3/6/13

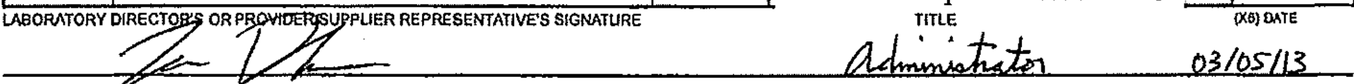
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345460	A. BUILDING ______ B. WING ______	C 02/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD HEALTH CARE CENTER	2041 WILLOW ROAD GREENSBORO, NC 27406

(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=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: 323 - G Based on Observation, resident interview, staff interview, record review, and hospital records the facility failed to use the mechanical lift during transfer which resulted in injury for 1 of 3 sampled residents (Resident #1) reviewed for accidents. Findings include: Resident #1 was originally admitted to the facility on 5/1/06 and readmitted on 08/27/12 with diagnoses that included, Cerebral Palsy, Quadriplegia, Obesity, Osteoarthritis of hips and knees, Lumbar Sacral Spondylosis. The MDS (Minimum Data Set) dated 8/27/12 revealed Resident #1 was totally dependent upon, and required the assistance of two staff members for transfers. The MDS further identified the resident as being cognitively intact. A review of Resident #1's Care Plan dated 8/28/12 revealed the resident had a Care Plan for Activities of daily Living (ADL). The Care Plan	F 323	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. **F323 How corrective action will be accomplished for each resident found to have been affected by the deficient practice –** Resident #1 was sent to the hospital for further evaluation and treatment due to a complaint of right knee pain (01/17/13). Resident #1 returned to facility in an immobilizer and a diagnosis of right fractured femur. Completion 03/01/2013	03/01/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 03/05/13



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 indicated the resident required assistance with ADL's with interventions that included the use of a mechanical lift for Resident #1's transfer needs. A review of the Physical Therapy Evaluation for Resident #1 dated 8/29/12 revealed Resident #1's functional status as dependent for bed mobility. The Physical Therapy Evaluation further indicated the resident was dependent with transfers with a Hoyer lift. A Progress Note dated 1/16/13 at 11:52pm was reviewed as written by Nurse #3. The Nurse ' s note stated that she was called to the resident ' s room by a Nurse Aid (NA). The note included, "Asked what happened, [unidentified NA] stated, 'did you know [Resident #1] can walk.' " The note also indicated that the NA told the nurse that Resident #1 could stand and that the NA said she and another NA had walked the resident to bed. The note further stated the NA reported a "pop sound from the resident's leg" when they were lifted onto her bed. The Progress Note further revealed that Resident #1 continued to report her right leg was hurting and swelling was observed. The Progress Note indicated the physician was notified of Resident #1's injury and Resident #1 was sent to the Emergency Room for evaluation. Review of the incident report dated 1/16/13 revealed Resident #1 sustained an injury during a transfer. The incident report indicated Nurse #3 was called to Resident #1's room by NA#2. NA #2 heard a pop sound when assisting (Resident #1) to bed. The incident report further indicated (Resident #1) stated her right knee was hurting "really bad" and the resident thought it was broken. The incident report identified the resident	F 323	**How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice –** All residents that currently use a hoyer lift have been assessed for appropriate seating and hoyer pad use by Therapy Director to validate that the same or similar event will not re-occur. Nursing Staff will be educated by the Staff Development Coordinator on contacting the nurse for direction on any resident that uses a Hoyer lift and the Hoyer lift is unavailable or situation prevents the use of Hoyer lift. The licensed Nurse will make decisions on transfers of residents that would require a deviation from the care plan. CNA #2 and CNA #3 will be observed on patient transfers by SDC, DON or Therapist beginning 1/25/13 2X weekly for 2 weeks, then 1X weekly X 4 weeks, 1X monthly X 3 months. Completion date: 03/01/2013	03/01/2013

PRINTED: 02/19/2013
FORM APPROVED
OMB NO. 0938-0391

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F 323	Continued From page 2 as being alert at the time of the incident. A review of Resident #1's hospital record reveal radiology report dated 1/17/13 indicated Resident #1 had an acute displaced spiral type fracture of the left distal femur above the knee. Hospital records further revealed Resident #1's bones appeared Osteopenic and muscular atrophy was noted. Emergency Room physicians Recommendations indicated a posterior splint, pain control and follow up due to patient's status and history of cerebral palsy and being non-ambulatory. An interview conducted on 1/29/13 at 2:50pm with Nurse #1 revealed Resident #1 was an alert and oriented resident who could communicate her wants and needs. Nurse #1 indicated that the resident was transferred by mechanical lift. Nurse #1 further stated that a mechanical lift was used to transfer the resident from bed to chair and 2 staff had to be present to use the mechanical lift. Nurse revealed the resident's legs did not bend and her body was very stiff. Resident #1 required total assistance from staff to complete most ADL's (activities of Daily living). Nurse #1 further stated that she had always observed staff transfer the resident using a mechanical lift. An interview conducted on 1/29/13 at 3:19pm with Resident #1 revealed she requested assistance from NA #1 to get into bed. Resident #1 stated that NA #3 came in with NA #1 but the two NAs were unable to get the mechanical lift pad from up under the resident to position it for lift with the lift. Resident #1 revealed that the NAs told Resident #1 that there was a rumor that she	F 323	**Measures to be put in place or systemic changes made to ensure practice will not re-occur -** New Nursing employees will be in-serviced on contacting the nurse for direction on any resident that uses a Hoyer lift and the Hoyer lift is unavailable or situation prevents the use of Hoyer lift. The licensed Nurse will make decisions on transfers of residents that would require a deviation from the care plan. 2 C.N.A's and 2 Licensed Nurses will be questioned about the correct process (contacting the nurse for direction on any resident that uses a Hoyer lift and the Hoyer lift is unavailable or situation prevents the use of Hoyer lift. The licensed Nurse will make decisions on transfers of residents that would require a deviation from the care plan) 2X weekly X2 weeks, then 1X weekly X 4 weeks, then monthly X 1. Completion date: 03/01/13	03/01/2013

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F 323	Continued From page 3 could walk, which Resident #1 denied. Resident #1 stated, "They (NA#2 and NA#3) tried leaning me forward and tried getting it (the lift pad) from under my legs and they couldn't get it." Resident #1 said NA #2 and NA #3 put the wheelchair close to the bed, stood her up on her legs and pivoted Resident #1 onto the bed by holding the resident up under her arms. Resident#1 stated a pop was heard when NA #2 and NA #3 stood her up on her feet to pivot and a second pop while NA #2 positioned the resident's legs in bed. Resident #1 revealed that until that day she was always transferred from chair to bed by the mechanical lift. An interview conducted on 1/30/13 at 3:53pm with NA #3 revealed that Resident #1 was supposed to be transferred by mechanical lift. NA #3 revealed on 1/16/12, she and two other NA transferred Resident #1 from the wheelchair to the bed. NA#3 indicated NA#1 requested assistance with putting Resident #1 to bed but they were unable to get the mechanical lift pad from under Resident #1. NA #3 revealed with the additional assistance of NA #2 the mechanical lift pad still could not be positioned under the resident properly. NA#3 stated we asked Resident #1 if she could transfer with the assistance of two people. NA#3 indicated Resident #1 stated that she would attempt to transfer. NA #3 said she (NA#3) got under one arm and NA #2 got under another arm and lifted Resident #1 and transferred her to the bed with the NAs bearing all of Resident #1's weight. NA # 3 stated Resident #1's feet never touched the ground during the transfer. NA #3 stated she did not hear a pop during the transfer.	F 323	**How facility will monitor corrective action(s) to ensure deficient practice will not re-occur-** 2 C.N.A's and 2 Licensed Nurses will be questioned about the correct process (contacting the nurse for direction on any resident that uses a Hoyer lift and the Hoyer lift is unavailable or situation prevents the use of Hoyer lift. The licensed Nurse will make decisions on transfers of residents that would require a deviation from the care plan) 2X weekly X2 weeks, then 1X weekly X 4 weeks, then monthly X 1. The Director of Nursing will report results of questionnaire and transfer observations with CNA #2 and CNA #3 to the weekly Quality Assurance Risk Management meeting X 4 weeks and Quarterly Quality Assurance meeting X1 for further problem resolution. Completion date: 03/01/13	03/01/2013

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F 323	Continued From page 4 An interview conducted on 1/30/13 at 4:17pm with Nursing Assistant (NA#2) revealed on 1/16/13 NA #1 needed help putting Resident #1 in bed. NA#2 revealed the NA ' s were unable to get pad from under resident due to resident's electronic wheelchair being too small for the resident and no room being available to put another mechanical lift pad under the resident. Resident #1 was persistent about wanting to get into bed. NA #2 stated, "We (NA#2 and NA#3) decided to use a two person transfer". NA #2 revealed NA #2 and NA #3 grabbed Resident #1 under her arms, bore most of the weight and positioned the resident into bed. NA #2 stated the resident's feet never hit the ground during the transfer. Following the transfer, NA #2 heard a pop while positioning resident legs in the bed. NA#2 stated Resident #1 stated that her knee was hurting. NA #2 said she told the nurse about Resident #1's knee was hurting after a pop was heard while positioning resident legs in bed. An interview conducted on 1/31/13 at 3:00pm with Nurse #2. Nurse #2 indicated that NA #1 revealed NA #2 and NA #3 had transferred Resident #1 without the required mechanical lift. Nurse #2 stated Resident #1 should never be moved without a mechanical lift. Nurse #1 told Nurse #2 that NA #2 stated that Resident #1 could walk. Nurse #2 stated Resident #1 revealed NA #2 and NA #3 stood Resident #1 and put her in the bed. Nurse #2 said Resident #1 also revealed NA #2 and NA #3 did not use the mechanical lift. An interview conducted on 1/31/13 at 3:22pm with Nursing Assistant (NA#1) revealed on 1/16/13 Resident #1 requested to get into bed. NA #1	F 323		

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F 323	Continued From page 5 indicated she was aware that Resident #1 used a mechanical lift for transfers. NA #1 indicated NA #3 attempted to assist initially but the pad was under the resident and could not be retrieved. NA #3 got NA #2 for additional assistance to retrieve the pad from under the resident. NA #1 stated the resident was sitting on the part of the pad that went around the resident's shoulders. NA #1 revealed a decision was made that NA #2 and NA #3 would transfer Resident #1. NA #1 stated that the chair was positioned as close to the bed as possible and NA #2 and NA #3 transferred Resident #1 to bed. NA #1 indicated the resident's feet never hit the ground during the transfer. NA #1 stated she did not hear a pop during the transfer of Resident #1. NA #1 further revealed that she had left the room to attend to another resident while NA #2 was positioning Resident #1 in the bed. An interview conducted on 2/1/13 at 1:30pm with Nurse #3 revealed the resident was heard to yell from down the hall as if in pain on 1/16/13. Nurse #3 indicated NA #2 said to her, 'did you know [Resident #1] can walk?' Nurse #3 revealed Resident #1 had never been observed to walk and was transferred by mechanical lift only. Nurse #3 further revealed that NA #1, NA #2, and NA #3 assisted the resident with the transfer. Nurse #3 stated that the resident communicated that her knee was hurting. Nurse #3 further indicated Resident #1 also revealed NA #2 and NA #3 stood the resident up on her feet and pivoted the resident into the bed. Nurse #3 indicated that she contacted the Doctor and ER for the resident to be transferred due to the pain the resident was in. Nurse #1 stated Resident's leg appeared to be broken.	F 323		

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