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 06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND TERRACE	**2300 ABERDEEN BOULEVARD 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
E 000	Initial Comments An unannounced recertification and complaint investigation was conducted 06/03/19 to 06/06/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 60VN11.	E 000		
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID# 60VN11.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		6/24/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/24/2019

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F 656	Continued From page 1 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident and staff interviews, the facility failed to transfer a resident using the total lift with two person assist for 1 of 1 resident observed during transfer (Resident #32). Findings included: 1. Resident #32 was admitted to the facility on 7/12/18 with diagnoses which included Parkinson's disease and pain. A review of the quarterly Minimum Data Set (MDS) dated 2/28/19 coded Resident #32 as cognitively intact and required two-person extensive assistance for transfers. A review of Resident #32's care guide, a guide that let's nursing staff know what type of care to provide for residents, dated 7/12/18 revealed he was a 2 person assist using a total lift for transfers.	F 656	The statements included are not an admission and do not constitute agreement with the alleged deficiency herein. The plan of correction is completed in 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 alleged deficiency cited have been or will be completed by the dates indicated. The facility maintains a Quality Assurance and Performance Improvement Committee that meets monthly to identify issues with respect to which quality assurance activities are necessary, develop and implement appropriate plans of action to correct identified quality deficiencies. AFFECTED RESIDENT:	

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F 656	Continued From page 2 A review of Resident #32's care plan dated 3/22/19 revealed he was to be transferred using a total lift. An observation was made on 6/03/19 at 2:20 PM of Nurse Aide #1 transferring Resident #32 from the bed to the wheelchair with the total lift with no assistance. An interview conducted on 06/03/19 at 2:31 PM with NA #1 revealed Resident #32's care guide indicated he was a total lift that required a 2 person assist. She stated she felt it was ok to transfer him alone since the housekeeper was in the room to watch. She further stated she was aware facility policy was to have for a 2 person assist with all total lift transfers. An interview with Resident #32 on 6/05/19 at 4:15 PM revealed he was transferred with 1 staff member on 06/03/19. He further stated sometimes he was transferred with the total lift by only 1 staff member but it was usually 2 staff members. An interview on 6/03/19 at 2:37 PM with the Director of Nursing (DON) revealed NA #1 should have asked for lift assistance and should not have transferred Resident #32 without another NA or nurse and the housekeeper being in the room was not the same as having 2 staff transfer a resident. The DON stated that NA #1 performed an unsafe transfer when utilizing the total life without 2 staff members. She further stated Resident #32's care guide was marked for a 2 person transfer with the total lift. An interview on 6/03/19 at 3:10 PM with the	F 656	Corrective actions as described in plan of correction were taken for Resident #32, relative to use of total lift required to safely transfer resident. NA#1 was provided education on 6/3/19 on following resident care plan and using two person assist when using total lift to transfer resident. POTENTIALLY AFFECTED RESIDENTS: As all residents using total lift for transfers could be affected, the following corrective actions have been taken. SYSTEMS CHANGE: Staff Development Coordinator initiated in-services on 6/3/19 and completed on 6/21/19 to all nursing staff regarding following resident care plan and using two person assist when using total lift during resident transfers. Any other staff member on LOAs or otherwise out will be educated prior to returning to assignment. MONITORING: An audit tool was developed to identify potential quality issues, including but not limited to following resident care plan and using two person assist when using total lift to transfer resident. Director of Nursing or designee shall be responsible to conduct and/or delegate said audits in an effort to identify quality of care and area of concern. Audits will be completed weekly x 4 weeks then monthly x 3 months. Audit will include 10% of current daily census. Weekly audits will start on 6/24/19 with the monthly audit completion on 9/22/19. As means of quality assurance, the	

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F 656	Continued From page 3 Administrator revealed that Resident #32 should have had 2 NAs to safely transfer him and she didn't know what happened or why NA #1 did not ask for assistance.	F 656	Director of Nursing shall report findings of aforementioned audits and immediate corrective actions taken to the QAPI committee meetings. Further corrective action shall be planned and executed by the committee as warranted with follow-up reporting provided, and reviewed to continually identify issues with respect to which quality assurance activities are necessary, develop and implement appropriate plans of action. Completion Date: 6/24/19	