| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345432 | A. BUILDING _____ B. WING _____ | C 10/11/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESTERN NORTH CAROLINA BAPTIST HOME | 213 RICHMOND HILL DRIVE ASHEVILLE, NC 28806 |

| (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 |
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| F 323 SS=D | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, resident and staff interviews, the facility failed to have 2 staff present when using a mechanical lift which resulted in a resident's head and knees being hit for 1 of 1 resident reviewed for accidents (Resident #17).<br><br>Findings included:<br><br>Resident #17 was readmitted on 5/18/16 with diagnoses that included peripheral neuropathy (nerve damage in the hands and feet), muscle weakness, right shoulder pain, and gout (pain and inflammation of the joints).<br><br>Review of the significant change Minimum Data Set (MDS) dated 8/2/16 coded Resident #17 as cognitively intact and required extensive to total assistance of 2 staff persons for bed mobility and transfers. The MDS indicated Resident #17 had 2 falls during the assessment period.<br><br>Review of Resident #17's care plans dated 8/10/16 revealed an active plan in place for Activities for Daily Living (ADL). The ADL care plan identified goals that addressed his need for | F 323 | A) The resident in question had their care plan updated to reflect the two person assist policy when using a mechanical lift. All residents could be affected and all residents care plans that use a mechanical lift were reviewed and updated to reflect any necessary updates. All nursing staff to include any "Agency staff" were/will be inserviced immediately/or prior to working with any residents needing a mechanical lift by the Director of Nursing as to the proper use of all of our mechanical lifts as well as the Baptist Home's policy of having two people assisting while using a mechanical lift.<br>B) All care plans have been updated to ensure the two person assist (per the Baptist Home policy) while using a mechanical lift were included. All nursing staff members have been inserviced as to those updates as well as the proper use of all the mechanical lifts available in the facility by the Director of Nursing.<br>C) All nursing staff were inserviced as to the updated to the residents care plans as well as the requirement that two staff members assist in transferring any resident at any time while using a mechanical lift. This will be done at the time of hire during orientation and biannually by the Director of Nursing to ensure compliance.<br><br>D) The Director of Nursing and the Care Plan Coordinator will inform the Quality Assurance Team (the Medical Director, Administrator, Director of Nursing, Care Plan Coordinator, Dietary Manager and the Activity Director) as to the nursing staffs compliance regarding using two staff members while transferring a resident using a mechanical lift monthly based on their observations and audit of daily care plan documentation for the next six months.<br><br>E) 3 November 2016 | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Christopher A. Elmer, NHA
TITLE: Administrator
(X6) DATE: 3 November 2016

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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extensive assistance with position changes, transfers and ambulation. Interventions included for staff to use a mechanical lift for all transfers, 2 staff persons and gait belt for all ambulation, and assist with turning and repositioning every 2 hours and as needed.

Review of the facility's resident care key (individualized guide that indicated the level of assistance needed) for Resident #17 indicated a mechanical lift was to be used for all transfers but did not specify the number of staff needed.

Review of the incident report dated 10/1/16 revealed Resident #17's head and knees were hit when the nurse aide (NA) transferred him using the mechanical lift. Staff actions at the time of the incident indicated Resident #17 was assessed with no injuries noted and the NA was educated on the facility's policy and procedure which required 2 staff assist with any transfer using a mechanical lift. Resident #17's description of the incident stated "she was in a hurry and I told her she needed someone else in here and she hit my head on the head board and my knees on the lift." The incident was investigated by the Director of Nursing (DON) who concluded Resident #17 had been improperly transferred by the agency NA.

During an interview and observation on 10/10/16 at 5:27 PM Resident #17 was sitting up in the recliner in his room waiting on staff to assist him back to bed. Resident #17 stated he was unable to get in or out of bed independently and was transferred by staff using a mechanical lift. Resident #17 confirmed he had an accident when only one NA had attempted to transfer him back to bed using a mechanical lift but could not

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remember the exact date. Two NAs arrived to assist Resident #17 back into bed but the transfer was unable to be observed due to Resident #17's request for privacy.

During an interview on 10/11/16 at 10:46 AM Nurse #1 stated it was the facility's policy that 2 staff persons were required when using lifts for all resident transfers.

On 10/11/16 at 11:25 AM the door to Resident #17's room was closed and the clanging of the mechanical lift could be heard through the door as staff assisted him back to bed after receiving a shower. At 11:41 AM NA #1 was observed leaving the room and pushing the mechanical lift to the shower room at the end of the hall. No other staff member was observed in the room.

During an interview on 10/11/16 at 11:41 AM NA #1 confirmed he had transferred Resident #17 back into bed using the mechanical lift without the assistance of another staff person. NA #1 stated the resident care key indicated the level of care each resident needed and when he had looked at Resident #17's it indicated 1 staff person assistance with transfers. NA #1 stated he received training on using lifts during orientation and from what he understood, the facility policy was 1 staff person.

During a follow-up interview on 10/11/16 at 11:52 AM Nurse #1 stated new employees were trained on the policy and procedure for using lifts during orientation. Nurse #1 confirmed that Resident #17 required the assistance of 2 staff persons when being transferred using the mechanical lift. Nurse #1 was unaware NA #1 had transferred Resident #17 without the assistance of another

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staff person and stated she would address the situation with NA #1.

During an interview on 10/11/16 at 5:39 PM the DON stated all new staff were trained during orientation on lift policy and procedure. The DON stated the number of staff assistance needed for transfers when using a lift was not specified on the care plan or resident care key because it was the facility's policy that all mechanical lifts required 2 staff assist. The DON was unaware NA #1 had transferred Resident #17 without the assistance of another staff person and stated she would reeducate NA #1 on lift policy and procedure.

During an interview on 10/11/16 at 8:25 PM the Administrator confirmed the facility's policy required 2 staff persons for use of mechanical lifts and staff were trained during orientation on the facility's policy. The Administrator stated it was his expectation that 2 staff persons would be present when using mechanical lifts for resident transfers.

During a follow-up interview on 10/11/16 at 8:28 PM the DON stated there was no current plan in place for the training of agency staff and trusted the facility staff to assist the agency staff with what they needed to know to care for the residents. The DON stated they were currently working on a plan to put into place for the training of agency staff.