

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425325	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER The Preston Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 87 Bird Song Way Hilton Head Island, SC 29926	

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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36917</p> <p>Based on record review, review of the facility investigation, interview, and facility policy review, the facility failed to ensure one (Resident (R)9) out of six residents reviewed for mechanical lift transfers out of a sample of 20 residents was safe when being transferred from a mechanical lift. This resulted in harm when R9 sustained a fractured clavicle when being transferred with a mechanical lift. This deficiency was cited as past non-compliance (PNC).</p> <p>Findings include:</p> <p>Review of the facility policy, revised July 2017, for utilizing the mechanical lifting machines stated at least two nursing assistants were needed to safely move a resident with a mechanical lift. Each resident is assessed the proper sling size according to manufacturer's instructions.</p> <p>Review of the Electronic Medical Record (EMR), Profile tab, revealed R9 was admitted to the facility on [DATE] with diagnoses to include Alzheimer's disease, dementia, and generalized anxiety disorder.</p> <p>A review of R9's EMR, revealed a quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 04/17/24, indicated R9 required maximum assistance for all activities of daily living (ADL's) and utilized the sit to stand mechanical lift for mobility transfers.</p> <p>Review of the Facility Reported Incident (FRI) investigated and reported by Director of Nursing (DON), submitted to the State Agency (SA), revealed on 07/01/24 Certified Nursing Assistant (CNA)1 attempted to transfer for R9 by herself from the bed to the chair, with a stand-up lift using the wrong sling. R9 fell from the sling with her arm hanging in the sling that resulted in a fracture of her clavicle. The incident report indicated the physician and R9's family were notified of the accident, along with her Hospice Agency.</p> <p>During an interview with the DON on 08/29/24 at 3:53 PM, confirmed CNA1 did not get assistance from another staff member and used the wrong sling when transferring R9 with the stand up lift resulting in the resident sustaining a fracture of the clavicle.</p> <p>Following the investigation on 08/29/24, the facility's corrective actions included:</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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>There were multiple implementations and interventions had been documented including training and policy/procedure acknowledgement for mechanical lift usage, old slings were discarded, and new ones were purchased, new assessments were conducted of each resident requiring a mechanical lift for transfers. Random checks of caregiving staff for competency and proper utilization of the mechanical lift have and are being completed.</p> <p>Review of CNA1's personnel file indicated she was immediately terminated on the date of the reported accident, (06/30/24), for poor performance to follow facility policy and procedure for the mechanical lift. Her file also documented she was previously trained and acknowledged the policies in place to prevent mechanical lift accidents. She has not been allowed to return to facility employment.</p> <p>Review of facility staff training logs dated 07/03/24, for utilizing a mechanical lift revealed all facility caregivers received re-training and acknowledgement of properly utilizing the lift.</p> <p>Observations during survey on 08/28/24 at 9:36 AM and 1:46 PM revealed CNA2 and Licensed Practical Nurse (LPN)1 demonstrated competency using the mechanical lift device.</p> <p>Review of the facility's corrective actions and interviews completed with staff regarding their education revealed that the facility was in compliance with F689 on 08/29/24.</p>		