STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **035256**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **08/07/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FREEDOM PLAZA CARE CENTER	**13714 NORTH PLAZA DEL RIO BLVD PEORIA, AZ 85381**

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)
F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on clinical record review, facility documentation, staff interviews and policy review, the facility failed to ensure one resident (#7) was free from neglect, due to an unsafe transfer. Findings include: Resident #7 was admitted to the facility on (MONTH) 5, (YEAR), with [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 13, (YEAR), revealed a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. The MDS included the resident required extensive assistance with bed mobility, transfers and hygiene, and had impairment to both upper and lower extremities. A care plan for activities of daily living dated (MONTH) 4, (YEAR) revealed the resident had a self care performance deficit related to weakness, decreased mobility and left side [MEDICAL CONDITION]. The goal was for the resident to maintain her current level of function. Approaches included the resident utilizes a wheelchair for mobility and requires two staff to assist when being transferred in the Hoyer lift. Review of a care plan revealed the resident was at risk for falls related to weakness, decreased mobility and impaired balance. The goal was the resident would not sustain serious injury. Approaches included to anticipate and meet the resident's needs, and for a Hoyer lift with the assistance of 2 persons for transfers. A nurse's progress note dated (MONTH) 20, (YEAR), revealed the nurse was called by a certified nursing assistant (CNA/staff #218) to the resident's room. The resident was laying on her left side near the foot of the bed, with her head resting on the bed frame. The Hoyer lift was noted to be in a high position and the sling was on. Staff #218 reported to the nurse that the resident had slipped out of the sling. Per the note, there was blood underneath the resident's head and the resident was not responding. The nurse called EMS to have the resident transported to the hospital. The resident became more responsive and complained of pain to her left hip. Review of the facility's investigative report revealed that resident #7 was non-ambulatory and required the use of a Hoyer lift for all transfers. On (MONTH) 20, (YEAR), staff #218 attempted to transfer the resident from the bed to the wheelchair, without a second staff member. During the transfer, the resident slid out of the sling and landed on the floor, hitting the right side of her head on the floor. The resident lost consciousness for 1 to 2 minutes. When the resident regained consciousness, a neurocheck was completed and the resident was within normal limits. The resident was then assessed by two nurses and had a hematoma/laceration to the left side of her forehead, and a laceration to her left elbow. The resident also complained of pain to her right hip. 911 was called and the resident was transferred to the hospital. The facility's investigative report further included that staff #218 was interviewed by the Administrator (staff #180) and stated that she had received training on using the Hoyer lift and knew that two staff were always needed when transferring a resident. Per the report, staff #218 was involuntarily terminated on (MONTH) 22, (YEAR) for not following facility policy and best practice, when transferring a resident in the Hoyer lift. Review of the hospital discharge summary dated (MONTH) 24, (YEAR) revealed that resident #7 had a left femur fracture, a left elbow laceration and a scalp laceration which resulted from a fall, while being transferred in the Hoyer lift. As a result of this incident, the facility implemented corrective action as follows: -A facility memo dated (MONTH) 20, (YEAR) was sent to Nursing staff/CNA from the Director of Nursing (DON/staff #199) and revealed the following: The goal of any transfer between surfaces such as bed or chair is to move the resident safely and easily while preventing injury to both the resident and staff. When performing mechanical lift transfers (Hoyer Lift, Sara Lift) licensed/certified nursing staff members must have two licensed/certified staff members present at all time to ensure safety is maintained. No mechanical lift transfers should be performed by a single staff member as this could lead to injury to residents or staff. This is facility protocol! Non-compliance with facility protocol will lead to disciplinary action. -According to Training Attendance Records dated (MONTH) 22, 23 and 24, (YEAR), licensed and non-licensed staff attended training regarding Hoyer lift transfers/mechanical lifts. -Additional trainings were completed as follows: a Training Attendance Record dated (MONTH) 6, (YEAR) included that nurses attended a training on abuse and neglect, policy and procedures for Hoyer lifts and supervision of CNA's, and a Training Attendance Record dated (MONTH) 7, (YEAR) included a CNA training for Hoyer lifts, transfers and slings, and the training included that staff provided a return demonstration. -The facility also completed Mechanical Lift Audits from (MONTH) 5, (YEAR) through (MONTH) 2, 2019. The audits included resident's names, if they utilized a Hoyer lift and how many staff were required to assist. On (MONTH) 6, 2019 at 12:44 p.m., an interview was conducted with a CNA (staff #176), who said that she has received training on how to use the Hoyer lift and there must be two staff to assist with the transfer at all times. She said that she also attended training on how to use the Hoyer lift a couple of months ago. On (MONTH) 6, 2019 at 12:50 p.m., an interview was conducted with a licensed Practical Nurse (LPN/staff #209), who stated that she had attended training on how to use the Hoyer lift a few months ago. She said there must be two staff present when transferring a resident in the Hoyer lift at all times, and that she would make sure the cloth/sling is under the resident. She also said that one staff should make sure the wheelchair does not move and is stable. An interview was conducted on (MONTH) 7, 2019 at 8:28 a.m. with the Administrator (staff #180). She stated that staff #218 attended orientation, which included Body Mechanics/Safe Lifting. She stated that this training included the Hoyer lift. She said that staff are trained, receive a demonstration and then must demonstrate how to use the Hoyer lift safely. She said there must always be two staff when using the Hoyer lift. She said when the CNA attempted to use the Hoyer lift by herself and the resident fell , the facility implemented a Corrective Action Plan. She said the plan was to provide in-service training for all employees. She stated that during the in-service trainings, the incident about the resident falling out of the Hoyer lift was discussed and the importance of following facility policy, which requires two staff at all times, when using the Hoyer lift for transfers. She stated that all staff have received in-service training. Review of the facility policy on mechanical lifts dated (MONTH) 4, (YEAR), revealed that all Hoyer mechanical lifts will always be operated by 2 staff members. Review of the Abuse/Neglect policy revealed that the facility is committed to maintaining a safe environment for each resident, visitor and associate. The policy included that the resident has the right to be free from abuse and neglect. Per the policy, neglect is defined as the failure of the facility, its employees or service providers to provide goods and

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 0600 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.