

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/07/2013
NAME OF PROVIDER OR SUPPLIER  REGENCY CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE DR LOUISVILLE, KY 40219		
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>An abbreviated survey investigating KY19720 was conducted February 5-7, 2013. KY19720 was substantiated and Immediate Jeopardy was identified at 42 CFR 483.25 Quality of Care (F323 at S/S of "J") and 42 CFR 483.75 Administration (F490 at S/S of "J") resulting in Substandard Quality of Care in F323, for failure to ensure an environment free from accident hazards for all residents that were transferred by a mechanical lift.</p> <p>On 01/21/13, three Certified Nursing Assistants were initiating a transfer of Resident #1 from the bed to the shower bed utilizing a lift. The sling used was not made for that lift, and was also placed on the lift backwards/inside. The left upper strap slipped off the hook and Resident #1 fell to the floor and sustained a laceration to the forehead which required sutures. The facility had rented two lifts (one in October and one in November, 2012); however, the staff continued to use the slings from their old lifts. Interviews with the staff and Director of Nursing revealed the slings were "universal" slings and could be used with any lift. Interview with the Manufacturer of the lift revealed the facility should use the sling that came with the lift. Interviews with CNAs also revealed they had received no training from the facility on how to utilize the lifts prior the resident falling from the lift. In addition, interview and record review revealed the facility failed to ensure the correct sized sling was utilized based on the resident's weight. At the time of the incident, the facility had sixteen residents utilizing a lift.</p> <p>Immediate Jeopardy was identified on 02/06/13, determined to exist on 01/21/13 through</p>	F 000			

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 000	Continued From page 1	F 000		
F 323 SS=J	01/29/13. The facility completed corrective actions prior to the State Survey Agency's investigation initiated on 02/05/13; therefore the Jeopardy was determined to be Past Jeopardy.  483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of facility policy, the investigation, and the manufacturer's guidelines, it was determined the facility failed to provide an environment free from accident hazards for one (1) of six (6) sampled residents. (Resident #1). On 01/21/13, facility staff used a mechanical lift with a sling (lift pad) to transport Resident #1 from the bed. The left top sling strap came off the lift's cradle bar, resulting in the resident falling onto the floor sustaining an injury to the resident's forehead. The resident was transported to the hospital for emergency care, received sutures for a laceration to the resident's forehead; and was transferred back to the facility. Interview with the nursing staff, present during the resident's fall, revealed the staff had identified the sling was on backwards/inside out, but they continued to transfer the resident. The facility's investigation also revealed the sling used to	F 323	Past noncompliance: no plan of correction required.	

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F 323	<p>Continued From page 2</p> <p>transfer Resident #1 was intended for use with a lift that was no longer in the facility and did not meet the manufacturer's guidelines for the current lift used to transfer the resident. The facility could not provide documented evidence the staff had been trained on the use of the mechanical lift prior to Resident #1's fall.</p> <p>In addition, the facility determined the resident required a large sling to be used with the lift related to the resident's weight. However, the resident lost ninety-seven (97) pounds over a period of two years. The facility failed to reassess the sling size after the resident lost the weight. Review of the manufacturer's manual, reference for what size lift sling to be used, recommended a medium sling for the resident's weight range. The staff used a large sling for transfer of Resident #1 on 01/21/13 when the sling strap came loose and the resident fell onto the floor.</p> <p>The facility's failure to assure equipment was used in a safe operational manner and in accordance with manufacturer's recommendations posed an immediate and serious threat to the safety of residents being transported via the mechanical lift with a sling. At the time of the incident, there were sixteen (16) residents that were transferred via a mechanical lift.</p> <p>The facility's failure to provide an environment free from accident hazards placed residents at risk for serious injury, harm, impairment or death. Immediate Jeopardy and Substandard Quality of Care was determined to exist on 01/21/13 through 01/29/13. The facility completed corrective actions prior to the State Survey</p>	F 323		

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F 323	<p>Continued From page 3</p> <p>Agency's investigation initiated on 02/05/13; therefore the Jeopardy was determined to be Past Jeopardy.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Patient Transfer Work Guide, dated November 2011, revealed residents who have no weight bearing capacity were to be transferred by a mechanical device. The policy stated a sling type lift supported the entire weight of the resident and a minimum of two assist was required for any mechanical device. The staff was to utilize the proper transfer/lift procedure for each resident.</p> <p>Review of the manufacturer's user-service manual for the Hoyer HPL 700 lift, not dated, revealed Hoyer lifts were specifically designed for Hoyer slings and accessories. "Warning" slings and accessories designed by any other manufacturer was prohibited and voided the warranty. Use only Hoyer slings and accessories to maintain user safety and product utility.</p> <p>Review of Resident #1's clinical record revealed the facility admitted the resident on 01/19/10 with diagnoses which included Dementia with Behavioral Disturbance, Alzheimer's Disease, Contractures, Chronic Pain, Depressive Disorder, and Adult Failure to Thrive. Review of the significant change in status assessment, dated 07/14/12, and the most recent quarterly assessment, dated 11/13/12, revealed the facility assessed the resident as requiring extensive assistance from staff for bed mobility, transfers, and locomotion. The facility assessed the resident to have a memory recall deficit with</p>	F 323		

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F 323	<p>Continued From page 4 severe impaired decision making skills.</p> <p>Review of the self-care deficit care plan, revised on 10/24/11, revealed a mechanical lift was to be used for all transfers. Review of the Certified Nursing Assistant (CNA) assignment sheet, dated 01/09/13, revealed the resident was to be transferred with a mechanical lift using a large sling with the assist of three.</p> <p>Review of the nurses' note, dated 01/21/13, revealed the resident experienced a fall from a mechanical lift sustaining an injury to the head. The resident was transported to a local hospital for emergency care. The record revealed the resident was treated and released from the hospital after sutures for a laceration to the forehead. The record revealed neuro checks were conducted by the facility nurses for forty-eight (48) hours. No deficits were noted.</p> <p>Review of the facility's investigation initiated on 01/21/13 revealed Resident #1 was being transferred from the bed to a shower bed by a mechanical lift when the sling's top left strap came off and the resident fell onto the floor. The investigation revealed there were four staff present during the fall, CNA #1, #2, #3 and Registered Nurse (RN) #1. In addition, the resident's daughter was present. The facility's investigation concluded CNA #1 had placed the sling (lift pad) under the resident backward/inside out. CNA #3 identified the error and informed CNA #1. However, the CNAs continued to proceed with the transfer without correcting the error. The resident was transported from the bed, without any staff member next to the resident, guiding the sling. In addition, the sling used for</p>	F 323		

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F 323	<p>Continued From page 5</p> <p>this transfer was not intended for the Hoyer lift and did not meet the manufacture's guidelines.</p> <p>Interview with the Administrator and Director of Nursing (DON), on 02/05/13 at 10:30 AM, revealed there were two Hoyer lifts in the building at the time of the incident. A 600 series lift and one 700 series lift. The lift used when Resident #1 fell was the 700 series. The DON stated she conducted a reenactment of the fall with the staff that were involved. The investigation found CNA #1 was in control of the lift and had placed the sling under the resident wrong. The other staff, CNA #2, CNA #3, and RN #1 were present. When the resident was lifted from the bed, CNA #3 identified the sling was on wrong. She informed CNA #1 (who had hooked the left side of the sling to the lift) and CNA #2 (who had hooked the right side of the sling). CNA #1 told them it did not matter and they proceeded with the transfer. When CNA #1 went to swing the lift around toward the shower bed, the left top strap of the sling came off the lift's cradle causing the resident to fall from the sling onto the floor. The DON discovered no staff was holding onto the resident when the lift was in motion. In addition, the nurse who was present did not stop the transfer when one of the CNAs stated the sling was on wrong. The DON stated the resident's daughter was in the room and witnessed the incident. The DON revealed the staff had used a large orange sling to transport the resident.</p> <p>Interview with RN #1, on 02/05/13 at 12:00 PM, revealed the nurse had worked at the nursing facility for about six (6) years. She stated she could not recall all the events. She stated CNA #1 was doing showers that day and she asked CNA</p>	F 323			

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F 323	<p>Continued From page 6</p> <p>#2 and CNA #3 to help with the transfer of Resident #1 onto the shower bed. She stated the resident had contractures and was a total assist with transfers with a mechanical lift. She stated she did not see the staff hook the sling to the lift, but knew CNA #1 had the lift's controls. She stated she heard the resident's daughter scream and turned around to see the resident lying on the floor. The resident had a small laceration to the forehead (right). She applied pressure to the wound to stop the bleeding. She did not know how the injury occurred and didn't know if the resident had hit the lift. She stated the resident was small now and could have slid out of the sling. She said it happened so fast and then she heard the daughter scream the staff had the lift sling on inside out. She didn't know how the daughter knew that. She revealed she occasionally would help staff with transfers using the mechanical lifts. She stated she had not received any training on how to use the mechanical lifts.</p> <p>Interview with Resident #1's daughter, on 02/05/13 at 12:30 PM, revealed she was visiting the resident when the fall from the lift occurred. She stated CNA #1 came into the room and was waiting for assistance to transfer the resident to the shower bed. Two CNAs came into the room to help and a nurse was also in the room. CNA #1 put the orange sling under the resident. Two CNAs put the straps on the mechanical lift. One of the CNAs told CNA #1 the lift pad was on inside out, but they proceeded anyway. A minute later, the resident slid from the lift pad/sling onto the floor but she did not see the strap come off. She thought the resident's head must have hit the lift's base and the resident landed on her/his back</p>	F 323		

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F 323	<p>Continued From page 7</p> <p>with their legs up in the air. The resident was bleeding from a cut to the forehead. The daughter indicated there were four (4) staff in the room and they were talking instead of holding onto the resident and they let go of the resident during the transfer. She stated the lift pad was not under the resident when she/he was on the floor. Per interview, the shower bed was at the foot of the resident's bed, the mechanical lift was at the middle of the bed, on the left side of the bed, toward the door.</p> <p>Interview with CNA #1, on 02/05/13 at 5:12 PM, revealed she took the shower bed and the mechanical lift into the resident's room so she could take the resident to the shower room for a shower. She stated the resident was a total lift and required several persons to assist with the transfer. She revealed a mechanical lift was used for all transfers with this resident. She stated she requested help from CNA #2 and #3. She said she had already placed the lift sling under the resident before the other CNAs came into the room to help. She revealed she hooked the left side of the sling to the lift while CNA #2 hooked up the right side. She stated they had put the sling straps on correctly. "I made sure it was secure." When she began the transfer, the resident was lifted from the bed and as she was turning toward the shower bed, the top left strap of the sling came off and the resident fell onto the floor. When asked, she confirmed she was the only person with the lift control. She said the strap did not break nor did the sling rip but instead the left top strap just slipped off the lift's cradle bar. She said she did not know how it came off. When asked if anyone had their hands on the resident during the transfer, she replied, "No." She stated</p>	F 323			

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F 323	<p>Continued From page 8</p> <p>the room was small and there was not enough room but CNA #2 was coming around the bed to assist when it happened. She revealed the top left strap of the sling was the only strap that came off. She did reveal another CNA had informed her that the lift sling pad was inside out, but she told them it didn't matter. She revealed a large, orange sling was used and this sling had been used before. She stated she had worked at the nursing facility for about four years and had not received training on the mechanical lifts. She stated she had been told the orange sling pad was for universal use and the large sling had been used for this resident many times.</p> <p>Interview with CNA #3, on 02/05/13 at 5:30 PM, revealed CNA #1 had requested assistance with Resident #1's transfer onto a shower bed. She went into the resident's room and she was holding the shower bed. She stated CNA #1 had already placed the sling pad under the resident. The resident's daughter was in the room and RN #1 was in the room. She observed CNA #1 and CNA #2 hook the sling to the lift; CNA #2 was on the right and CNA #1 was on the left. CNA #1 brought the resident up in the air (off the bed) and she saw the lift pad was inside out, because the loops used to hold the resident (secure) during a transfer were not showing. She informed them the lift sling was on the wrong side and CNA #1 told them she didn't think it made a difference and proceeded to raise the resident off the bed. When CNA #1 went to swing the lift around toward the shower bed, the top left strap of the sling came off and the resident fell onto the floor. Interview revealed this had happened once before. She stated one other time when she and CNA #2 were using this lift with the orange lift sling for another</p>	F 323		

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F 323	<p>Continued From page 9</p> <p>resident, a sling strap (she could not remember which one) came off but that time the resident was still lying on the bed. She stated if the sling strap was not placed completely around the lift's cradle hook, it could slip off. After that incident, she made sure she always placed the sling strap to the bottom of the hook (C shaped hook) and she has had no further problems. The CNA revealed she had not reported this problem to anyone because the resident didn't get hurt and she thought the problem was fixed. Further interview revealed there were no instructions on the mechanical lifts for reference. She received training on mechanical lifts during CNA classes (about 9 years ago), but had not been trained on this lift at the facility and she had worked at the nursing facility for about two years.</p> <p>Interview with CNA #2, on 02/05/13 at 6:45 PM, revealed she was in the resident's room during the incident. She stated CNA #1 requested assistance to transfer the resident onto the shower bed. CNA #1 had operated the hand control for the lift and she had already placed the lift pad/sling under the resident before she entered the room. She stated she hooked up the right side of the sling, top and bottom. She said everything looked fine but when CNA #1 lifted the resident off the bed and was turning the lift around, she heard a loud "pop" and saw the resident fall from the sling onto the floor. She stated they had used the orange sling (large) that they used everyday. She stated the sling was not ripped from the hook, it just came off. The CNA stated no one was holding onto the resident during the transfer. She indicated because there was limited space in the room, the shower bed was placed at the bottom of the resident's bed</p>	F 323		

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F 323	<p>Continued From page 10</p> <p>and the lift was on the left side of the bed (middle). She was on the right side of the bed and she was trying to get to the other side of the bed to assist but the resident fell from the sling before she could get there. Interview revealed this had happened before when the sling strap had come off the lift cradle when she and CNA #3 was attempting to transfer another resident. The sling strap came off while the resident was still on the bed so she just figured it happened because she had not pulled the sling strap tight. She did not report this to anyone because she assumed this happened because the sling was not on all the way. She stated she had not received any training on this particular lift prior to use. She stated she learned how to operate mechanical lifts in CNA classes, but this nursing facility had not train her. She stated she overheard the DON and Administrator say something about the wrong sling being used with this lift. She indicated the large orange sling was used and she had been told the sling was universal. They always used the large sling because the CNA assignment sheet instructed the use.</p> <p>Further interview with the DON, on 02/05/13 at approximately 4:45 PM, revealed the orange slings were universal and could be used with different types of lifts. She indicated she did not know how the sling's strap had come off during this incident.</p> <p>Interview with the Corporate Nurse Consultant, on 02/06/13 at 9:30 AM, revealed she had worked with the Administrator and DON after the incident. The investigation revealed the wrong sling was used with the Hoyer lift. She revealed the nursing facility owned two different lifts that needed</p>	F 323		

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F 323	<p>Continued From page 11</p> <p>repair. Those lifts were sent out for repair and two Hoyer lifts were rented sometime last fall. The facility's investigation found the staff was using the lift slings intended for the T.H.E. (old) lifts and not for the new Hoyer lifts. She stated the resident fell from a HPL 700 series. In addition, the investigation found the staff proceeded with the transfer even after a CNA had identified the sling was on the wrong side.</p> <p>Interview with the Hoyer Lift Company Representative, on 02/06/13 at 10:21 AM via telephone, revealed he was not sure when the first Hoyer lift was delivered to the nursing facility and did not know if any lift slings were provided at that time. He stated two (2) lift slings were usually provided with each lift and if the facility wanted more, they would have to order. He could confirm a Series 600 lift and a Series 700 lift was in use at the nursing facility prior to the incident. Interview revealed it did matter which type of sling was used and stated "It is recommended to use Hoyer slings with Hoyer lifts. He stated there were guidelines to follow with weight and height of each resident to be considered when choosing what size sling to use. The Hoyer slings were gray with color coded trim for sizes. The representative stated whenever the company tech delivers a Hoyer lift to a facility, it was routine to provide instructions on how to operate the mechanical lift. An operator's manual would also be provided. However, he said he could not confirm training had occurred prior to the incident. He stated he provided training on the new Hoyer lifts that were delivered after the fall to some of the staff. He stated the facility then would train the rest of the staff on the use of the lift.</p>	F 323			

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F 323	<p>Continued From page 12</p> <p>Review of the company's invoice revealed a 600 Series mechanical lift was delivered on 10/27/12 and a 700 series delivered on 11/08/12. The correspondence from the company indicated a large and x-large sling was delivered with the lifts.</p> <p>Observation, on 02/05/13 at 4:30 PM, revealed the facility had bagged all the old slings that had been used with the old lifts prior to Resident #1's fall. Inspection of the slings (six bags) revealed multiple orange slings with the initials of T.H.E. and a few blue slings. The slings were in good condition with no tears, no worn places, not frayed, or discolored. There were no gray slings with color trim that indicated Hoyer type slings had been used.</p> <p>Further interview with the DON, on 02/06/13 at 3:00 PM, revealed the orange sling used with the lift was a universal sling and could be used with different types of lifts. The DON stated there was no documented evidence found regarding training, but she recalled a corporate nurse came in March 2012 for a mock survey and found the facility was in 100% compliance. However, she provided no documentation of that visit and did not know if the facility was evaluated on the old lifts. She said she recalled a representative from the rental lift company provided training to some of the staff and other staff was trained by Staff Development. However, the Staff Development person was no longer working at the facility and they thought she must have misplaced or thrown away the training records. She stated staff was trained in orientation; however, she could not find any records of this.</p> <p>Interview with Staff Development, on 02/06/13 at</p>	F 323		

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F 323	<p>Continued From page 13</p> <p>3:45 PM, revealed she had just been in this position since October 2012. She said she was responsible for new hire orientation and new employees were supposed to get training on the proper use of mechanical lifts during the orientation process. However, she could not provide documented evidence that training on the lifts had been done prior to this incident. She stated new employees view a video on the mechanical lift; however, when the video was viewed, it was information regarding the old lift not the rented Hoyer lift.</p> <p>In addition, review of the manufacturer's user-service manual revealed a patient size guide reference for the 4-point sling was provided. The patient guide recommended a medium size sling for weights between 99-210 pounds. Review of the facility's comprehensive weight summary for Resident #1 revealed the resident's weight recorded on 10/03/10 was 219.5 pounds and 122 pounds on 01/04/13.</p> <p>Interview with the Director of Nursing (DON), on 02/05/13 at 2:15 PM, revealed she checked the lift's sling right after the resident's fall on 01/21/13 and found the staff had used a large sling. She stated the correct sling size was used according to their assignment sheet, which instructed them to use the large sling. She stated the sling size was based on each resident's size, weight and height. Interview revealed the DON was responsible to determine what size sling would be used with each resident. However, she could not provide any evidence Resident #1 had been reassessed after the resident's weight loss. She indicated she was aware of the resident's weight loss; however, she had not re-measured the</p>	F 323		

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F 323	<p>Continued From page 14 resident for a different size sling.</p> <p>The facility took the following corrective actions in response to the incident on 01/21/13:</p> <p>*The facility removed both lifts and all slings from resident care areas and a representative from the manufacturer conducted a maintenance check and found the lifts were working properly. The facility decided to returned those lifts and requested new lifts from the rental company. Two new lifts, Hoyer 700 series were delivered on 01/23/13.</p> <p>*The facility reassessed all residents for accurate transfer status on 01/22/13. All residents presently using a mechanical lift for mode of transfer/transport was reassessed to determine if the resident still required the lift for transfers. Residents were measured and weighed to determine the correct size sling on 01/22/13.</p> <p>*The facility obtained new manufacturer recommended slings for each resident as determined by weight and height on 01/22/13.</p> <p>*The facility educated and completed disciplinary actions (termination) with the staff involved in the incident on 01/21/13.</p> <p>*The facility notified Physicians of the residents who required lift transfers for orders to either stay in bed or complete a manual lift transfer until the new lifts/slings were delivered and staff education with return demonstration was completed. Families were also notified on 01/21/13.</p> <p>*The Hoyer lift company completed education</p>	F 323		

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F 323	<p>Continued From page 15 with the DON and ADON with return demonstration on 01/22/13.</p> <p>*The facility notified the Medical Director of the incident on 01/21/13 and a special Quality Assurance meeting was held on 01/22/13 with the Medical Director in attendance.</p> <p>*The facility developed an audit tool to observe at least two (2) residents lift transfers five (5) times per week for four (4) weeks and then monthly for five (5) months. The findings of the audits will be submitted to the PI committee at least monthly times six (6) months. Any issues found with noncompliance will be addressed with either education or disciplinary actions as appropriate by the facility.</p> <p>The following measures were validated as completed prior to the survey exit on 02/07/13:</p> <p>*Review of the invoice from the Hoyer lift manufacturer, dated 01/22/13, revealed orders for seventeen slings with each resident's specific weight and size of sling requested. Resident #1 with a weight of 122 pounds required a medium sling.</p> <p>*Residents were measured and weighed to determine the correct size sling on 01/22/13. Interview with the DON, on 02/05/13 at 2:15 PM, revealed all residents were measured after the fall to determine which sling size was to be used with the Hoyer lifts. Resident #1's weight and height indicated a medium size sling would be needed to be used with the Hoyer lift.</p> <p>*Interview with Staff Development, on 02/06/13 at</p>	F 323		

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F 323	<p>Continued From page 16</p> <p>3:45 PM, confirmed since the incident, the facility had the manual from the lift company and they sent two videos on the Hoyer lifts. A representative from the company came to the facility and conducted a training on the 700 Series lifts. He did a demonstration using a staff person and then made the staff do a return demonstration. He also trained staff on how to size and measure each sling for each resident. She stated 100% of staff had been trained. She had a new employee in orientation today and they watched the video and performed a return demonstration to ensure they understood how to use the lifts correctly.</p> <p>*The DON and ADON (Staff Development) and designated licensed nurses who had been trained, completed 100% education with all nursing staff with a return demonstration required on 01/29/13. The training was validated through sign in sheets against the facility staff roster. In addition, interviews with 9 different CNAs on both west and north wing, and 3 LPNs validated the staff was knowledgeable of what was presented in the training and how to apply that information.</p> <p>*Review of those residents who were transferred via mechanical lift revealed the residents had been assessed and the care plan had been revised to reflect any changes by 01/29/13.</p> <p>*Observation of transfers with the mechanical lifts were conducted during the survey (February 5-7, 2013) for sampled Residents #2, #3, and #6 which validated the correct transfer method was used according to each resident's assessment and care plan and the correct sling was used. Observation, on 02/05/13 at 9:25 AM, revealed a</p>	F 323		

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F 323	Continued From page 17 medium size lift sling lying in a chair in Resident #1's room. Interview with Certified Nursing Assistants (CNAs) # 9 and #10 (who were in the room at the time of the observation) revealed when the resident was transferred with the mechanical lift, a medium sling is used. They stated a large sling was used prior to the resident's fall from the lift. The CNAs stated all residents have their own slings now and the staff do not use them for any other residents.  *Interview with the Medical Director on 02/06/13 and review of the QA sign in sheet dated 01/22/13 validated the notification and the QA meeting.  *Review of the audit tools was conducted on 02/06/13 and found the audits began on 01/28/13 and continued during the survey.	F 323			
F 490 SS=J	<b>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</b>  A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to be administered in a manner which enabled it to use it's resources effectively and efficiently to attain and maintain the highest practical, physical, mental, and psychosocial well-being of each	F 490	Past noncompliance: no plan of correction required.		

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F 490	<p>Continued From page 18</p> <p>resident (Resident #1) in a selected sample of six (6) residents. The facility's administration failed to have an effective system to ensure staff had adequate knowledge on how to operate a mechanical lift with the appropriate sling for the sixteen (16) residents being transported via mechanical lifts when the Hoyer lifts were brought into the building for use and the manufacturer's instructions/manual was not provided to the staff for reference. The administration failed to assure equipment (mechanical lift slings) was the correct size and type in accordance with manufacturer's instructions. On 01/21/13 the facility staff utilized a mechanical lift with a sling lift pad to transport Resident #1 from the bed. The top left sling strap came off the lift's cradle, resulting in the resident falling onto the floor sustaining a laceration to the forehead. The resident was transported to the emergency department for treatment (sutures) and returned to the facility. In addition, Resident #1 had experienced a weight loss over a two year period; however, the facility failed to reassess the resident for appropriate sling size.</p> <p>The facility's failure to be administered effectively placed all residents who were transported by mechanical lifts at risk for serious injury, harm, impairment or death. Immediate Jeopardy and Substandard Quality of Care was determined to exist on 01/21/13 through 01/29/13. The facility completed corrective actions prior to the State Survey Agency's investigation initiated on 02/05/13; therefore the Jeopardy was determined to be Past Jeopardy. (Refer to F323)</p> <p>The findings include:</p> <p>Review of the manufacturer's user-service</p>	F 490		

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F 490	<p>Continued From page 19</p> <p>manual for the Hoyer HPL 700 lift, not dated, revealed Hoyer lifts are specifically designed for Hoyer slings and accessories. "Warning" slings and accessories designed by any other manufacturer was prohibited and voided the warranty. Use only Hoyer slings and accessories to maintain user safety and product utility.</p> <p>On 01/21/13, Resident #1 was being transferred from the bed to a shower bed by a mechanical lift when the sling's top left strap came off and the resident fell onto the floor. There were four staff present during the fall, Certified Nursing Assistant (CNA) #1, #2, #3 and Registered Nurse (RN) #1. CNA #1 had placed the sling (lift pad) under the resident backward/inside out. CNA #3 identified the error and informed CNA #1. However, the CNAs continued to proceed with the transfer without correcting the error. The resident was transported from the bed, without any staff member next to the resident, guiding the sling. In addition, the sling used for this transfer was not intended for the Hoyer lift and did not meet the manufacture's guidelines.</p> <p>Interview, on 02/05/13 at 5:12 PM, 5:30 PM, and 6:45 PM, with CNA #1, CNA #2, and CNA #4, revealed they had not received any training on the lifts or which sling to use. In addition, there was no reference material to refer to by the staff. They had been informed by the DON that the orange slings were universal and could be used on any lift. The CNAs stated they were instructed to use the orange sling and this sling was designated on the CNA assignment sheet for use.</p> <p>Further interview with the DON, on 02/05/13 at 2:15 PM, revealed the correct sling size was used</p>	F 490		

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F 490	<p>Continued From page 20</p> <p>according to the CNA assignment sheet, which instructed them to use the large sling. The DON stated she was responsible to determine what size sling would be used with each resident. However, she could not provide any evidence Resident #1 had been reassessed after the weight loss, nor evidence of any assessments to determine the appropriate sling size to use for the other fifteen residents utilizing the lift.</p> <p>Interview with the Administrator and Director of Nursing (DON), on 02/05/13 at 10:30 AM, revealed there were two Hoyer lifts in the building at the time of the incident. During the transfer the left top strap of the sling came out off the lift's cradle causing the resident to fall from the sling onto the floor. No staff was holding onto the resident when the lift was in motion. A large orange sling was used by the staff to transport the resident and the sling was not recommended for use with the Hoyer lift. The T.H.E. brand of sling was used with the previous mechanical lifts that were no longer in the facility. The Director of Nursing (DON) instructed the staff to use the wrong sling stating the slings were universal and could be used with the Hoyer lift. However, review of the Hoyer lift manual revealed instructions that said "you must use Hoyer slings with Hoyer lifts." The facility could not provide evidence training had occurred when the rented Hoyer lifts was brought into the facility and used for transfers of sixteen (16) residents.</p> <p>Interview with the Hoyer Company Representative, on 02/06/13 at 10:21 AM, revealed "It is recommended to use Hoyer slings with Hoyer lifts." He stated there were guidelines to follow with weight and height of each resident</p>	F 490		

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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 490	<p>Continued From page 21</p> <p>to be considered when choosing what size sling to use. The Hoyer slings were gray with color coded trim for sizes.</p> <p>Interview with the Corporate Nurse Consultant, on 02/06/13 at 9:30 AM, revealed the investigation identified the wrong sling was used with the Hoyer lift which were rented sometime last fall. In addition, the investigation found the staff proceeded with the transfer even after a CNA had identified the sling was on the wrong side.</p> <p>The facility took the following corrective actions in response to the incident on 01/21/13:</p> <p>*The facility removed both lifts and all slings from resident care areas and a representative from the manufacturer conducted a maintenance check and found the lifts were working properly. The facility decided to returned those lifts and requested new lifts from the rental company. Two new lifts, Hoyer 700 series were delivered on 01/23/13.</p> <p>*The facility reassessed all residents for accurate transfer status on 01/22/13. All residents presently using a mechanical lift for mode of transfer/transport was reassessed to determine if the resident still required the lift for transfers. Residents were measured and weighed to determine the correct size sling on 01/22/13.</p> <p>*The facility obtained new manufacturer recommended slings for each resident as determined by weight and height on 01/22/13.</p> <p>*The facility educated and completed disciplinary actions (termination) with the staff involved in the</p>	F 490		

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F 490	<p>Continued From page 22 incident on 01/21/13.</p> <p>*The facility notified Physicians of the residents who required lift transfers for orders to either stay in bed or complete a manual lift transfer until the new lifts/slings were delivered and staff education with return demonstration was completed. Families were also notified on 01/21/13.</p> <p>*The Hoyer lift company completed education with the DON and ADON with return demonstration on 01/22/13.</p> <p>*The facility notified the Medical Director of the incident on 01/21/13 and a special Quality Assurance meeting was held on 01/22/13 with the Medical Director in attendance.</p> <p>*The facility developed an audit tool to observe at least two (2) residents lift transfers five (5) times per week for four (4) weeks and then monthly for five (5) months. The findings of the audits will be submitted to the PI committee at least monthly times six (6) months. Any issues found with noncompliance will be addressed with either education or disciplinary actions as appropriate by the facility.</p> <p>The following measures were validated as completed prior to the survey exit on 02/07/13:</p> <p>*Review of the invoice from the Hoyer lift manufacturer, dated 01/22/13, revealed orders for seventeen slings with each resident's specific weight and size of sling requested. Resident #1 with a weight of 122 pounds required a medium sling.</p>	F 490		

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F 490	<p>Continued From page 23</p> <p>*Residents were measured and weighed to determine the correct size sling on 01/22/13. Interview with the DON, on 02/05/13 at 2:15 PM, revealed all residents were measured after the fall to determine which sling size was to be used with the Hoyer lifts. Resident #1's weight and height indicated a medium size sling would be needed to be used with the Hoyer lift.</p> <p>*Interview with Staff Development, on 02/06/13 at 3:45 PM, confirmed since the incident, the facility had the manual from the lift company and they sent two videos on the Hoyer lifts. A representative from the company came to the facility and conducted a training on the 700 Series lifts. He did a demonstration using a staff person and then made the staff do a return demonstration. He also trained staff on how to size and measure each sling for each resident. She stated 100% of staff had been trained. She had a new employee in orientation today and they watched the video and performed a return demonstration to ensure they understood how to use the lifts correctly.</p> <p>*The DON and ADON (Staff Development) and designated licensed nurses who had been trained, completed 100% education with all nursing staff with a return demonstration required on 01/29/13. The training was validated through sign in sheets against the facility staff roster. In addition, interviews with 9 different CNAs on both west and north wing, and 3 LPNs validated the staff was knowledgeable of what was presented in the training and how to apply that information.</p> <p>*Review of those residents who were transferred via mechanical lift revealed the residents had</p>	F 490			

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F 490	<p>Continued From page 24</p> <p>been assessed and the care plan had been revised to reflect any changes by 01/29/13.</p> <p>*Observation of transfers with the mechanical lifts were conducted during the survey (February 5-7, 2013) for sampled Residents #2, #3, and #6 which validated the correct transfer method was used according to each resident's assessment and care plan and the correct sling was used. Observation, on 02/05/13 at 9:25 AM, revealed a medium size lift sling lying in a chair in Resident #1's room. Interview with Certified Nursing Assistants (CNAs) # 9 and #10 (who were in the room at the time of the observation) revealed when the resident was transferred with the mechanical lift, a medium sling is used. They stated a large sling was used prior to the resident's fall from the lift. The CNAs stated all residents have their own slings now and the staff do not use them for any other residents.</p> <p>*Interview with the Medical Director on 02/06/13 and review of the QA sign in sheet dated 01/22/13 validated the notification and the QA meeting.</p> <p>*Review of the audit tools was conducted on 02/06/13 and found the audits began on 01/28/13 and continued during the survey.</p>	F 490			