STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035064	A. Building B. Wing	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothills Rehabilitation Center	2250 North Craycroft Road Tucson, AZ 85712

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47911 Based on clinical record review, staff and resident interviews, facility records and facility policy the facility failed to ensure that one resident (#1) out of 3 sampled is free from preventable falls. This deficient practice could result in resident injury and mortality. Findings include: Resident #1 was admitted on [DATE] with diagnosis including MS (multiple sclerosis) chronic respiratory failure, tracheostomy, hemiplegia and hemiparesis affecting the right dominant side, chronic pain, muscle weakness, wedge compression fractures, fracture of right tibia, and fracture right fibula. A review of the MDS (minimum data set) dated November 13, 2024 revealed a BIMS (brief interview of mental status) score of 15, indicating that the resident was cognitively intact. A review of the resident's care plan revealed that a focus area noting that the resident required the use of a mechanical lift device (Hoyer lift) and a 2-person assist was initiated on December 5, 2023. A review of the progress notes revealed that on November 15, 2024 at 8:00 A.M. that staff was called into the room of resident #1. It was notated that resident #1 was found on the floor face down. Documentation revealed that the fall occurred during a Hoyer lift transfer from the shower gurney back into bed. The resident was noted to be bleeding from the nose and a laceration to the forehead was evident. There was not reported loss of consciousness. Progress notes further revealed that the resident received initial treatment and that notifications transpired. The progress notes further revealed that the resident was complaining of bilateral lower extremity pain. A subsequent progress note entry on November 15, 2024 at 9:00 P.M. revealed that the resident had returned from the hospital via stretcher. It was noted that the right leg below the knee to the toes was splinted, and a laceration to the forehead was observed. A new order of oxycodone 5 milligrams every 4 hours was also noted. (continued on next page)

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.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the facility 5-day investigation revealed that resident #1 had been sent to the hospital post Hoyer lift fall and returned the same day. It was noted that the resident did not require surgery for the incurred compression fracture of lumbar vertebrae 1 and 3 or the right ankle fracture. The report further revealed that staff #12 CNA (certified nursing assistant) was terminated post incident. The report indicated that the facility reviewed the fall in their quality assurance and performance improvement meeting and that precautionary measures, to include review of documentation for orders and care plans linked to point of care the CNA's to facilitate appropriate transfers were present. It was noted that an in-service was initiated for Hoyer transfer training on November 18, 2024 with an noted completion date of one week, excluding staff that are on vacation. Furthermore, the report indicated that weekly audits would be started and would continue for four months to ensure that staff are following facility protocol regarding Hoyer lift transfers. A review of the in-service training logs revealed a training for Hoyer transfers ranging from November 18, 2024 through November 25, 2024. It was noted that staff #12 participated in previous Hoyer lift transfer training in 2023 and again in 2024. An interview was conducted on November 25, 2024 at 10:32 A.M. with a Certified Nursing Assistant (CNA/staff #34). Staff #34 stated that a Hoyer lift transfer always requires 2 staff members. She stated that as a CNA she has to make sure that the right size sling for the Hoyer lift to accommodate the resident is being utilized. She further stated that she would always advise the resident of what is about to happen and ensure their comfort. Staff #34 stated that there is never a good reason to conduct a Hoyer lift transfer with only one staff person. Staff #34 stated that the risk for not conducting a 2-person Hoyer lift would include not knowing if sling is properly positioned, if it looks right', that the resident could fall and would not feel safe with only one person assisting. An interview was conducted on November 25, 2024 at 10:40 A.M. with a CNA (CNA/staff #18(. Staff #18 stated that she usually works the unit where resident #1 resides. She stated that resident #1 requires a Hoyer lift transfer. She stated that a Hoyer lift transfer is always a 2-person assist, unless the person is on a ventilator, in which case the resident is a 3-person assist. Staff #18 stated that at no time can a resident who is a Hoyer lift be transferred by only one staff member. She stated that she was aware of a Hoyer lift fall that occurred the previous week involving resident #1. Staff #18 stated that she was there the day of the fall, but had not been assisting with the transfer. She stated that she was called, after the resident had fallen and was assessed to help put the resident back into bed. She stated that the resident had sustained ankle and back injuries, as well as scratches to the forehead and leg, but stated that she felt he was recovering well at this time. Staff #18 further stated that resident #1 had a tracheostomy in place but was not on a ventilator, therefore he would require a 2-person assist with the Hoyer lift transfer. She stated that the risk for the resident in not having 2-staff members facilitate the transfer would include not effectively being able to keep an eye on the resident and potential injury. Staff #18 stated that she had just received Hoyer lift training the previous week, but did not recall on which day. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on November 25, 2024 at 10:46 A.M. with resident #1. The resident stated that there was only one staff member assisting him with the Hoyer lift transfer when the fall occurred. He stated that he thought everything was secured on the Hoyer lift. Resident #1 further stated that during the transfer, while he was in the Hoyer lift, the batteries had given out and staff # had to retrieve new batteries. He stated that at the time he was on the Hoyer lift above the shower bed and thought it was about 2 minutes before staff # returned. He stated that when the staff # returned, he asked him if he was ready to proceed. He said once the transfer progressed, he was not sure how it happened but did a backflip out of the Hoyer lift and landed on his face. He stated that he thought his legs hit the side of the Hoyer lift. Resident # stated that his right foot had a fractured ankle and is currently in a sling and that his back is fractured. Resident #1 stated that he does have pain but usually more in the ankle. An interview was conducted on November 25, 2024 at 10:54 A.M. with a Licensed Practical Nurse (LPN/staff #159). Staff #159 stated that a Hoyer lift transfer always requires 2-staff members to assist. She stated that generally one staff member would utilize the remote, while the other would check for proper connection of the sling. She further stated that the benefit of using 2 staff members includes the ability to have extra eyes on the resident while rolling them and properly positioning them. She stated that ultimately it is an issues of safety for the resident. Staff #159 stated that she had received Hoyer transfer training last week but could not recall any prior Hoyer lift trainings. She stated that the risk with a 1-person Hoyer lift transfer is that the staff member may miss a critical element to ensure resident safety. A telephone call was placed on November 25, 2024 at 11:22 A.M. to a Registered Nurse (RN/staff #42). The call went to voicemail and a message was left. Staff #42 was noted to be present on the day of the incident. No return call was received. An interview was conducted on November 25, 2024 at 11:39 with an LPN (LPN/taff #127). Staff #127 stated that Hoyer lift transfer is always a 2-person transfer. She stated that if another CNA is not available a nurse would assist to ensure that there are always 2 people present. She stated that she thought there were quarterly trainings on Hoyer lift transfers. Staff #127 stated that the benefit of requiring the 2-person Hoyer lift transfer is that one person watches the resident while the other is maneuvering the resident into the proper position. She stated that the risk of only one person transferring the resident could include falls. She stated that she had never seen anyone on her hall conducting a one-person Hoyer lift. A telephone call was placed on November 25, 2024 at 11:51 A.M. to a CNA (CNA/staff #12). The call went to voicemail and a message was left requesting a call-back. An interview was conducted on November 25, 2024 at 12:05 P.M. with the Director of Nursing (DON/staff #180) and The Administrator (admin/staff #96). Staff #180 stated that all Hoyer lift transfers require a 2-person assist. Staff #180 stated that staff receive Hoyer lift training upon hire and annually thereafter. She stated that the risk for not conducting a Hoyer lift transfer, as required by facility policy, could result in injury to the resident. She stated that staff #12 was immediately terminated and that all other staff received Hoyer lift training. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A return telephone call from a CNA (CNA/staff #12) was received on November 26, 2024 at 9:37 A.M. Staff #12 stated that he recalled the fall involving resident #1. He stated that the resident was Hoyer lift transfer requiring a 2-person assist. Staff #12 stated that he was by himself when he was attempting to get the resident ready for a shower. He stated that he did not ask for assistance from other staff as he thought he could conduct the transfer by himself. He said at one point, the battery on the Hoyer lift had given out and he had to obtain a new battery. Staff #12 stated that at the time he went to replace the battery, the resident was on the shower gurney and not on the Hoyer lift. He stated that once the battery was replaced, he proceeded to transfer the resident with the Hoyer lift. He then stated that 'it all happened so fast, he flipped out of the Hoyer lift and landed on his face' at which time he immediately called for help. Staff #12 stated that he had participated in Hoyer lift training in the past year and was aware that a Hoyer lift transfer required 2-staff members to participate in the transfer. Staff #12 stated that the risk for not having 2-staff present to facilitate the transfer could result in residents, like resident #1, getting hurt. A review of the facility policy entitled Lifting Machine with a copyright date of 2001 revealed that at least 2 nursing assistants are needed to safely move a resident with a mechanical lift. Review of facility guidance entitled Hoyer Lift Transfers revealed that the transfer is with 2-staff members from start to finish and that staff should 'NEVER' transfer with a Hoyer lift by themselves.