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OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555823	A. BUILDING _____ B. WING _____	C 01/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTERCOMMUNITY CARE CENTER	2626 GRAND AVENUE LONG BEACH, CA 90815

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F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during the investigation of two complaints. Complaint Numbers: CA00713691 and CA00714547 Representing the Department of Public Health: Health Facilities Evaluator Nurse ID: 41489 The inspection was limited to the specific complaints investigated and does not represent the findings of a full inspection of the facility. One deficiency was written for complaint numbers CA00713691 and CA00714547.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to transfer one of three sampled residents (Resident 1) using a two-person assist as per the facility's training manual for the use of a mechanical lift (a device	F 689	This plan of correction constitutes our written allegation of compliance for the deficiencies cited Submission of this plan of correction is not an admission that each alleged deficiency exists or that it is cited accurately. This plan of correction is submitted to meet state and federal requirements and without any admission of liability.	

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

NHA — ADMINISTRATOR — 1/19/21

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 689	Continued From page 1 used to move residents from one location to another). Resident 1, who had a high risk for falls and was totally dependent on staff for all care was transferred from the bed to a Geri-chair (a wheeled stretcher that can be configured into a chair position used for transporting residents) with a mechanical lift and a one-person physical assist which resulted in injury to Resident 1. This deficient practice of not using a two-person physical assist while using the mechanical lift resulted in the lift falling to the side causing the sling bar (metal bar suspended on the lifting arm of the machine in which the lifting sling [device in which residents are positioned in to be lifted] is attached) to hit Resident 1 in the face sustaining a comminuted nasal fracture (broken bones in several places) and contusion (bruising) to Resident 1's eyelid and periocular (area surrounding the eyeball) area. Resident 1 was transferred to a general acute care hospital (GACH) for further evaluation, care, and treatment. Findings: During a review of Resident 1's Admission Record it indicated Resident 1 was admitted to the facility on 5/31/2013 and last readmitted on 11/23/2020. Resident 1's diagnosis included gastrointestinal hemorrhage (bleeding in abdominal area), acute respiratory disease (condition when lungs cannot provide enough oxygen), vascular dementia (progressive memory loss), and fracture of nasal bones. During a review of Resident 1's care plan titled, "Self-care deficit" dated 7/19/2019 indicated Resident 1 was totally dependent on the staff	F 689	F689 Immediate Action: Resident#1 were assessed and first aid treatment were rendered by Registered Nurse (RN) together with LVN#1. LVN#1 called the primary physician for notification and PMD made an order to apply ice pack and do a STAT X-ray of the nasal bones. Family members were also notified of the event. Nurse#3 were counselled by the charge nurse with the proper use of the mechanical lifts. Date: 11/22/2020 Identification of Other Affected Residents: RN Supervisor reviewed all residents' ADL- transferring with the use of the mechanical lifts, no other residents have been affected by the alleged deficiency. Date: 11/22/2020	

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F 689	Continued From page 2 during transfers, locomotion on unit, eating, dressing, bathing, toilet use, and personal hygiene. During a review of Resident 1's care plan titled, "Risk for falls" dated 7/19/2019, it indicated the staff should use appropriate device as ordered. During a review of Resident 1's Minimum Data Set (MDS), a resident assessment and care-planning tool, dated 10/15/2020, it indicated Resident 1 was totally dependent in care and required full staff performance when transferring to or from bed, chair, and or wheelchair. During a review of a Situation, Background, Assessment, Recommendation ([SBAR] an internal communication), dated 11/22/2020 and timed at 6:15 a.m., indicated Resident 1 had a laceration (deep cut) on the bridge of her nose. The SBAR indicated the physician ordered a stat (done immediately) x-ray, neuro checks (brain function and nervous system assessment) to be performed every 72 hours, application of an ice pack to the nose, and a mild pain reliever, as needed for pain. During a review of the facility's Incident /Investigation Form, dated 11/22/2020 and timed at 6:30 a.m., indicated Resident 1 had a laceration (deep cut) to nasal bones and was taken to a GACH Emergency Department (ED). The form indicated the root cause of Resident 1's injury was improper lifting and safety rule not enforced. During a review of Resident 1's Physician orders, dated 11/22/2020 and timed at 6:35 a.m., it indicated an order for an immediate x-ray of the	F 689	<u>Systemic Changes:</u> Director of Staff Development gave an in-service to all nursing staff on "Lift – Mechanical" properly use. Date: 11/23/20 and on-going Director of Nursing and/or designee will do a monthly random check with nursing staff during the ADL's care to observe staff during the resident's transfer from bed to WC/Geri-chair and vice versa. Date: 11/23/20 and on-going Any improper handling of transfer with the use of the mechanical lifter will be called to the Director of Staff Development office for re-education and re-training, any non-compliance will lead to suspension and/or termination. Date: 11/23/20 and on-going	

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F 689	Continued From page 3 nasal bones, neuro checks every 72 hours, an ice pack to Resident 1's nose, and to cleanse the mid-nasal bone with normal saline (saltwater solution) pat dry apply thin layer of Bacitracin (an antibiotic to prevent infection) ointment two times a day for 14 days. During a review of Resident 1's Physician orders, dated 11/22/2020 and timed at 4 p.m., it indicated an order for Resident 1 to be transferred by ambulance to the GACH for further evaluation. A review of Resident 1's Notice of Discharge or Transfer form dated 11/22/2020 indicated Resident 1 was transferred to GACH. During a review of Resident 1's GACH ED Physician note, dated 11/22/2020, it indicated Resident 1 was brought in by ambulance after an accident with a mechanical lift with injury to the nasal bridge. The ED note indicated Resident 1 presented with edema (swelling) and discoloration underneath both eyes. The ED's physician note, dated 11/23/2020 and timed at 5:19 a.m., indicated Resident 1's diagnosis was a nasal fracture, bilateral eye contusion (bruises under both eyes), and a superficial (occurring at the surface) nasal laceration with steri-strips (for wound closure) applied. The ED notes indicated Resident 1 had a computed tomography ([CT] x-ray in which computer controls the motion of the x-ray to produce an image) scan. The results of the CT scan indicated Resident 1 had a comminuted (break of bone into more than two parts) and displaced (moved from natural position) fracture with collapse of the nasal ridge and a fracture of the nasal septum (bone that separated the two nostrils). During a review of Resident 1's Nursing Progress	F 689	<u>Quality Assurance:</u> Director of Staff Development will submit a non-compliance report to administrator's office in monthly basis for review and/or recommendations. Administrator will present the report to the Quality Assurance Committee in a quarterly basis. Date: 11/23/2020 and on-going	

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F 689	Continued From page 4 Note, dated 11/22/2020 and timed at 6:15 a.m., it indicated at 6:15 a.m. that day, Certified Nursing Assistant (CNA) 3 reported Resident 1's nose was bleeding. Licensed Vocational Nurse (LVN) 1 responded and applied pressure and an ice pack to Resident 1's nose. The nursing progress note indicated the physician ordered an x-ray, ice pack to nasal bone, and neuro checks to be performed every 72 hours. The nursing progress note indicated CNA 3 stated, "I was trying to transfer the resident (Resident 1) from the bed to the Geri chair using the lift, but the hanger swung around and hit resident's nose." During a review of Resident 1's Interdisciplinary Committee Minutes (IDT), dated 11/27/2020, indicated Resident 1 had an unavoidable accident [sic] that caused injury during transfer from the bed to the Geri-chair with use of the mechanical lift. The IDT note indicated "staff failed to spread the lift's base that caused it to fall and hit the resident's face that caused trauma." During a telephone interview, on 12/2/2020 at 8:30 a.m., Resident 1's responsible party (RP 1) stated the facility's staff called her on 11/22/2020 to notify her Resident 1 had an accident and was transferred to the hospital. RP 1 stated the facility informed her that a mechanical lift arm hit Resident 1 on her nose and Resident 1's nose was fractured. During an interview, on 12/2/2020 at 1:35 p.m., CNA 1 stated there must be two people to assist Resident 1 in and out of the lift. CNA 1 stated, "If the lift was being used properly, there should not be any way for the bar to hit a resident in the face because one staff should hold the bar while the other staff puts the resident in the swing."	F 689		

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F 689	Continued From page 5 During a concurrent interview and observation , on 12/2/2020 at 1:45 p.m., CNA 2 stated "We make sure there are two staff members when we use the Hoyer lift (mechanical lift). The only way the swing bar can hit the resident's head is if we slide the lift in wrong. The bar should not swing. The other staff should hold the bar to prevent it from swinging." During a concurrent interview and observation , on 12/2/2020 at 2:15 p.m., the Director of Nursing (DON) stated she believed an LVN (LVN 1) entered Resident 1's room after the incident and saw the CNA (CNA 3) working alone. During a telephone interview, on 12/2/2020 at 2:36 p.m., CNA 3 stated, "When I came into Resident 1's room, I had no one to help, so I decided to carry her alone. I tried to be careful and position her (Resident 1), but the Hoyer lift fell sideways while I was putting her in the Geri-chair. The center part that swings, hit her (Resident 1) in the head and she fell onto the Geri-chair. The bar hit her directly on the nose. I was frustrated because I was all alone." CNA 3 stated after Resident 1 was hit the licensed nurse put ice on her nose to stop the bleeding. During a telephone interview, on 12/3/2020 at 7:37 a.m., LVN 1 stated at 6:15 a.m. on 11/22/2020, CNA 3 came and told her Resident 1 was bleeding. LVN 1 stated she entered the room and saw Resident 1 in a Geri-chair bleeding from her nose. LVN 1 stated CNA 3 stated the mechanical lift turned around and hit the resident's nose. LVN 1 stated there should always be two staff members operating the mechanical lift and CNA 3 did not ask her for	F 689		

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F 689	Continued From page 6 help. During an interview, on 12/3/2020 at 8:14 a.m., the Director of Staff Development (DSD) stated CNA 3 forgot to open the mechanical lift legs appropriately and the mechanical lift fell to the side. The DSD stated Resident 1 did not fall to the floor but the mechanical lift's swing hit Resident 1 in the face, because the legs were not opened properly, and the mechanical lift was unstable. The DSD stated CNA 3 was working alone and the facility's number one rule was to not to work alone, especially when using the mechanical lift. The DSD stated the staff were aware they are supposed to use a two-person assist while operating the mechanical lift. During an interview, on 12/3/2020 at 8:34 a.m. the DON stated, "The CNA (CNA 3) said she did not open the legs of the mechanical lift and because of that, the machine dropped, and the swing hit Resident 1 on the nose. According to what the CNA (CNA 3) wrote in the interview, she was working alone, and it was a requirement for two people work together to use this machine." During an observation of the facility's video surveillance camera with the administrator on 12/8/2020 at 9:30 a.m. indicated the following occurred on 11/22/2020: 1. At 6:10 a.m., CNA 3 was observed entering Resident 1's room alone. 2. At 6:19 a.m., CNA 3 exits Resident 1's room alone and proceeds to Nurse Station B. 3. At 6:20 a.m., LVN 1 and Registered Nurse (RN) 1, accompanied by CNA 3 went back to Resident 1's room.	F 689		

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F 689	Continued From page 7 A review of the facility's policy and procedure (P/P), revised in 12/2007 and titled, "Falls and Fall Risk, Managing," it indicated staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. A review of the facility's in-service training manual titled "Hoyer Lift Device for Transferring Patients" indicated "The Hoyer lift should always be used with two people. One person should be helping control movement of patient while the other operates the lifting mechanism and opens the legs of the lift for optimal stability. Remember, one person should always maintain control of the patient in the sling while the second person operates the lift. Never, never, never, use a two-person Hoyer lift by yourself. Patients have slipped, tipped, and fallen out of the slings and have been seriously injured and some have died. Follow manual and healthcare facility instructions regarding the Hoyer lift to the letter."	F 689		