implemented", Staff B received education on the mechanical lift.

Staff B CNA documented on a fall investigation for CNAs dated 8/18/17 that she hooked the resident up to the lift and as she began lifting the resident, Staff C (the other CNA in the room) approached the chair. In midair the right shoulder strap popped off and the resident fell to the floor. In the area "what factors could have contributed to the fall?", Staff B documented she could have double checked the straps and could have waited until both staff had hands on the resident before

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lifting. In the area, "what new interventions would you suggest to prevent the fall from happening?", Staff B documented "wait until both staff have hands on resident and double check straps".

On 10/10/17 at 1:05 p.m. Staff B CNA stated she finished caring for the residents on her hall when Staff C called for help with a transfer. They placed Resident #1's roommate in the bathroom and Staff C stayed in the bathroom to finish assisting the roommate. While Staff C was in the bathroom, Staff B went over to Resident #1 and hooked the sling pad to the mechanical lift in preparation for the transfer. Staff B stated she waited for Staff C and when Staff C came out of the bathroom, Staff B pressed "up" on the lift as Staff C came towards her. When Staff C was an arms length away, Staff C had Resident #1 suspended in the lift. The resident's weight shifted and when it shifted, the loop came over the bar and it came right off. The resident fell to the floor. Staff B stated she should have double checked the sling straps as the resident rose up from the wheelchair. Staff B stated she received no orientation that morning. She had worked at the facility twice before a year ago and had not returned to the facility since. On 8/18/17, she received a sheet of paper and went to work on the floor. The paper had resident names and if they used an EZ stand. It did not contain the number of staff needed for the transfer. Staff B denied anyone told her the facility policy was to have 2 staff for all lifts and stated she wasn't told that until after Resident #1's incident. Staff B stated she did gave another staff present who was an arms length away. When asked if she could do anything over, what would it be? , Staff B stated she would make sure Staff C had her hands on the resident and she would double

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check the straps. Staff B stated nothing on the sling was torn or frayed.

Review of an updated transfer list, updated on 9/26/17 identified "mechanical lift" by Resident #1's name with no number of staff included. On 10/10/17 at 1:32 p.m. the ADON (assistant director of nursing) stated the transfer list did not have the number of staff listed by the mechanical lift directive because it is facility policy to use 2 staff with all lifts.

Staff C CNA documented on a fall investigation for CNAs dated 8/18/17 that she lowered Resident #1's roommate on the toilet from the sit stand and made sure the resident was secure. As she walked out of the restroom to assist Staff B with Resident #1, Staff B already had the resident rising up in the mechanical lift and the resident fell out. In the area "which factors could have contributed to the fall? " Staff C documented 2 aides were not present for the transfer. In the area "what new interventions would you suggest to prevent the fall from happening?" Staff C documented "to make sure 2 aides are present during transfer".

On 10/5/17 at 1:50 p.m. Staff C CNA stated after lunch they placed Resident #1's roommate on the toilet because the resident liked to sit there while they got Resident #1 in bed. Staff C stated after they placed the roommate on the toilet, Staff B left the bathroom to hook up Resident #1 while Staff C finished situating the roommate. When Staff C exited the bathroom, Staff B had Resident #1 1/2 to 3/4 suspended up in the mechanical lift. Staff C began to walk over to help and didn't make it in time. The resident fell. Staff C stated the resident fell because one of the sling straps

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wasn't hooked on. She stated it didn't break and nothing was torn or frayed. Staff C stated agency staff are supposed to come to the facility one hour early to get information and they do rounds. Agency staff gets a sheet that tells them resident transfer needs. Now agency staff gets a checklist and watches a video before starting work.

On 10/10/17 at 12:05 p.m. Staff A RN identified self as charge nurse when Resident #1 fell from of the mechanical sling. Staff called her to Resident #1's room and the resident was on the floor. Staff B was panicking and hysterical. Staff B stated the resident fell out. Staff A stated Staff B didn't hook up the sling correctly. Staff A looked the sling over and did not observe rips or tears. Staff B thought she hooked the strap on the bar but it was not hooked. Staff B also transferred the resident by herself. Staff A stated Staff B was aware she should use 2 staff for the transfer because Staff A told her that morning. Staff A told her to get Staff A if she couldn't find someone to assist her with transfers. Staff A stated other staff also informed Staff B that she needed to use 2 staff with a mechanical lift transfer.

On 10/11/17 at 8:26 a.m. Staff F CNA stated at 6:20 a.m. on 8/18/17 Staff B told her she transferred a resident alone with the stand. At that time, Staff F stated she informed Staff B that two staff are used with all lifts.

Staff B's information:

Information from the staffing agency showed Staff B only worked on 8/18/17 (the day of the incident) in 2017. A weekly time sheet showed Staff B clocked in at 6 a.m. and out at 1:35 p.m. on 8/18/17. There was no orientation checklist to

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show Staff B received orientation. Records from the staffing agency showed Staff B passed a skills test for mechanical lift transfers on 10/1/14.

On 10/11/17 at 2:27 p.m. the Director of Nursing (DON) stated Staff C was in the room with Staff B. They put Resident #1's roommate on the toilet and Staff C got the roommate situated. When Staff C exited the bathroom, Staff B had hooked up Resident #1 and he/she was already falling out if the sling. The sling strap was not hooked to the bar. She stated she examined the sling approximately 15 minutes after the incident and there was no fraying or tearing. She stated procedure for agency staff at the time of the incident was that they were to come in 1 hour early and train with staff and go through a checklist. She stated Staff B did not get a checklist because facility staff thought Staff B worked there before. Staff B just happened to pick up the shift on 8/18/17 at the last minute and staff did not orient her. The DON stated she wasn't sure if Staff B got any training. After the incident, they decided agency staff should not perform lift transfers until they watched a video and had an audit with management. Staff B told her she did not wait for Staff C to assist her with the transfer.

After the incident:

On 10/11/17 at 9:20 a.m. the Administrator stated the facility implemented the following after the 8/18/17 incident: From 8/18/17 to 8/25/17 agency staff could not use lifts. At that time, the facility decided agency staff could use lifts if they went through orientation and watched a video. The agency staff came in early for the orientation and video.

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When asked about audits to ensure their new policies were implemented, the corporate nurse stated on 10/11/17 at 11:25 a.m. that there was nothing in writing. On the same date at 11:36 a.m. the ADON stated she works the floor so she watches staff and had not caught anyone not following policy.

Agency staff interviews:

On 10/10/17 at 4:19 p.m. Staff H (agency CNA) stated she worked at the facility 3 or 4 times, used lifts and had not seen the video yet. Staff H's orientation checklist contained a checkmark by "watch EZ lift video", Staff H stated it was checked because it was something she was supposed to complete and had not completed it yet.

On 10/10/17 at 4:17 p.m. Staff E (agency CNA) stated she worked with Resident #1's roommate after the 8/18/17 incident and did not have a second staff present. The resident told her that she should use 2 staff for the transfer after she placed him on the toilet. She stated she worked at another facility prior to coming to the Avoca facility where it was Ok to transfer EZ lift residents with one staff. She could not remember if anyone at the Avoca facility told her to use 2 staff. She did not watch the training video until after that incident.

In a written statement dated 10/10/17 the Administrator documented that a CNA (Staff F) asked Staff E if Staff E was certified for lifts at the facility and if Staff E watched the video. Staff E replied "yes". On 9/27/17 Resident #1's spouse told Staff F that Staff E transferred Resident #1's

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roommate by self. Staff F informed the Administrator and then Staff E watched the training video.

Policies:

Facility Policy for Mechanical Lift dated January 2015 revealed the lift was used to provide safe transfer for non-ambulatory residents. The policy directed 2 staff perform mechanical lift transfers. The policy also directed staff to check to ensure all straps were secured and evenly placed.
On 10/11/17 at 1:55 p.m. the corporate nurse stated the facility did not have policies for agency staff including training/orienting agency staff to facility rules, policies procedures.

Agency Agreement:

An agreement with the agency dated 2/16/16 revealed the facility would orientate agency staff to their facility including its rules, regulations, policies, procedures, physical layout, emergency protocol, emergency evacuation and equipment on any unit to which the agency staff is assigned. The facility will complete an orientation checklist for the agency staff upon completion of the orientation and fax the completed checklist to the agency. The agreement revealed the facility will be responsible for the establishment of staff competences during the initial orientation period and on an ongoing basis during the contact period.

On 10/11/17 at 9:36 a.m. the Administrator stated Staff B did not have an orientation sheet.

On 10/11/17 at 12:30 p.m. the corporate nurse

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stated Staff B did not turn in a checklist to the agency and there was no checklist available to indicate Staff B completed orientation. He stated the facility audits all staff in mechanical lift skills quarterly, upon orientation and with their annual review. The last audits done were last quarter and the facility is now starting their 4th quarter audits of all staff.

The EZ Way Smart Lift Operator's Instructions revised on 7/5/17 revealed the lift was designed to lift persons from the bed, chair, toilet and or floor safety with precautions to follow including warnings and operating instructions. A safety note and warning behoove persons using the lift be trained before using with residents. The lift noted one caregiver can operate the lift however, depending on the situation, facility policy, and resident's condition, two caregivers may be necessary for operating the lift safely.
The operating instructions revealed steps for attaching the sling to the lift and instructed staff to make a final check of all four loop attachment points to ensure each loop is sufficiently attached to the respective hook of the hanger bars before lifting the resident. The step for lifting the resident included the following: push the UP button on the hand control to initiate the upward motion of the lift; continue the upward motion until there is tension on the legs of the sling, making sure all the loops on the sling are securely hooked on the hanger bars. The operating instructions included a safety checklist to assist in proper training.

Observation:

On 10/5/17 at 1:05 p.m. observation showed 3 staff transfer the resident to bed via full body sling. There were no fraying or tears observed on

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