STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345350	A. BUILDING _____ B. WING _____	C 03/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND TERRACE	2300 ABERDEEN BLVD GASTONIA, NC 28054

(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: Based on observations, staff interviews and record review the facility failed to secure a resident's legs during a mechanical lift transfer resulting in a fall with arm fracture (Resident #3), and failed to use two staff for mechanical lift transfers (Resident # 2 and #3) for 2 of 3 sampled residents. The findings include: 1. Resident #3 was admitted to the facility on 05/18/10 with diagnoses that included left sided hemiplegia, history of cerebrovascular accident, osteoporosis and others. The most recent Minimum Data Set (MDS) dated 01/18/13 specified the resident had short and long term memory impairment and moderately impaired cognitive skills for decision making. The MDS also specified the resident was totally dependant on staff for activities of daily living (ADL) and the resident was transferred with a mechanical lift. Review of Resident #3's medical record revealed a nurse's entry made by Nurse #1 dated 02/07/13 that specified the resident had pain and swelling	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 facility has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the dates indicated. Knowledge of proper mechanical lift transfer procedures confirmed with NA #1 and NA #2 by the Staff Development Coordinator. Education Provided to NA#1 and NA#2 by the Staff Development Coordinator to ensure understanding of communication of transfer recommendations for each resident, and the proper use of mechanical lifts.	4/15/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kimberly R. Bowers — TITLE: NHA — (X6) DATE: 4/15/13

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.

Original Signature 4/10/13

Received Black Mountain SRO DHSR APR 16 2013 by: PAM

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F 323	Continued From page 1 in his left arm. A physician was in the facility to assess Resident #3 and ordered an X-ray of the left arm. The X-ray results dated 02/07/13 specified the resident's left humerus was fractured. Resident #3 was sent to the hospital for treatment of the fracture. Resident #3's ADL/care plan guide revealed a document titled "Transfer Recommendation" dated 03/19/13 that specified Resident #3 required 2 person assistance with a mechanical total lift for transfers. Attached to the ADL/care plan guide was a document (not dated) that specified, "Resident #3 is to be transferred in the Hoyer lift (a type of mechanical lift) with 2 assist. Always use 2 persons for any transfer, turning and positioning." On 03/20/13 at 10:45 AM nurse aide (NA) #1 was interviewed and reported she was assigned to care for Resident #3. She stated she was aware the resident had fractured his arm. NA #1 explained that Resident #3 was totally dependant on staff for care and was to be transferred with the total lift (a lift that used a sling pad and lever arm to physically move the resident not requiring involvement of the resident). She stated she was assigned to give Resident #3 a shower on 02/04/13. She explained that she was not sure how to transfer the resident to shower him because the sling pad for the total lift was not to get wet. She added she asked NA #3 how to transfer the resident in the shower room and was told by NA #3 to use the sit to stand lift rather than the total lift. NA #1 explained she used the sit to stand lift to transfer Resident #3 out of his Broda chair into a large reclining shower chair. She added that NA #3 assisted her with the	F 323	Resident #2 and Resident #3 assessed by the Director of Nursing to determine the appropriate transfer recommendation. All residents requiring assistance with transfer identified as having the potential to be affected. Audit conducted by the Director of Nursing to assess and determine the recommended transfer for each resident. Transfer needs will be assessed for each new admission by the Assistant Clinical Manager. Inservice related to communication of transfer needs for each resident and procedures for providing proper transfer with the use of a mechanical lift conducted by the Staff Development Coordinator for nursing staff to ensure compliance.	4/15/13 4/15/13 4/15/13 4/15/13

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F 323	Continued From page 2 transfer. NA #1 reported that in the process of transferring the resident his foot (not specified right or left) slipped off the foot rest and the resident slumped down in the sling. She stated NA #3 called Nurse #1 for assistance and together they lowered the resident into a wheelchair. NA #1 reported that after the incident Resident #3 did not complain of pain and she did not recall him bumping or hitting his left arm. During the interview, NA #1 reported that she was trained to reference a resident's ADL/care plan guide to know how to safely transfer a resident. She stated that on 02/04/13 she did not refer to Resident #3's ADL/care plan guide prior to transferring him in the shower room. NA #1 reported she was trained on the use of mechanical lifts. She stated that she was trained that when using the "sit to stand" lift she had to ensure the resident's feet were squarely on the platform and secured with a safety belt that fastened around a resident's lower legs and that the resident had to hold onto the handles of the lift while the lift was in use. She stated that in the case of Resident #3 he was not able to hold on to both handles because of his paralysis on the left side. NA #1 was unable to recall if Resident #3's feet were secured with the safety belt. She offered no explanation how the resident's foot could have slipped off the foot rest if his feet were secured with the safety belt. On 03/20/13 at 11:00 AM Nurse #1 was interviewed and reported that on 02/04/13 she was called into the shower room because Resident #3 had slid down in the sit to stand lift while being transferred. She stated the resident did not fall but was lowered into a wheelchair.	F 323	Transfer Monitoring Tool implemented to ensure compliance. Transfer Monitoring Tool used to document observation of recommended transfer of resident, and the observation of proper procedures for providing transfer with each mechanical lift (including number of caregivers needed to provide safe transfer). Monitoring Tool to be completed by the Assistant Clinical Manager each shift,daily for 2 weeks; then each shift, 3 days per week for 2 weeks; then each shift, 1 day per week for 2 weeks; then each shift, 1 day per week for 2 months. Transfer Monitoring Tool incorporated into facility monthly Quality Assurance and Performance Improvement Program to evaluate effectiveness and ensure compliance. The Director of Nursing will be responsible for reporting the results/outcome of the Transfer Monitoring Tool. Results of observations of transfers provided with the use of the mechanical lift will be evaluated and assessed to determine the effectiveness of assessment of transfer needs, training, communication system and compliance of providing safe transfer with the each mechanical lift.	4/15/13

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F 323	Continued From page 3 She stated she assessed the resident and he did not complain of pain. Nurse #1 was unable to recall if the resident's legs were secured with the safety belt on the sit to stand lift. Nurse #1 was unaware if Resident #3 was assessed for being safe to transfer with the sit to stand lift. She explained that the resident's left side was paralyzed and he was unable to support his left side. On 03/20/13 at 11:25 AM nurse aide (NA) #2 was interviewed and reported that she was trained on the use of the mechanical lifts and specified the "Hoyer" or total lift required 2 trained staff persons to transfer a resident. She added that she was able to use the total lift by herself and it was her usual practice to not use 2 persons when transferring a resident in the total lift. She stated she was assigned to care for Resident #3 and when she transferred him with the mechanical lift she did it by herself. She added that when she transferred the resident out of bed on 03/20/13 into his Broda chair (specialized wheelchair) she did it by herself. She stated she was trained to reference the "ADL/care plan guide" to know how to transfer residents. On 03/20/13 at 11:50 AM the Staff Development Coordinator (SDC) was interviewed and stated nurse aides were trained when using the total mechanical lift they were to have 2 persons. She stated this was for the safety of the residents. She added that the therapy department assessed residents to determine their transfer status and nurse aides were expected to transfer residents accordingly. On 03/20/13 at 12:30 PM the Administrator was	F 323		

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F 323	Continued From page 4 interviewed and reported she and the Director of Nursing (DON) conducted an investigation for an injury of origin when Resident #3 was diagnosed with a fractured left arm. She explained that she concluded the reasonable cause of injury was determined to be related to the resident's foot slipping from the foot rest on 02/04/13. She added that Resident #3 was assessed on 04/07/11 to be safe to be transferred with the sit to stand lift. The Administrator was unaware if the resident's general condition had changed since 04/07/11 that would cause him to not be appropriate for the sit to stand lift. She added that since the incident the resident was reassessed and determined that he was only to be transferred with the total mechanical lift. On 03/20/13 at 1:55 PM the physician was interviewed and reported that on 02/07/13 he was asked to assess Resident #3 for pain and swelling in his left arm. The physician stated that Resident #3 had very brittle bones and stiffness on his left side with contractures. He reported that Resident #3 most likely sustained the fracture to his left arm during the event that occurred in the shower room on 02/04/13. On 03/20/13 at 2:05 PM NA #2 was observed transferring Resident #3 from his Broda chair to bed. She used a mechanical total lift by herself to lift the resident out of the chair and over onto the bed. On 03/20/13 at 2:10 PM the Director of Nursing (DON) was interviewed and stated the nurse aide was to have 2 people in the room to assist with the transfer and operation of the mechanical lift.	F 323		

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F 323	Continued From page 5 On 03/20/13 at 2:15 PM the DON was interviewed. DON stated the safety belt should have been secured around the resident's lower legs and was unable to explain how the resident's foot slipped off the foot rest if the safety belt was secured around his legs. On 03/20/13 at 2:20 PM NA #3 was interviewed and stated that she had cared for Resident #3 many times and had always used the sit to stand lift to transfer the resident for a shower. She explained that all other times she used the total lift to transfer the resident. She added that she helped NA #1 transfer the resident on 02/04/13 using the sit to stand lift and the resident's foot slipped off the foot rest. NA #3 reported she thought the resident's legs were secured with the safety belt at the time of the incident. She offered no explanation how the resident's foot could have slipped off the foot rest if his feet were secured with the safety belt. 2. Resident #2 was admitted to the facility on 04/25/12 with diagnoses that included osteoporosis, Diabetes and others. The most recent Minimum Data Set (MDS) dated 01/09/13 specified the resident's cognition was not impaired and that she required extensive assistance with activities of daily living (ADL). The MDS also specified the resident had a fall while in the facility. Review of Resident #2's ADL/care plan guide revealed a document titled "Transfer Recommendation" dated 03/19/13 that specified the resident was dependent on 2 people to transfer her with the mechanical total lift. The document also specified the resident had a	F 323		

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F 323	Continued From page 6 change in transfer status and to remind resident that a lift must be used for safety. On 03/20/13 at 10:45 AM nurse aide (NA) #1 was interviewed and reported that she was trained on the use of the mechanical lifts and specified the "Hoyer" or total lift required 2 trained staff persons to transfer a resident. She added that she was able to use the total lift by herself and it was her usual practice to not use 2 persons when transferring a resident in the total lift. She stated she was assigned to care for Resident #2 and when she transferred her with the mechanical lift she did it by herself. She stated she was trained to reference the "ADL/care plan guide" to know how to transfer residents. On 03/20/13 at 11:50 AM the Staff Development Coordinator (SDC) was interviewed and stated nurse aides were trained when using the total mechanical lift they were to have 2 persons. She stated this was for the safety of the residents. She added that the therapy department assessed residents to determine their transfer status and nurse aides were expected to transfer residents accordingly. On 03/20/13 at 2:12 PM NA #1 was observed transferring Resident #2 out of her wheelchair into bed. NA #1 used a mechanical total lift by herself to transfer the resident. On 03/20/13 at 2:15 PM the Director of Nursing (DON) was interviewed and stated the nurse aide was to have 2 people in the room to assist with the transfer and operation of the mechanical lift. On 03/20/13 at 3:20 PM the Rehabilitation	F 323		

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F 323	Continued From page 7 Manager was interviewed and stated she developed a new form titled "Transfer Recommendation" for nurse aides to utilize to know a resident's transfer status. She reported that she had assessed residents to determine the safest transfer method. She also reported that changes had been made to some of the residents transfer status. She reported the changes were filed in the ADL/care plan guide book for nurse aides to review. She confirmed she had not notified nurse aides or educated them on the use of the new document but stated nurse aides were aware they should reference the book at the beginning of each shift to see if changes had been made.	F 323		