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

PRINTED: 11/14/2011
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
	345103	A. BUILDING _____ B. WING _____	C 11/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE	600 FULLWOOD LANE MATTHEWS, NC 28105

(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 000	INITIAL COMMENTS The original complaint survey was conducted on 10/25/11. Based on management review, the survey team reentered the facility on 11/8/11 and the survey exit date was extended.	F 000	CARRINGTON PLACE'S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW.	
F 323 SS=G	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 staff interviews and medical record review, the facility failed to use the total lift for one (1) of three (3) sampled residents.(Resident #1) The findings are: Resident # 1 was admitted to the facility on 10/31/08 with diagnoses of Alzheimer's Dementia and history of stroke. A fall risk assessment dated 06/15/11 stated Resident #1's gait as non ambulatory and required assistance with transfer. The Care Area Assessment dated 06/29/11 stated Resident # 1 was totally dependent on staff for assistance with ADLs (activities of daily living). Resident # 1 was non ambulatory and required two staff person assistance with transfer and use	F 323	• F-323: CORRECTIVE ACTION(S) THAT WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The two CNA's involved in the transfer and injury were disciplined following investigation into the injury. CNA #1 was suspended on 10/18/2011 and CNA #2 was suspended on 10/12/2011. All CNA's have been re-inserviced on the importance of using the proper lift and how to properly use the different lifts by the facility Staff Development Coordinator. All facility staff have been in-serviced on the importance of following established policies and procedures. The Nurse Managers and Staff Development Coordinator are making random QA checks on the units to ensure that staff are using the proper lifts in the proper manner. HOW OTHER RESIDENTS HAVE BEEN IDENTIFIED FOR HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND THE CORRECTIVE ACTION(S) THAT HAVE BEEN OR WILL BE TAKEN: Any resident may have the potential	12/06/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cathy L. Almon — TITLE: Administrator — (X6) DATE: 11/18/2011

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 of total lift. The Quarterly MDS (minimum data set) dated 09/10/11 assessed Resident # 1 as having problems with short and long term memory and having impaired cognitive skills for daily decision-making skills. Resident #1 was totally dependent on staff for ADLs and dependent on staff for transfers. The Care Plan dated 09/10/11 assessed Resident #1 as totally dependent on staff for assistance with all ADLs and used a total lift for transfers. The care plan approaches included two staff person to assist with transferring of the resident. A Resident Transfer form dated 10/05/11 stated Resident # 1 was transferred from bed via standing mechanical lift to a shower chair for a shower. Resident # 1's right third toe tip was off with approximately a two centimeter laceration. Resident # 1's right fourth toe had approximately a one centimeter laceration with moderate bloody drainage. Resident # 1 was unable to state origin of laceration to her right toes. A nurses note dated 10/05/11 stated Resident # 1 was on the shower chair in the shower room and was observed bleeding from a deep laceration to her third and fourth toe. Resident # 1 showed no signs or symptoms of pain or discomfort. The nurse's note documented the nurse practitioner (NP) was notified and the NP ordered for Resident #1 to be sent to the hospital for evaluation. Resident # 1 return to the facility on 10/05/11 on the 11:00 PM to 7:00 AM shift	F 323	to be effected by this practice. The two CNA's involved in the transfer and injury were disciplined following investigation into the injury. CNA #1 was suspended on 10/18/2011 and CNA #2 was suspended on 10/12/2011. All CNA's have been re-inserviced on the importance of using the proper lift and how to properly use the different lifts by the facility Staff Development Coordinator. All facility staff have been in-serviced on the importance of following established policies and procedures. The Nurse Managers and Staff Development Coordinator are making random QA checks on the units to ensure that staff are using the proper lifts in the proper manner. **MEASURES AND/OR SYSTEMIC CHANGES MADE OR TO BE MADE TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR:** All CNA's have been re-inserviced on the proper way to use the lifts and on the importance of using the proper lift. All staff have been re-inserviced on the importance of following established policy and procedures. The Staff Development Coordinator has conducted competency checks on all CNA's and their use of lifts. Additionally, all new hire CNA's will have to demonstrate competency in using lifts properly and following policy/procedure correctly before	

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F 323	Continued From page 2 A hospital emergency room note document on 10/05/11 that an x-ray was performed and documented possible soft tissue injury of the distal third toe with the skin sheared off. The hospital emergency department licensed nursed documented on 10/05/11 at 6:46 PM that Resident # 1's right second toe tip amputated, deep laceration to third toe noted and bleeding controlled. A hospital emergency department licensed nurse documented on 10/05/11 at 8:46 PM that an orthopedic doctor at bedside to suture toe, placed dressing and post operation shoe on Resident # 1. During an interview with the Director of Nursing on 10/25/11 at 12:00PM, she revealed the unit managers, licensed nurses and therapy assess residents for the need of lifts. She revealed the unit managers complete and update the CNA assignment sheets. She revealed the NAs follow the CNA assignment sheet to know the type of equipment to use on a resident. She revealed unit managers and licensed nurses observed the NAs throughout the day. She further revealed both NAs were disciplined and staff was inserviced on lifts. During a telephone interview with NA # 1 on 10/25/11 at 2:16 PM, she revealed NA # 2 asked her to assistance her in transferring Resident # 1 onto a shower chair. NA # 1 revealed they transferred Resident #1 with the standing lift into the shower chair. NA #1 revealed Resident #1 did not hit her foot against lift or shower chair during the transfer and does not know how Resident # 1 injured her toes. NA #1 revealed she was not aware of the type of lift Resident #1 required because Resident # 1 was not assigned to her.	F 323	finishing orientation. The Nurse Managers and Staff Development Coordinator are making random QA checks weekly on the units to ensure that staff are using the proper lifts in the proper manner. HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THAT ITS SOLUTIONS ARE ACHIEVED AND SUSTAINED AND HOW THE PLAN WILL BE EVALUATED FOR IT'S EFFECTIVENESS: The Nurse Managers and Staff Development Coordinator are making random QA checks weekly on the units to ensure that staff are using the proper lifts in the proper manner. The results of these QA checks will be reviewed at the Department Head Meetings and at the Quarterly QA Meetings for discussion and change in policy/procedure if necessary to ensure that the solution is achieved, sustained, and effective. The weekly QA checks will be done on an ongoing basis for a minimum of one year or until the QA Committee decides that the schedule should be changed.	

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F 323	Continued From page 3 NA # 1 revealed she used the CNA assignment sheet to know what equipment each resident required. During an interview with NA # 2 on 10/25/11 at 3:04 PM, revealed she had worked with Resident # 1 for two years. NA # 2 revealed NA # 1 assisted her with transferring Resident # 1 with a standing lift onto a shower chair. NA # 2 revealed she was aware that Resident # 1 required a total lift. NA # 2 stated she decided to use the standing lift because the standing lift pad had holes in it, which allowed her to clean Resident # 1 better during the shower. NA # 2 revealed Resident # 1 did not hit her foot on the lift or shower chair and does not know how Resident # 1's toes were injured. NA # 2 stated when Resident # 1's sock was removed in the shower room, she saw the blood on her toes and notified the licensed nurse. NA # 2 revealed she used the CNA assignment sheet to know what equipment each resident required. During an observation on 11/08/11 at 11:48 AM the Director of Nurses (DON) demonstrated the operation of the sit to stand lift that was used to transfer Resident #1 on 10/25/11. This demonstration revealed the lift had a black plastic footrest that supported a resident's feet while being transferred. She further demonstrated the black plastic footrest could be lifted up several inches in the front and there was a metal bar under the front of the footrest that supported it. During a follow up interview with the (DON) on 11/08/11 at 12:00 PM, she stated the black plastic footrest on the lift could have been lifted up in the front during the transfer and Resident #	F 323		

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F 323	Continued From page 4 1 got her right (R) foot caught up under it. She further explained Resident # 1's left (L) foot would have been on top of the footrest and her (R) foot would have been under the footrest between the edge of the plastic footrest and the metal bar underneath. She stated when Resident # 1 was lifted up her left foot would have pressed down on the footrest and the pressure could have injured her toes. During a follow up interview with NA # 2 on 11/08/11 at 12:44 PM, she revealed Resident # 1 did not have any open areas on her feet at the start of her shift. NA # 2 revealed that she used the standing lift instead of the total lift to transfer Resident # 1 from the bed to the chair shower. NA # 2 further revealed after the transfer, she noticed blood on the bottom of her pants but did not know the origin of the blood.. NA # 1 revealed she removed Resident # 1's sock in the shower room and notice her right toes were bleeding. During an interview with the NA # 3 on 11/08/11 at 2:43 PM, she revealed she cared for Resident # 1 on 10/05/11 but left her shift early before the resident was transferred with the lift. She revealed she dressed Resident #1 that morning and put socks on her and she did not have any injuries to her toes.	F 323		