A complaint investigation was conducted on 8/24/11 for TN00028542 with actual harm (G level deficiency) being cited at F323. This will be a no opportunity to correct with daily civil monetary penalties being imposed. The facility has been cited a double G, which means during the annual survey completed on 7/7/11 the facility was cited a G level deficiency and during the complaint investigation completed 8/24/11 a G level deficiency was cited.

F 323  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 review of the facility's investigation summary, medical record review and interview, it was determined the facility failed to ensure interventions were implemented to prevent accidents for 1 of 4 (Resident #1) sampled residents identified with falls. The failure to implement the interventions to protect Resident #1 resulted in actual harm when Resident #1 sustained a fracture during a transfer.

The findings included:
Review of the facility's event summary dated 8/8/11 documented, "[Resident #1's name and room number] Event Date: 8/2/11 at 7:45 PM An investigation was completed regarding above stated incident... [staff] didn't use a mechanical lift to transfer the patient... The two CNAs [Certified Nurse Assistants] attempted to transfer the patient using a "2 man lift" technique that resulted in injury to the patient. The patient was transferred to the hospital and admitted for orthopedic treatment. The patient's daughter has reported that there is a "broken femur"..." A Follow-up Report dated 8/8/11 for Resident #1 documented, "...8/3/11 F/U [follow-up] phone call + [positive] femur fx [fracture]...

Medical record review for Resident #1 documented an admission date of 12/10/08 and a readmission date of 5/4/11 with diagnoses of Peripheral Vascular Disease, Left Below Knee Amputation, Muscle Weakness, Rheumatoid Arthritis, Bipolar Disorder and Osteoarthrosis. Review of a physician telephone order dated 8/2/11 documented, "Send to [hospital name] for evaluation of Rt [right] knee." The lift/transfer assessment form dated 6/8/11 documented, "...TOTAL LIFT REQUIRED yes..." The care plan dated 5/4/11 documented, "...At risk for falls r/t [related to] requires total assist with transfers... Ensure adequate staff and proper equipment for safe transfers... Use hoyer lift for transfers..."A nurses note dated 8/2/11 at 10:42 PM documented, "...resident [#1] sitting on floor upright position but rt [right] leg bent in odd position it was laying sideways... shower chair was next to bed this nurse was told by CNA that resident was being transferred to shower chair..."
### Summary Statement of Deficiencies

Each deficiency must be preceded by full regulatory or LSC identifying information.

<table>
<thead>
<tr>
<th>F 323</th>
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<tbody>
<tr>
<td></td>
<td>from bed resident's leg caught in shower chair. CNA attempted to reposition leg heard a pop</td>
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<td>CNAs attempted to assist resident back on to bed resident unable to stand CNAs assisted the</td>
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<td>resident to the floor...&quot;</td>
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During an interview in the administrator's office on 8/24/11 at 4:30 PM, the Director of Nursing stated, "...[CNA] got a shower chair, supposedly looked for a lift, said none [no lift available], got co-worker assist to transfer [Resident #1] to shower chair. The resident's leg wrapped around the chair... [CNA] tried to lay her down and heard a pop... "

The failure to implement the interventions documented on the lift/transfer assessment and care plan to protect Resident #1 resulted in actual harm when Resident #1 sustained a fracture during a transfer on 8/2/11.