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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425314	A. Building B. Wing	12/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Piedmont Post-Acute	109 Bentz Road Piedmont, SC 29673

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. 38293 Based on interview, record review, and facility document and policy review, the facility failed to ensure two staff members assisted with a mechanical lift transfer for 1 Resident (R)1 of 4 residents reviewed for mechanical lift transfers. The failure resulted in R1 sustaining a laceration to the top right side of their head, which required three staples to repair. Findings included: A facility policy titled, Lifting Machine, Using a Mechanical, revised 07/2017, revealed, 1. At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift. 2. Mechanical lifts may be used for tasks that require: a. Lifting a resident from the floor; b. Transferring a resident from bed to chair; c. Lateral transfers; d. Lifting limbs; e. Toileting or bathing; or f. Repositioning. 3. Types of lifts that may be available in the facility are: a. Floor based full body sling lifts; b. Overhead full body sling lifts; and c. Sit-to-stand lifts. 4. Lift design and operation vary across manufactures. Staff must be trained and demonstrate competency using the specific machines or devices utilized in the facility. The policy revealed, 18. Once the resident's weight is released, stop the lowering and ensure that the sling bar does not hit the resident. An Admission Record revealed the facility admitted R1 on 04/07/2016. According to the Admission Record, the resident had a medical history that included diagnoses of dementia, anxiety disorder, bipolar disorder, schizophrenia, morbid obesity, muscle weakness, and abnormalities of gait and mobility. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/02/2024, revealed R1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated that the resident was dependent on staff for chair-to-bed transfers. R1's care plan included a focus area initiated on 04/07/2016 that indicated the resident required assistance with activities of daily living (ADLs) and mobility. Interventions directed staff to use a mechanical lift with two staff members (revised 12/29/2023). (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 Five-Day Follow-Up Report, dated 09/12/2024, revealed that, on 09/07/2024 at 7:40 AM, R1 was transferred by staff from bed to a wheelchair via mechanical lift. The report revealed the resident was transferred to the wheelchair without difficulty. Per the report, upon unclipping the sling from the mechanical lift, the metal arm (sling bar) on the lift swung and made contact with the top of the resident's head. The report revealed the resident had a 3 centimeters (cm) long laceration to the top right side of their head. The report revealed the resident was sent to the emergency department for treatment and returned with three staples to repair the laceration. The report revealed R1's representative and physician were notified. R1's Progress Notes, dated 09/07/2024 at 8:40 AM, revealed R1 had an open head injury related to making contact with a mechanical lift. The notes revealed the provider was notified, and orders were received to send the resident to the emergency room . The notes revealed emergency medical services transported the resident to the hospital. R1's ED [Emergency Department] Provider Notes, dated 09/07/2024, revealed that the resident had a 3 cm right-sided scalp laceration. The hospital After Visit Summary, dated 09/07/2024, revealed the resident received staples to close the laceration. During an interview on 12/13/2024 at 4:05 PM, Certified Nursing Assistant (CNA)1 stated that she worked at the facility through a staffing agency. She stated that, on 09/07/2024, she started her rounds at 4:00 AM, and a nurse told her to not get R1 up because they were a fall risk and to get them up last, noting that she was unaware of the nurse's name. She stated that she finished her charting around 7:20 AM. CNA1 stated she was running behind and that her shift was supposed to end at 7:00 AM, but she still had to get R1 up for the day. She stated she went into the resident's room and did not see a sling for the mechanical lift, and the nurse stated that she would get her one. CNA1 stated that she got the resident dressed, and the nurse left a sling outside the door. She stated that the nurse did not come in and ask if she needed help, noting she just left the sling outside the door. She stated that the nurse that left the sling outside the door worked with her on the night shift, and by the time she was ready to transfer the resident, the night shift staff had left for the day. She stated that she grabbed the mechanical lift next to the resident's room. She stated that she, while working alone, transferred the resident to a wheelchair with the mechanical lift. CNA1 stated the resident was seated in the wheelchair when she removed the hooks from the sling, and the arm of the lift (sling bar) swung and hit the resident in the head. She stated the resident was bleeding, and she ran out of the room to get help. She stated there was a CNA that asked if she needed help, but she told that CNA she needed a nurse, noting that she was unaware of the CNA's name. She stated that a nurse came and provided aid to the resident, noting that she was unaware of the nurse's name. CNA1 stated the day shift staff had started their shift and were there before she transferred the resident. She stated she knew she needed two staff members to operate the mechanical lift when transferring a resident, but she did not ask the day shift staff for help. She stated she had not worked at the facility since the incident on 09/07/2024. CNA1 stated that after the incident the staffing agency provided her with training on the proper use of the mechanical lift and having two staff members present when operating the lift for resident transfers. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/13/2024 at 4:54 PM, Licensed Practical Nurse (LPN)2 stated that, On 09/07/2024, he worked the day shift and had just finished receiving report from the night shift nurse when a night shift CNA came and got him, stating that the mechanical lift had hit R1 in the head, and they were bleeding, noting that he was unaware of the night shift CNA's name. He stated that he could not remember all the details of the care that he provided to the resident, but noted he remembered putting something on the resident's head to control the bleeding and then notifying his supervisor. He stated he was unaware that the CNA was in the room with the resident, transferring the resident alone with a mechanical lift. He stated that the CNA never asked for his help with the transfer. LPN2 stated that the night shift nurse did not inform him during report that the CNA was still getting the resident up and that she was still there during the day shift. He stated that two staff members must be present when operating a lift for resident transfers. During an interview on 12/14/2024 at 10:41 AM, CNA3 stated that, on 09/07/2024, she worked the day shift, and at the beginning of her shift she was at the nurses' station when a night shift CNA came out of R1's room, noting that she was unaware of the night shift CNAs name. She stated that she asked the CNA if she needed help, and the CNA told her that she did not need her help but needed a nurse. CNA3 stated that she got the nurse, and they went to the resident's room. She stated that was when she found out that the CNA had transferred the resident alone with the mechanical lift, and the arm of the lift (sling bar) had swung and hit the resident on the head. CNA3 stated that the resident was bleeding and had to be sent to the hospital. She stated that she did not know that the night shift CNA was still working during the day shift and was in the room with the resident, transferring the resident alone. CNA3 stated she never saw the CNA get the mechanical lift and thought the CNA had left for the day. She stated that the CNA never asked for help. She stated two staff members were required to use the mechanical lift to transfer a resident. She stated that she would have helped the CNA if she had asked for help. During an interview on 12/14/2024 at 10:25 AM, the Director of Nursing (DON) stated that after she and the Administrator completed an investigation into the incident that occurred on 09/07/2024 where R1 was transferred with a mechanical lift and was injured, it was determined that CNA1 transferred the resident alone. The DON stated that no other staff members were in the room with CNA1 during the transfer. She stated that when the sling to the mechanical lift was removed from the hook, since no other staff member was holding the arm (sling bar), the arm swung and hit R1 on the head. She stated that the resident had a laceration to the top of their head. She stated two staff members were required to operate the mechanical lift when transferring a resident. The DON stated it was important to have two staff members present when operating the mechanical lift to ensure the resident was safe. She stated that if two staff members had been present during the transfer, one staff member could have held the arm to the lift so that it did not move, and it might not have hit R1 in the head. She stated that she could not say for sure that the arm of the lift would not have hit the resident, but she did not think it would have with two staff members present. The DON stated that the facility was not short-staffed the day of the incident, and the day shift staff were available to assist CNA1 if she had asked for help. She stated that R1 was sent to the hospital and received three staples to repair the laceration to the top of their head. The DON stated she expected two staff members to be present when using the mechanical lift to transfer a resident. During an interview on 12/14/2024 at 11:36 AM, the Administrator stated that after he completed an investigation, he determined that CNA1 transferred R1 with a mechanical lift without another staff member assisting, which was against facility policy. He stated he expected at least two staff members to be present when operating the mechanical lift to transfer a resident.