STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 10/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. 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	F 323	Resident #1 suffered no harm. Resident #1 no longer resides in the facility. Residents who require the use of a mechanical lift for transfer have the potential to be affected. On 10.9.15, after the incident, the Executive Director immediately removed the lift used during the incident from circulation. All other mechanical lifts were also inspected by the facility Maintenance Director on 10.9.15. All other lifts were found be operating properly. On 10.15.15, the mechanical lift used during the incident was inspected by a Joernes (mechanical lift manufacturer)representative. The mechanical lift was found to be in good working condition. The facility's Executive Director, Director of Clinical Services, and Consulate Corporate Nurses, inspected all mechanical lift slings found in the facility. One worn mechanical lift sling and 4 incompatible mechanical lift slings were discarded. Current residents were reviewed to ensure transfer assessments	11/10/15

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

Electronically Signed | 11/12/2015

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	Continued From page 1 required the use of a total body lift with an extra large sling. 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 extremeties and limited range of motion to one lower extremity. 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. 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. Resident #1 complained of pain in bilateral lower extremeities. The report indicated steps taken to prevent reoccurence would be for residents to be assessed for appropriate sling size to accompany lift. Review of physician order dated 10/9/15 at 1:05 PM stated to transfer Resident #1 to the emergency room for evaluation. 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 injuires and no new orders. 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. 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	F 323	were in place. Resident transfer assessments include appropriate transfer methods as well as residents appropriate mechanical lift sling size. This review was conducted 10.10.15, and again on 11.9.15. In addition to resident transfer assessment reviews, residents care plans were reviewed and updated as needed, to include their transfer methods. Residents' kardexes were also reviewed and updated as needed to include their transfer methods and appropriate mechanical lift sling size for residents requiring a mechanical lift transfer (10.10.15 and 11.9.15). The facility's Director of Clinical Services and Executive Director re-educated nursing staff on duty at the time of the incident (10.9.15) on the proper use of the facility's mechanical lifts, and checking the resident's kardex for appropriate mechanical lift sling size and transfer status. Nursing staff not present on 10.9.15 were reeducated on each shift through 10.10.15 by the Director of Clinical Services and/or facility Nurse Managers prior to use of any facility mechanical lifts. Nursing staff not trained, were not allowed to utilize facility mechanical lifts for residents' transfers until reeducation and training was complete. The facility contracted the services of an outside qualified agency to provide a directed educational in-service. A Registered Nurse from Pathway Health Services reeducated staff working at the facility on supervision and prevention of accidents on 11/9 and 11/10/15. Staff	

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F 323	Continued From page 2 she hooked up on the straps on one side and Nurse #1 hooked up the straps on the other side. NA #1stated 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. 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. 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. 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	F 323	unable to attend will receive the training prior to their next scheduled shift by viewing the recorded training and passing a written post test. The Executive Director held an emergency Quality Assurance Performance Improvement Committee Meeting on 10.13.15. Purpose of this meeting was to review and further discuss this incident and the action plan, steps and interventions implemented to help reassure this incident did nor reoccur. The Director of Clinical Services began conducting Quality Improvement Monitoring on date 10.15.15 to ensure staff knowledge and ability to return demonstrate appropriate use of facility mechanical lifts. Staff interviews were also conducted to ensure staff knew to review resident kardexes for transfer methods and proper mechanical lift sling size. Quality Improvement monitoring is conducted randomly on all shifts three times per week for 8 weeks, then 2 times per week for 8 weeks and then one time per week for 8 weeks, utilizing a sample size of 4 staff members. The results of the Quality Improvement Monitoring are documented on a Quality Assurance Performance Improvement Monitor Form. The Director Clinical Services will report the findings monthly to the Facility Quality Assurance Performance Improvement Committee.	

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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 interveiw with the corporate Nurse Consulant 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		