STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES NURSING CENTER	1404 N LAFAYETTE ST SHELBY, NC 28150

(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, record reviews, and staff interviews, the facility failed to utilize the correct lift to transfer 1 of 3 sampled residents resulting in a fractured arm. (Resident #63) The findings included: Resident #63 was admitted to the facility 09/03/08 with diagnoses which included osteoporosis, chronic obstructive pulmonary disease, spinal stenosis, and Alzheimer's disease. A review of Resident #63's medical record revealed hospice services were initiated 03/25/13 relating to adult failure to thrive and Alzheimer's dementia. A quarterly Minimum Data Set (MDS) dated 07/23/13, indicated Resident #63 demonstrated memory loss and unclear speech but was usually understood and usually understood others. The MDS specified the resident's cognition was moderately impaired with poor decision making and required staff cueing and supervision. The MDS described Resident #63 as totally dependent on staff assistance for all care	F 323	Past noncompliance: no plan of correction required. DHSR NHL&C Black Mountain WRO Received NOV 14 2013 by: SKH	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charlotte Young — TITLE: Administrator — (X6) DATE

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 including transfers from bed to chair and did not ambulate during the assessment period. Resident #63's weight was recorded on this MDS as 122 pounds. A care plan dated 08/06/13 identified Resident #63 with a self care deficit related to impaired mobility and memory. The care plan specified the resident had decreased safety awareness. The care plan goal included the resident would receive no injuries from falls. Care plan interventions contained instructions for a mechanical lift for transfers. A review of Resident #63's medication administration records (MAR) dated 09/01/13 through 09/30/13 and 10/01/13 through 10/31/13 was conducted. Physician orders were documented on both MARs for pain medications of Duragesic 25 micrograms per 24 hours topical patch to be applied to skin every 72 hours and Hydrocodone 5 milligrams/325 milligrams by mouth every 12 hours and every 4 hours as needed for breakthrough pain. Comparing the 09/2013 MAR with the 10/2013 MAR revealed no notable increase in dosages or frequency of pain medication had been administered through 10/21/13. A review was conducted of a "Help-Me" guide for nursing assistants updated 10/08/13. The guide provided instructions to utilize a mechanical lift for transfers for Resident #63. Further review of Resident #63's medical record revealed a nurse's note dated 10/13/13 at 3:25 PM. The note specified a nursing assistant reported the resident had a raised area on the forehead. The nurse documented the resident	F 323		

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F 323	Continued From page 2 was up in a high-backed cushioned chair and vital signs and oxygen saturations were within normal limits for this resident. The documentation also included when the resident was asked how this raised area occurred, the resident responded "I don't know." An additional nurse's note dated 10/13/13 at 6:00 PM documented the resident complained of right arm and shoulder pain upon movement. An assessment of the resident revealed slight swelling was noted to the right shoulder and a small abrasion was noted to the right lower leg. The note continued the physician was notified and requested the resident be sent to the hospital for evaluation. A review of Emergency Department (ED) Physician documentation dated 10/13/13 at 7:22 PM was conducted. The ED Physician described Resident #63 as nonambulatory for more than 5 years and required evaluation of a bruise on the forehead and swelling and pain in the right upper arm. The report also noted some abrasions on the back of the resident's lower legs. The resident was further described as unable to turn over in the bed without assistance. Further review of the ED Physician's documentation revealed x-rays of the right arm and shoulder and a computed tomography (CT) of the head were completed. Results of the shoulder and arm x-ray revealed a fracture of the upper right arm and an additional diagnosis of wide spread osteopenia (a process of loss of bone density increasing the risk of breaking a bone). The CT showed no evidence of trauma to the head. The ED Physician's documentation specified the resident's right arm was placed in a sling with a swath for further support and returned to the facility. No medication changes were ordered.	F 323		

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F 323	Continued From page 3 Continued review of Resident #63's medical record revealed a nurse's note dated 10/13/13 at 11:30 PM. The note documented the resident's return to the facility. The note contained information describing the sling was in place. The note documented, after the resident was positioned in the bed, the resident acknowledged she was comfortable and without pain. A review was conducted of a statement provided to the Director of Nursing (DON) by Nursing Assistant (NA) #3 on 10/14/13 after NA #3 was called at 4:30 PM to return to the facility. The statement specified at around 11:30 AM on 10/13/13, NA #3 was returning from her break. She observed NA #2 coming out of Resident #63's room with a sit to stand lift. NA #3 stated NA #2 asked NA #3 what lift was used by Resident #63. She replied the mechanical lift. NA #2 stated she could not find that lift and asked if NA #3 would help her use the sit to stand lift to transfer Resident #63 from her bed to the chair. NA #3 obliged and assisted NA #2 with the transfer using the sit to stand lift. NA #3 stated she did notice a bruise on Resident #63's forehead that contained a small scratch in the middle of the bruise. Other statements from staff members that worked 10/13/13 on Resident #63's unit including NA #2 were reviewed. These statements were dated as obtained on 10/14/13 through 10/15/13. Review of these statements revealed NA #2 was interviewed multiple times on these days. NA #2 provided conflicting information. A handwritten physician's progress note dated 10/18/13 and signed by the Medical Director (MD) was reviewed. The note indicated the MD	F 323		

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F 323	Continued From page 4 determined Resident #63's fractured arm was a result of the incorrect lift being utilized for a transfer of the resident from her bed to the chair. An observation of Resident #63 being transferred from bed to chair was conducted on 10/21/13 at 11:59 AM. Nursing Assistant (NA) #1 and Nurse #1 were observed utilizing a mechanical lift for the transfer. The resident was observed with a sling on her right arm that contained a pillow for support. The nursing assistant and nurse placed a sling under the resident's body while the resident was lying in bed. The sling extended from the resident's head to her knees and supported her legs, arms, and torso. The corners of this sling were then attached to bars on the mechanical lift. As the bars were lifted via a motor contained within the lift, the sling cradled the resident's body. The resident's body was raised from the bed and guided by the staff to a chair. The chair was high-backed and contained cushions for support. At no time during the transfer did the resident call out, grimace, or indicate she experienced pain. After being position in the cushioned chair, NA #1 asked the resident if she was comfortable. The resident was observed nodding her head to indicate her answer was yes. An interview with the Administrator was conducted 10/21/13 at 2:53 PM. The Administrator stated she was first notified by facility staff at approximately 5:40 PM on 10/13/13 that Resident #63 was complaining of right arm pain and would be sent to the hospital for evaluation per physician's order. The Administrator stated about 8:30 PM she was notified by facility staff the preliminary report from the hospital determined the resident had	F 323		

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F 323	Continued From page 5 sustained an arm fracture. The Administrator called the facility at approximately 2:00 AM on 10/14/13 and received a report confirming the resident had returned to the facility and did have a fracture to the right upper arm. The origin of the fracture was unknown. The Administrator stated at that time she notified the police via phone. Around 9:25 AM on 10/14/13 two policemen came to the facility. They informed the Administrator the police would not investigate until the facility investigated and suspected a crime against the elderly had been committed. At 9:41 AM on 10/14/13 a 24 hour report was faxed to the Department of Health Services Regulation. Throughout that day the facility investigation was conducted by the Administrator, Director of Nursing (DON), and Clinical Coordinator. Nurses and nursing assistants were interviewed and statements taken. Residents were also interviewed and no concerns were identified by the residents. On 10/14/12 it was determined NA #2 and NA #3 used an incorrect lift during the transfer of Resident #63 on 10/13/13. Both of these nursing assistants were suspended that day. The Administrator stated due to multiple discrepancies in NA #2's statements she provided explaining how the incident occurred, she was terminated 10/16/13. NA #3 was suspended during the investigation. She was re-educated on the proper transferring of residents and will be monitored for one month to ensure compliance with facility policies. The Administrator stated the conclusion that the sit to stand lift was used was reached by demonstrations of the use of the sit to stand lift. The way the straps fit the arms and the placement of the feet on the base of the lift were consistent with the fracture to the upper arm and abrasions noted on Resident #63's lower legs.	F 323		

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F 323	Continued From page 6 The Administrator stated the Medical Director also concluded via demonstration of the sit to stand lift, the fractured upper arm was consistent with the strap on the sit to stand lift pulling under the right arm as the lift raised the resident. The Administrator added the resident was too weak to hold onto the lift handles and hold her back straight without slumping as was required to utilize this lift. The Administrator stated during the investigation, Resident #63's roommate who was deemed interviewable, reported a lot of noise going on behind the curtain on the day of the incident. The Administrator explained NA #2 had reported the noise occurred when she attempted to push the lift close to the resident's bed. The Administrator added the facility concluded this was how the resident had hit her head on the lift and sustained the forehead bruise. Additional interview with the Administrator revealed beginning 10/14/13, education was provided to all clinical staff regarding facility policies concerning resident transfers. Also on this day, the facility staff development nurse began performing nursing assistant competencies which required return demonstrations of utilization of lifts and other nursing assistant tasks. The Administrator stated since this incident occurred the DON and Clinical Supervisor had audited other residents to ensure the correct lift was used. The Help-Me guides were also audited to ensure the correct lift was listed for each resident that required use of a lift for transfers. On 10/17/13 at 12:40 PM, a 5 day report was filed with the Department of Health Services Regulation. The report contained the results of this investigation as previously stated. Additional interviews on 10/21/13 at 3:50 PM with	F 323		

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F 323	Continued From page 7 the Administrator and DON revealed re-education of clinical staff was initiated 10/14/13 and monitoring nursing assistants for the selection and use of lifts had begun. The facility plan also included the formation of a new committee called Performance Improvement. This committee will consists of direct care staff that will review all aspects of resident care including proper transfers. The committee will make recommendations as needed to management staff for improvement in systems and techniques. On 10/14/13, the Administrator made the decision to take this incident with the action plan to the next Quality Assessment and Assurance committee meeting this month. — Today 11-8-13 Observations, review of facility documentation and interviews with staff during the survey of 10/21/13 revealed the facility had implemented corrective actions. Observations of residents being transferred utilizing mechanical lifts revealed the proper lift was used correctly on 3 sampled residents. Interviews with staff revealed they had been instructed to use the correct lift and 2 staff members were required for each lift. Review of facility documentation revealed monitoring of NAs transferring residents safely with the recommended lift. Facility documentation review also revealed education and return demonstrations of lift operation began on 10/14/13.	F 323		

Attachment to 2567
Cleveland Pines Nursing Center
1404 N. Lafayette Street
Shelby, NC 28150
Corrective Action Plan
Complaint Investigation and Revisit Survey October 21, 2013
Charlotte Young, Administrator

10/14/13 Resident# 63 was re-assessed to ensure the current mechanical lift device was appropriate.

a. CNA#2 (PRN) terminated
(Prior to incident education was provided to CNA#2 on Preventing, Recognizing & Reporting Resident Abuse/Neglect 9/30/13, Resident Rights 9/23/13, Accident Prevention 9/14/13, Resident Lifting & Transfers 9/24/13, Performance Improvement 9/27/13 through Silver Chair Modules) (Abuse/Neglect Education provided through In-Service 3/5/13 & 9/23/13)

b. CNA#3 (Full-Time) Re-educated on Preventing, Recognizing & Reporting Resident Abuse/Neglect, Resident Rights, and Resident Lifting & Transfer policies and is being monitored during transfers for one month and randomly thereafter.
(Prior to incident education was provided to CNA#3 on Preventing, Recognizing & Reporting Resident Abuse/Neglect 5/1/13, Resident Rights 3/4/13, Accident Prevention 3/4/13, Resident Lifting & Transfers 3/4/13, Performance Improvement 7/29/13 through Silver Chair Modules) (Abuse/Neglect Education provided through In-Service 2/19/13, 3/5/13, 3/11/13 & 9/23/13)

c. Resident #63 is being monitored by Supervisor and/or Nurse for pain, proper sling placement, transfers, and clothing requirements.

d. Working in collaboration with family to provide high quality care for resident #63.

10/14/13 worked in collaboration with DSS, resident #63 family, Shelby Police and attending physician through the investigation process.

10/15/13 all other residents were assessed to ensure the current method of lifting and transferring in their care plans was appropriate.

10/14/13 – 10-15-13 Social Worker/RN Supervisors Interviews with alert and oriented residents completed to address possibility of improper lift having been used with them; no identified concerns.

10-14-13 – 10/15/13 Social Worker/RN Supervisors completed Interviews with clinical staff to ask whether any other improper transfers had occurred and to re-educate staff concerning proper transfers and the consequences of not transferring in accordance with a resident's plan of care; no identified concerns.

10/14/13 Therapy assesses all residents on admission and residents that have declined in mobility status for appropriate transfers. Staff can send referrals for therapy evaluation.

10/14/13 Education by the Director of Nursing/Designee began regarding facility policies and procedures provided to all clinical staff regarding proper transfers using mechanical lift devices and importance of the use of the Help-Me-Guides.

10/14/13 – 10/18/13 Staff Development Coordinator began mandatory competencies for all certified nursing assistants, which includes transfers using mechanical lifts that require the CNA to demonstrate the utilization of lifts, as well as other related nursing assistant tasks; re-education provided as needed.

10/14/13 Nurses (Floor Nurses, RNs, & Safety Officer) are monitoring 3 mechanical lift transfers each shift for compliance, will continue indefinitely.

10/15/13 Plant Operations Director/Designee has inspected all mechanical lift devices for proper functioning, no identified issues.

(Continued)
Cleveland Pines Nursing Center
Corrective Action Plan
Complaint Investigation and Revisit Survey October 21, 2013
Charlotte Young, Administrator

10/17/13 Performance Improvement Team utilizing front line staff has been initiated that will evaluate a variety of quality issues as needed. Resident transfers will be considered periodically by the Performance Improvement Team for one year.

10/17/13 The facility's investigation was completed with substantiated neglect on the part of CNA#2 who was terminated. CNA#3 was re-educated on facility policies regarding resident neglect, patient safe handling (lifts & transfers), and resident rights and is being monitored during her resident transfers for one month, then periodically thereafter. 5-Day Working Report sent to DHSR

Findings will be reviewed and discussed in Monthly Quality Meetings.

RN Supervisor update, as changes occur, the CNA Help-Me-Guides which includes transfer instructions as well as other pertinent care instructions.

During Orientation all new CNAs are educated and required to demonstrate the proper use of mechanical lifts. Competences completed yearly with the staff person demonstrating his or her competency on the use of mechanical lifts.

Staff Development Coordinator monitors/instructs all new CNAs after orientation, education provided if needed.

CNAs are required to complete education modules on Preventing, Recognizing, & Reporting Resident Abuse/Neglect, Resident Rights, Performance Improvement, Accident Prevention & Management, Resident Lifting & Transfers as well as many other required education modules through our Silver Chair modules and attend education in-services related to Resident Abuse/Neglect, Resident Rights each year.

Cleveland Pines will continue to follow DHSR regulations for reporting Resident neglect. Cleveland Pines Nursing Center is committed to compliance with the Center of Medicare and Medicaid Services' regulations.

Sincerely,

Charlotte Young
Administrator