| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495209 | A. Building<br>B. Wing | 03/12/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Raleigh Court Health and Rehabilitation Center | 1527 Grandin Road Southwest<br>Roanoke, VA 24015 |

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) |
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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>28567<br><br>Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure 1 of 28 residents (Resident #99) was free of accident hazards as evidenced by failure to ensure the resident was transferred with the correct size sling when using the mechanical lift, which resulted in resident injury.<br><br>The findings included:<br><br>Resident #99 was transferred with the incorrect sling when being transferred with the Hoyer lift. This resulted in the sling breaking and the resident fell to the floor. Resident #99 was evaluated at a local hospital and was diagnosed with a closed reduction (dislocation) left shoulder.<br><br>This was a closed record review due to an FRI (facility reported incident) that was reported to the OLC (Office of Licensure and Certification).<br><br>The face sheet in the EHR (electronic health record) included the diagnoses cerebral infarction, essential (primary) hypertension, and morbid (severe) obesity.<br><br>Section C (cognitive patterns) of the resident's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 05/12/2019 included a BIMS (brief interview for mental status) summary score of 13 out of a possible 15 points. Section G (functional status) was coded to indicate the resident required extensive assistance of two people (3/3) for bed mobility and transfers. Walk in room/corridor was coded (8/8) indicating this activity did not occur. The resident was coded as having functional limitation in range of motion in the upper and lower extremities on one side (1/1). For mobility devices, the resident was coded as using a wheelchair.<br><br>The resident's comprehensive care plan included the focus area resident has an activities of daily living self-care performance deficit. Interventions included Hoyer lift with 2-person assist.<br><br>Resident #99's height located under the vital sign tab in the EHR was documented as 65 inches. There was no documented weight for 07/2019. On 06/06/2019, the residents weight was documented as 260.4 pounds for 08/01/2019 the residents weight was documented as 261 pounds.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The clinical record included the following progress note dated 07/08/2019 at 2:37 p.m., This nurse alerted to resident's room by CNA (certified nursing assistant), observed resident on the floor beneath the Hoyer lift, lying on left side. Resident stated, I fell from the lift. CNA's reported that lift pad had ripped while resident was in the air .Assessed resident from head to toe., VS (vital signs) BP (blood pressure) 195/85, temp 97.7, O2 (oxygen) 93, Notified Dr.____ MD, order to send to ED (emergency department) for eval. RP (responsible party) _____ aware .<br><br>The facility provided the surveyor with a copy of the ED (emergency department) report dated 07/08/2019. This ED report read in part, .presents to _____ ED via EMS (emergency medical service) from _____ (facility) with chief complaint of shoulder pain s/p (status post) fall. Friend at bedside reports patient as being lifted in a Hoyer lift into bed today, however at the highest point above the height of the bed, one side of the lift broke, causing pt (patient) to fall onto the hard ground and onto .left side .did hit .head, for which . complains of a generalized headache, but denies any LOC (loss of consciousness) .Xrays have processed. Left shoulder is dislocated .Performing nerve block to the left shoulder at bedside .Attempting closed shoulder reduction at bedside. Reduction unsuccessful. Will prep for conscious sedation .Performed conscious sedation and closed reduction at bedside .Medications administered in ED .metoprolol tartrate (LOPRESSOR) tablet 100 mg .cloNIDine .0.1 mg .morphine .2 mg Intravenous .Procedures: Nerve Block . Conscious Sedation .The patient was given Propofol .CLOSED REDUCTION (DISLOCATION)-Left shoulder . the patient will be discharged back to nursing facility .Care Timeline 1505 Arrived .2316 discharged .<br><br>New orders transcribed on 07/09/2019.<br><br>Tramadol 50 mg give 1 tablet by mouth every 6 hours for pain until 07/14/2019.<br><br>Acetaminophen 500 mg every 6 hours for pain until 07/19/2019 give with tramadol.<br><br>Sling to left arm to remain in place every shift for dislocated left shoulder for 3 days.<br><br>The resident had a previous prn (as needed) order for tramadol that was put on hold when the scheduled order was obtained. The facility nursing staff documented they administered this on 07/09/2019 at 7:54 a.m. for a pain level of 8. The facility staff documented this medication was effective.<br><br>The office of OLC received a fax from the facility indicating that on 07/08/2019 the Resident fell to floor from Hoyer lift. Lift pad ripped while in air. The facility sent the office of OLC a follow-up to this incident on 07/10/2019 that read in part, This letter is in regards to a Facility Reported Incident submitted on 7/8/2019. On 7/8/2019, _____ (Resident #99) fell to the ground from the hoyer lift. The hands on the pad used to lift her, ripped while 2 CNA's (certified nursing assistants) had .suspended in the air .sent to the hospital for evaluation immediately following the incident and returned several hours later with a dislocated left shoulder, and no other injuries. Staff education is being completed related to using the hoyer lift. Our investigation concludes that no abuse or neglect occurred. There is no follow up needed at this time . The facility administrator had signed this letter.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 03/11/2020 3:05 p.m., during an interview with the DON (director of nursing) the DON provided the surveyor with a typed statement that revealed the resident had fell from the lift when 2 CNA's (CNA #1 and CNA #2) were using the wrong size lift pad, the pad broke, and the resident fell to the floor incurring a left shoulder dislocation. This statement read in part, On July 8, 2019, _____ (Resident #99) fell from the hoyer lift, while . suspended in the air. Several staff members assisted resident back into the bed. The physician was notified and we received an order to send .to the hospital. _____ CNA #2 and _____ CNA #1 were the CNA's using the lift pad to transfer ____ (Resident #99). They were interviewed and stated while lifting .from chair to bed, one of the straps broke . (Resident #99) fell to the floor. The lift pad was observed and rip confirmed in one of the straps. We removed it from floor and discarded it. All other pads were reviewed to ensure integrity of the straps. Further investigation revealed it was not the proper pad .the CNA's used a pad that was too small. The CNA's were both educated and provided with disciplinary action. The resident returned from the hospital the same day, with a diagnosis of closed dislocation of the left shoulder. Reduction was successful in the ED and her pain was controlled. We educated staff on how to choose the proper hoyer pad. We completed an audit on all residents who require use of mechanical lift to ensure they had the proper hoyer pad. Our investigation determined that no intentional abuse occurred. This typed letter was unsigned. Per the DON, CNA's #1 and #2 were no longer employed at the facility.<br><br>The Nurse Consultant and DON verbalized to the surveyor that they had completed a plan of correction and provided a copy of this to the survey team. This plan of correction was dated 07/08/2019 and did not include The title of the person responsible for implementing the acceptable plan of correction as per the CMS (Centers for Medicare & Medicaid Services) S&C (Survey and Certification) letter dated June 16, 2017. When the DON was asked who was responsible for implementing the acceptable plan of correction the DON stated myself.<br><br>5 Step Plan-Mechanical Lifts 7/8/2019<br><br>1. Failure to utilize proper lift pad when transferring resident using a mechanical lift.<br><br>2. Current residents requiring use of mechanical lifts were reviewed by nursing leadership and therapy. Patients were measured per manufacturer guidelines, and correct lift pads ordered for all current residents who require use of the mechanical lift.<br><br>3. Current nursing staff were educated on procedures for using a mechanical lift, and selecting the appropriate lift pad, with return demonstration. Mechanical lift transfers will be reviewed and observed with new nursing staff during orientation period. SDC (staff development coordinator) or designee will randomly review three lift transfer weekly X4 to ensure standard procedures are being followed.<br><br>4. Process will be reviewed in next quarterly QA (quality assurance).<br><br>5. 8/2/19.<br><br>The surveyor asked the DON to provide the survey team with credible evidence regarding the above 5-step plan.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The DON provided the surveyor with a copy of an Inservice/Education record dated 07/11/2019 and a copy of the staff that would have been employed at the facility during that timeframe that would have been responsible for patient care. These two lists were compared. There were numerous discrepancies between the two lists indicating that step 3 was incomplete.<br><br>03/11/2020 3:57 p.m., meeting with the Administrator, DON, Nurse Consultant, and ADON (assistant director of nursing). The DON verbalized that this resident had fell from the lift during a transfer when the wrong lift pad was being used. The DON stated part of the training on hire was the Hoyer lift and there was a skill check off. The DON stated the resident had an assigned pad and they ended up finding it in laundry that day so the staff had just grabbed another pad.<br><br>The facility provided the surveyor with copies of skills competency validation records to indicate CNA #1 and #2 had been trained on demonstration of Hoyer lift with no less than 2 people and proper transfer techniques. Both of these were dated prior to the incident on 07/08/2019.<br><br>03/12/2020 8:24 a.m., during a meeting with the Administrator, DON, and Nurse Consultant the DON verbalized to the survey team that the wrong lift pad had been used when transferring Resident #99. The DON stated that prior to the incident with Resident #99, the lift pads were stored in a bin and the CNA's would just get what they needed at their own discretion.<br><br>03/12/2020 8:53 a.m., the surveyor requested the facility copy of the FRI. After reviewing the FRI the surveyor stated this FRI does not mention that the wrong pad was being used during the transfer. The DON replied, that is correct.<br><br>03/12/2020 9:16 a.m., the DON and Nurse Consultant were notified that they had discrepancies between the inservice list and the employee list. The DON verbalized to the surveyor that they sent an email to the other employees. Copies of emails were provided to the surveyor which included an email to the laundry staff dated 07/15/2019 indicating they needed to get together to .discuss the process for washing the hoyer lift pads An email to the unit managers dated 07/09/2019 stated, I need a complete sweep of both your units complete today for any hoyer lift pads. I also need a list of our residents we currently use the hoyer lift on. We need to make sure each patient has an assigned lift pad-let me know if this is not the case.<br><br>An email addressed to the team dated 07/25/2019 reflected that they had ordered four new hoyer lift pads and assigned them to identified long term care residents which included Resident #99. They were labeled with resident names in multiple places on the pad, and were given out. They were measured to fit the residents per manufacturer guidelines. The email reflected the facility went through a lot of other hoyer pads and discarded old ones or ones that were not compatible with their machine and if a pad was needed for another resident, nursing management would need to know to ensure the correct pad was selected. The email reflected the pads would no longer be stored in the clean linen rooms. Formal training would be conducted on lift machines and pads by the vendor who supplies them on Wednesday, August 7th .<br><br>03/12/2020 9:25 a.m., RN (registered nurse) #1 verbalized to the surveyor that they would have expected the staff to know what kind of sling to use for a resident. They received training on using the Hoyer lift, they have preceptors on hire, and they thought each patient had their own sling.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The DON provided the surveyor with a copy of an Inservice/Education record completed by an outside vendor. This document was dated 08/07/2019, which would have been after the date on the 5 step plan provided to the survey team.<br><br>The surveyor requested the facility policy on the Hoyer lift. On 03/12/2020 at 10:05 a.m., the MDS coordinator provided the surveyor with a copy of their policy titled, Mechanical Lift with an effective date of 11/01/19 and this policy read in part, POLICY: A mechanical lift may be used to enable staff to lift and transfer a patient safely.<br><br>The surveyor requested the manufactures instructions regarding the sling and use of the Hoyer lift. On 03/12/2020 at 10:15 a.m., the DON provided the surveyor with a copy of document titled, ProCare Medical this document read in part, .Sizing UNI-FIT SLINGS should be long enough to fit from the bottom of the patient's coccyx to the top of, or a few inches above, the patient's head and wide enough for sling fabric to extend at least two inches in front of the patient's anterior shoulder .Measurements are from the top of the head support to the bottom of the horseshoe area .<br><br>03/12/2020 11:14 a.m., during a meeting with the Administrator, DON, and Nurse Consultant, the staff were asked if they had any further information regarding this resident and the incident on 07/08/2019. The staff verbalized they did not have any further information. |