

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115412	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/02/2024
NAME OF PROVIDER OR SUPPLIER  Harborview Tifton		STREET ADDRESS, CITY, STATE, ZIP CODE  1451 Newton Drive Tifton, GA 31794	

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)
<p>F 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 15650</p> <p>Based on record review and staff interviews, the facility failed to develop care plan interventions to address the transfer needs of one resident (R) (R1) who required the use of a mechanical swing lift during transfers from a sample of 11 residents. This failure resulted in actual harm on 6/13/2024 when R1 slid down in the sling of a stand lift causing a chest wall hematoma with subsequent anemia requiring a blood transfusion.</p> <p>Findings include:</p> <p>R1 was admitted to the facility on [DATE] with the following but not limited to diagnoses: intracranial injury, schizophrenia bipolar type, mood disorder, anxiety disorder, and morbid obesity.</p> <p>A review of the resident's annual Minimum Data Set (MDS) with an assessment reference date of 3/25/2024 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 7 which indicated the resident was severely cognitively impaired, had fluctuating inattention, had impairments on both sides of the lower extremities, and was dependent on staff for chair/bed-to-chair transfer.</p> <p>Review of the care plan dated 3/1/2023 indicated the resident needed extensive to total assistance but the care plan did not specify that the resident required a mechanical swing lift for transfers.</p> <p>(continued on next page)</p>

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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<p>F 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's investigation completed on 6/21/2024 revealed that on 6/16/2024 the Administrator was notified that the resident had bruising to the right breast with edema and bruising to the abdomen related to the stand lift sling pinching her during a transfer earlier that day. During a follow up body audit on 6/17/2024, the Director of Nursing (DON) notified the Administrator of worsening bruising and edema to the right breast, abdomen and chest wall. According to the 6/17/2024 Situation, Background, Assessment, Recommendation (SBAR) form, the resident was assessed by the Nurse Practitioner and gave an order to send the resident to the hospital for uncontrolled pain and bruising to the right side of the chest and abdomen. On 6/18/2024 the DON interviewed three certified nursing assistants (CNA) (CNA AA, CNA BB, and CNA CC) who were involved with the stand lift transfer. It was determined that during a transfer on 6/13/2024, as the CNA's began to lift the resident the sling belt slipped due to the resident being unable to bear any weight. According to the facility investigation, because the resident is obese with a weight of 342 pounds, the slip in the sling caused it to apply pressure to her right breast, chest wall, right shoulder, and right arm causing the bruising. The investigation revealed three CNA's had received stand lift training competencies prior to incident but failed to act appropriately when the resident slipped in the sling by continuing to transfer the resident. All three CNA's were terminated on 6/17/2024.</p> <p>During an interview with the DON on 6/26/2024 at 1:45 pm, she stated that through their investigation, it was determined that the incident happened on 6/13/2024 on the evening shift when three CNA's used the stand lift instead of the mechanical swing lift to transfer the resident. She stated the staff should have used the mechanical swing lift since the resident was not able to bear 50% of her weight while standing. She confirmed the care plan that was in place at the time of the incident did not specify that the resident required a mechanical swing lift for transfers.</p> <p>Review of the PIP form indicated a start date of 6/21/2024 for safe transfer technique using the mechanical swing lift and stand lift and revealed the following actions:</p> <ol style="list-style-type: none"> <li>1. Re-education of CNA's regarding proper use of the stand/hoyer lift following the current plan of care which included education for the correct use of the mechanical swing lift and stand lift and what to do if the resident begins falling or slipping provided by the DON and the Director of Therapy starting on 6/18/2024 and is ongoing. The re-education included return demonstration.</li> <li>2. All residents were assessed by therapy on 6/18/2024 for correct transfer types which included lift status with care plan revisions made as indicated.</li> <li>3. Review of Active/Historical Risk Reports showing no injuries caused by the mechanical swing lift or stand lift.</li> <li>4. The DON or Unit Manager to conduct twice per week transfer competencies for four weeks, then monthly for three months.</li> <li>5. Quality Assurance and Performance Improvement (QAPI) meeting held on 6/25/2024 regarding risk review lift competencies. The DON to report to QAPI monthly effectiveness of plan and any revisions with the plan to achieve outcome of safe transfers.</li> </ol> <p>A review of the education provided to nurses and CNA's revealed 38 of 43 nursing staff had received re-education regarding the proper use of the stand lift and mechanical swing lift following the current care plan.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the therapy re-evaluation of transfer/lift status, random review of care plans for transfers, and observation of resident transfers revealed the facility's plan of correction was implemented with no additional deficient practice identified.</p> <p>Cross refer F689</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 15650</p> <p>Based on record review, staff interviews, and review of policy titled Lifting Machine, Using a Mechanical and Accidents and Incidents-Investigating and Reporting, the facility failed to transfer a resident with the correct transfer lift for one of 11 sampled residents (R) (R1). This failure resulted in actual harm on 6/13/2024 when R1 slid down in the sling of a stand lift causing a chest wall hematoma with subsequent anemia requiring a blood transfusion.</p> <p>Findings include:</p> <p>Review of the facility policy titled Lifting Machine, Using a Mechanical with a revision date of July 2017 noted the purpose of the procedure is to establish the general principles of safe lifting using a mechanical lifting device. It is not a substitute for manufacturer's training or instructions. The policy noted the following Steps in the Procedure: 1. Before using a lifting device, assess the resident's current condition, including: a. Physical: (1) Can the resident assist with transfer? (2) Is the resident's weight and medical condition appropriate for the use of a lift? b. Cognitive/Emotional: (1) Can the resident understand and follow instructions? (2) Does the resident express fear or appear anxious about the use of a lift? (3) Is the resident agitated, resistant, or combative?</p> <p>Review of the facility policy titled Accidents and Incidents-Investigating and Reporting with a revision date of July 2017 had the following policy statement: All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator.</p> <p>R1 was admitted to the facility on [DATE] with the following but not limited to diagnoses: intracranial injury, schizophrenia bipolar type, mood disorder, anxiety disorder, and morbid obesity.</p> <p>A review of the resident's annual Minimum Data Set (MDS) with an assessment reference date of 3/25/2024 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 7 which indicated the resident was severely cognitively impaired, had fluctuating inattention, had impairments on both sides of the lower extremities, and was dependent on staff for chair/bed-to-chair transfer.</p> <p>Review of the manufacturer's instructions for the standing lift indicated the stand lift is a mobile raising aid intended to be used on a horizontal surface for raising to a standing position and short transfer of residents (e.g. raising from bed and transit to wheelchair, or from wheelchair to toilet) in hospitals, nursing homes or other health care facilities where the resident has been clinically assessed to correspond to the following categories; Category C</p> <ul style="list-style-type: none"> <li>- Sits in a wheelchair</li> <li>- Is able to partially bear weight on at least one leg</li> <li>- Has some trunk stability</li> <li>- Dependent on carer in most situations</li> </ul> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>- Physically demanding for carer</p> <p>- Stimulation of remaining abilities is important</p> <p>The safety instructions instructed that before attempting to use the stand lift, a full clinical assessment of the resident his/her condition, and suitability must be carried out by a qualified person.</p> <p>A review of the facility's investigation completed on 6/21/2024 revealed that on 6/16/2024 the Administrator was notified that the resident had bruising to the right breast with edema and bruising to the abdomen related to the stand lift sling pinching her during a transfer earlier that day. During a follow up body audit on 6/17/2024, the Director of Nursing (DON) notified the Administrator of worsening bruising and edema to the right breast, abdomen and chest wall. According to the 6/17/2024 Situation, Background, Assessment, Recommendation (SBAR) form, the resident was assessed by the Nurse Practitioner and given an order to send the resident to the hospital for uncontrolled pain and bruising to the right side of the chest and abdomen. On 6/18/2024 the DON interviewed three certified nursing assistants (CNA) (CNA AA, CNA BB and CNA CC) who were involved with the stand lift transfer. It was determined that during a transfer on 6/13/2024, as the CNA's began to lift the resident and the sling belt slipped due to the resident being unable to bear any weight. According to the facility investigation, because the resident is obese with a weight of 342 pounds, the slip in the sling caused it to apply pressure to her right breast, chest wall, right shoulder, and right arm causing the bruising. The investigation revealed three CNA's had received stand lift training competencies prior to incident but failed to act appropriately when the resident slipped in the sling by continuing to transfer the resident. All three CNA's were terminated on 6/17/2024.</p> <p>Review of documentation from local hospital indicated R1 admitted to the hospital on 6/17/2024 due to bruising and swelling of right arm, shoulder, and abdomen. R1 was noted to have chest wall hematoma with subsequent anemia requiring the resident to receive a blood transfusion.</p> <p>During an interview with the DON on 6/26/2024 at 1:45 pm, she stated that through their investigation, it was determined that the incident happened on 6/13/2024 on the evening shift when three CNA's used the stand lift to transfer the resident. She stated the staff should have used a mechanical swing lift since the resident was not able to bear 50% of her weight while standing. She stated she had the CNA's come to the facility to demonstrate what happened on 6/13/2024. CNA BB did not show up but CNA's AA and CC both returned to demonstrate how the resident was transferred. CNA AA explained that the resident slipped in the sling and was in a hang glider position with her arms raised. When CNA AA put the sling on the DON for demonstration, the sling was placed on the DON wrong causing the sling to be up over her chest and put her in the hang glider position with her arms raised. CNA CC stated the resident slipped while in the sling. She stated when CNA CC put the sling on she put the sling on upside down. Both CNA's stated they should not have proceeded with the transfer once the resident slipped but they went ahead and transferred the resident to the bed. They also could not explain to the DON why they used the stand lift to transfer the resident. The DON stated the staff know if a resident can't bear 50% of their weight then the stand lift should not be used. She confirmed the care plan that was in place at the time of the incident did not specify that the resident required a mechanical swing lift for transfers.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Administrator on 6/25/2024 at 3:15 pm, she stated the three CNA's never reported the incident that occurred on 6/13/2024. Once the bruising was identified on 6/16/2024 they immediately started an investigation and placed in a Project Improvement Plan (PIP).</p> <p>Review of the PIP form indicated a start date of 6/21/2024 for safe transfer technique using the mechanical swing lift and stand lift and revealed the following actions were initiated:</p> <ol style="list-style-type: none"> <li>1. Re-education of CNA's regarding proper use of the stand lift and mechanical swing lift following the current plan of care which included education on the correct use of the mechanical swing lift and stand lift and what to do if the resident begins falling or slipping provided by the DON and the Director of Therapy starting on 6/18/2024. The re-education included return demonstration.</li> <li>2. All residents were assessed by therapy on 6/18/2024 for correct transfer types which included lift status with care plan revisions made as indicated.</li> <li>3. Review of active/historical risk reports showing no injuries caused by mechanical swing or stand lift.</li> <li>4. The DON or Unit Manager to conduct twice per week transfer competencies for four weeks, then monthly for three months.</li> <li>5. Quality Assurance and Performance Improvement (QAPI) meeting held on 6/25/2024 regarding risk review lift competencies. The DON to report to QAPI monthly effectiveness of plan and any revisions with the plan to achieve outcome of safe transfers.</li> </ol> <p>A review of the education provided to nurses and CNA's revealed 38 of 43 nursing staff had received re-education regarding the proper use of the stand/Hoyer lift following the current care plan.</p> <p>A review of the therapy re-evaluation of transfer/lift status, random review of care plans for transfers, and observation of resident transfers revealed the facility's plan of correction was implemented with no additional deficient practice identified.</p>		