

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

PRINTED: 11/02/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/20/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>WILORA LAKE HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>6001 WILORA LAKE ROAD</b> <b>CHARLOTTE, NC 28212</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to utilize the correct total lift sling size per manufacture's recommendations for safe transfer resulting in a fall for 1 of 1 resident reviewed for accidents (Resident #1). The findings included: Review of manufactur's Tollos single pateint use disposable sling recommendations attached to lift pad used to transfer Resident #1 on 10/09/15 stated that it was an extra extra large in size. Information located under a warning label stated in part: "IMPROPER sling size, improper sling attachment or improper sling and lift inspection can cause death or serious injury. Read instructions and warnings in manual." Review of medical record revealed that Resident #1 was admitted to facility on 09/23/15 from an acute care hospital with diagnoses which included lymphedema and surgical aftercare of skin and subcutaneous tissue of right posterior thigh. Review of Resident #1's care plan dated 9/23/15 indicated that Resident #1 required a total lift with 2 person assist. Review of the facility's transfer/mobility status criteria dated 9/30/15 revealed that Resident #1</p>	F 323			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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 323	<p>Continued From page 1</p> <p>required the use of a total body lift with an extra large sling.</p> <p>Review of the admission Minimum Data Set (MDS) dated 09/30/15 revealed Resident #1 was cognitively intact and required extensive assist of 2 people with transfers and walking did not occur. Further review of the admission MDS noted Resident #1 had limited range of motion to bilateral upper extremities and limited range of motion to one lower extremity.</p> <p>Review of a resident care guide utilized by the nursing staff revealed Resident #1 was a total lift and required an extra large sling size.</p> <p>Review of incident/accident report dated 10/09/15 revealed that during a transfer from electric wheel chair to the bed one of the lift pad straps slipped and the resident was lowered to the floor.</p> <p>Resident #1 complained of pain in bilateral lower extremities. The report indicated steps taken to prevent reoccurrence would be for residents to be assessed for appropriate sling size to accompany lift.</p> <p>Review of physician order dated 10/9/15 at 1:05 PM stated to transfer Resident #1 to the emergency room for evaluation.</p> <p>Review of nurses notes dated 10/09/15 at 9:00 PM the resident was returned to the facility from emergency room with no noted injures and no new orders.</p> <p>Observation of total lift sling that was used to transfer Resident #1 on 10/09/15 from electric wheel chair to bed revealed that it was a extra extra large total lift sling.</p> <p>An interview with nurse aide (NA) #1 on 10/20/15 at 2:11 PM confirmed she transferred Resident #1 on 10/09/15 and was assisted by Nurse #1. She stated that Resident #1 had requested to go to bed after lunch, so she went and got the lift and the lift pad was already under Resident #1 so</p>	F 323			

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F 323	<p>Continued From page 2</p> <p>she hooked up on the straps on one side and Nurse #1 hooked up the straps on the other side. NA #1 stated she started to lift Resident #1 and as the resident was being lifted to approximate chair height she heard a pop sound and the residents right leg came out of the sling. She immediately lowered the lift and Resident #1 to the seat of her electric wheel chair and then Resident #1 slipped from the seat of her electric wheel chair to the base of the electric wheel chair. NA#1 stated she left Nurse #1 in the room with Resident #1 and went to get further assistance.</p> <p>An interveiw with NA #2 on 10/20/15 at 2:44 PM confirmed that she had gotten Resident #1 up that morning with a lift pad that was in Resident #1's room. NA #2 stated that Resident #1 told her that the lift pad was in the closet and which mechanical lift to use. NA#2 stated that she had not consulted Resident #1's care guide that morning, because Resident #1 was alert and oriented and was able to tell her what to use. NA #2 stated she was aware of the facility's practice to consult the care guide for proper sling size for safe transfers. She could not recall the size of the lift pad that she used to get Resident #1 up on 10/09/15.</p> <p>Review of email communciation from Nurse #1 to the facility revealed Nurse #1 assisted with the transfer of Resident #1 on 10/09/15 and that Nurse #1 had attatched 2 of the straps on the lift sling to the mechanical lift. This communication also revealed that she had never been trained to use a mechanical lift in the facility.</p> <p>An interveiw with Director Of Nursing (DON) on 10/20/15 at 3:45 PM revealed that she expected the NA's and Nurse's to look at the care guide and use the care guide for proper lift size for safe transfer. She confirmed that the lift that was used on 10/09/15 to lift Resident #1 was no longer in</p>	F 323			

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F 323	Continued From page 3 use. She also confirmed that Nurse #1 was an agency nurse and they are no longer using agency staff in the facility. An interview with the corporate Nurse Consultant on 10/20/2015 at 3:45 PM revealed Nurse #1 was an agency nurse and that they had an expectation that the agency staff would have a basic knowledge of proper mechanical lift use with the correct sling size and that the facility provided education on procedures but did not include education on proper use of mechanical lift.	F 323		