STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING ______ B. WING ______	C 04/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / GREENVILLE	2578 WEST 5TH STREET GREENVILLE, NC 27834

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F 323 SS=D	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 observation, record review, staff and resident review, the facility did not ensure that direct care staff was transferring 1 of 1 sampled residents (Resident #1) safely while using the mechanical lift device. Findings included: Resident #1 was admitted to the facility on 08/19/13 after an open reduction internal fixation (ORIF) of a right humerus fracture. Cumulative diagnoses included end stage renal disease with dialysis, congestive heart failure, hypertension and reflux disease. According to the Admission Minimum Data Set (MDS) assessment of 08/26/13, Resident #1 was independent with decision making and had no memory problems. It was noted that Resident #1 had a fall in the past. It was noted that Resident #1 had limited range of motion in both lower extremities and required minimal assistance with transfers. According to the Care Area Assessment (CAA) detail, Resident #1 triggered in falls and was to be addressed in the care plan. A physician's telephone order of 11/19/13 noted Resident #1 was to have a bed and chair alarm.	F 323	1.) Corrective action will be accomplished for the resident found to be affected by deficient practice as follows: All staff inserviced via paycheck insert on 3-24-14. CNAs that were involved in the deficient practice were inserviced again individually on 4-3-14 on manual lift policy with emphasis on the use of two staff members when using mechanical lifts. They verbalized understanding. 2.)Corrective action taken for those residents having the potential to be affected by the same deficient practice as follows: DON, Unit manager or designee to observe use of mechanical lift by 7-3, 3-11, and 11-7 shifts weekly x 4 weeks to ensure ongoing compliance with mechanical lift policy. Completion date will be 3.)Measures put in to place to ensure deficient practice will not occur are as follows: DON added to orientation paperwork a memo that states: When a mechanical lift is in use there must be two	4/21/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/25/2014

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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	345181	A. BUILDING ______ B. WING ______	C 04/03/2014

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F 323	Continued From page 1 Placement and function were to be checked every shift. The most recent Quarterly MDS of 03/07/14 indicated Resident #1 required total assistance with transfers. A nurse's note of 03/15/14 at 7:09 AM indicated that Resident #1 had slipped out of his chair while trying to get himself comfortable. Resident #1 lowered himself to the floor to prevent falling. A dycem cushion was placed in the chair. A nurse's note of 03/20/14 at 8:28 AM indicated that Resident #1 was observed lying supine parallel to the bed after sliding out of the motorized wheelchair. It was noted that Resident #1 had been lowered to the floor by staff. Resident #1 denied any pain or discomfort. Resident #1 was assisted back to bed. A therapy note of 03/20/14 at 11:06 AM indicated that Resident #1 had reported that he had to be lowered to the floor this morning related to a mechanical lift malfunction which resulted in pain and swelling to his left knee. A review of the Report of Resident Fall for the event of 03/20/14 revealed that Nurse Aide #1 (NA #1) reported while placing Resident #1 in his chair he started sliding out so NA #1 assisted him slowly to the floor. The activity at the time of the event was noted to be attempting to get out of bed unattended. The chair alarm was in place and functioning. It was noted that Resident #1 complained of left knee pain following the incident. The "lift" was noted as the assistive device that was in place at the time of the incident.	F 323	staff members present at all times. If another CNA is not available, report to your hall nurse or unit manager and do not proceed with the lift until another staff member is present! Please note emergency release button on mechanical lift that is to be used in case of battery power failure. This will safely lower resident. Never disconnect straps unless resident is stable on supportive surface. This will ensure that all new staff members are aware that all mechanical lifts are to be done with two staff members. 4.) The facility plans to monitor each shift by observing CNA's performing transfers with mechanical lifts weekly x 4 weeks. Deficient practice will be discussed in monthly QA meetings x 6 months to monitor compliance and effectiveness. 5.) Inservicing was done for employees involved in incident on 4-3-14. Observation of mechanical lift transfers done by staff to be done weekly x 4 weeks and to be completed by 5-9-14. Implementation of orientation insert on use of mechanical lift equiptment is to be ongoing. Any negative findings will be discussed in the monthly QA meetings x 6 months. Heather G. McLamb LNHA	

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F 323	Continued From page 2	F 323		

Resident # 's care plan, last revised on 03/20/14, identified him as being at risk for falls. Interventions included transferring with the use of the mechanical lift utilizing 2 staff members. It was documented that he had a staff assisted fall on 03/20/14.

The Director of Nurses (DON) was interviewed on 04/0214 at 3:20 PM. She stated Resident #1 was involved in an incident on 03/20/14 when the mechanical lift malfunctioned during a transfer and he had been lowered to the floor by staff. She stated she completed an incident report even though it was reported to her that he did not actually fall.

Resident #1 was observed sitting in the electric wheelchair with the safety belt intact on 04/03/14 at 11:00 AM. When questioned about the incident of 03/20/14, he reported that he preferred to be gotten out of bed on third shift. He stated NA #1 came into his room to transfer him using the mechanical lift device from the bed into his electric wheelchair. Resident #1 stated NA #1 always used the lift device alone when she transferred him. Resident #1 stated he wasn't sure if the device malfunctioned or what actually happened but NA #1 had unhooked one of the straps causing him to fall to the floor hitting his left knee. He reported that additional staff came into the room after he fell onto the floor. Resident #1 commented that since that incident 2 staff members operated the device when transferring him. Resident #1 also commented that he reported the same information to the DON.

An observation of a mechanical lift transfer was conducted on 04/03/14 at 11:10 AM. NA #3 and

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	345181	A. BUILDING ______ B. WING ______	C 04/03/2014

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UNIVERSAL HEALTH CARE / GREENVILLE	2578 WEST 5TH STREET GREENVILLE, NC 27834

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F 323	Continued From page 3	F 323		

NA #4 came into Resident #1's room to transfer him from the electric wheelchair into his bed. NA #3 was operating the device and NA #3 was assisting. They connected the sling straps to the arm of the device. NA #4 locked the brakes of the device and began lifting Resident #1 into the air. NA #3 assisted Resident #1 with placement onto the bed as NA #4 lowered him down onto the mattress.

NA #3 was interviewed immediately after the observation on 04/03/14 at 11:20 AM. She stated there was an emergency button on the device in case it malfunctioned while transferring residents. She stated the button would allow the unit to lower even if the battery was dead. NA #3 reported the aides were instructed to always use 2 staff members when operating the mechanical lift for safety reasons.

Resident #4 was observed in her room sitting in her electric wheelchair on 04/03/14 at 11:40 AM. It was noted that a mechanical lift sling pad was placed underneath her in the chair. She was also identified as being transferred via a mechanical lift device by Nurse #3. She reported that one staff member usually operated the mechanical lift device when transferring her.

Resident #5 was observed sitting in her chair on 04/03/14 at 11:45 AM. There was a mechanical lift sling pad noted underneath her in the chair. She reported she was unable to transfer herself and staff used the mechanical lift to get her out of bed. She stated there were usually 2 staff members using the mechanical lift device but at times only one used the machine while transferring her.

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	345181	A. BUILDING ______ B. WING ______	C 04/03/2014

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F 323	Continued From page 4	F 323		

During an interview with the unit supervisor (US) on 04/03/14 at 12:10 PM, she stated staff had been taught to use 2 staff members when operating the mechanical lift device. She stated one staff member was to operate the machine and the other was to assist the resident. The US stated staff members were to check the straps to make sure they were attached properly and ensure the resident was positioned properly on the sling before lifting. The US reported the hall nurses were also trained in operation of the lift devices in case the nurse aides needed assistance. She also commented she had "drilled" it into the nurse aides time and time again to always ask for assistance to operate the device. The US stated staff members were aware not to move residents alone with the lift devices. She also stated it was recommended by the manufacturer of the device to use 2 staff members for safety reasons. The US also commented that it was noted on each resident's kardex that 2 staff members were to transfer when using the lift devices. She stated there was a red pull pin device on each lift which would lower the resident if the machine malfunctioned or the battery died. During the interview, the DON came into the room. She reported that Resident #1 told her that during a transfer with the mechanical lift device the staff member took the loop off the device and he fell to the floor hitting his knee. The DON stated when she interviewed NA #1 she was given a different accounting of the incident. The DON stated Resident #1 complained of left knee pain but the xray results indicated gout as the reason for the pain.

A telephone interview was conducted with NA #1 on 04/03/14 at 1:55 PM. She stated she worked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING ______ B. WING ______	C 04/03/2014

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F 323	Continued From page 5	F 323		

on third shift and had always transferred Resident #1 using the mechanical lift device without assistance from other staff. NA #1 commented she had been instructed to use 2 staff members but she was accustomed to doing it alone. She stated she was the person who was transferring Resident #1 on third shift the night of 03/20/14. She reported she didn't ask for assistance because everyone was busy. NA #1 stated she used the device to raise Resident #1 into the air but when she started lowering him into the chair the pillow in the chair began to slip. NA #1 reported she continued to lower him down and then he started sliding along with the pillow so she guided him to the floor. She stated he didn't fall because she helped him to the floor. NA #1 commented she left the room to seek assistance after she lowered him to the floor. When questioned if she unhooked the loops of the sling from the arm of the device, she responded that Resident #1 was still in the sling and the sling was still attached to the arm of the device when she lowered him to the floor. NA #1 commented Resident #1's top half of his body was still in the sling but the bottom half was not which enabled her to be able to slide him to the floor without injury. NA#1 commented Staff #1 was present and helped remove the sling from underneath Resident #1 so they could move him. NA #1 reported she had been interviewed by the DON and the Administrator following the incident.

Resident #6 was interviewed on 04/03/14 at 2:05 PM. She was sitting in her chair with a mechanical lift sling pad noted underneath her in the chair. She stated usually 2 staff members were present when getting her out of bed but at times there was only one operating the device when she was transferred back to bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 6	F 323		

Continued From page 6

Nurse #1 was interviewed on 04/03/14 at 2:20 PM. She stated she was in the building the morning of 03/20/14. She stated she didn't witness the incident. She stated she was told that staff had been assisting Resident #1 to get out of bed when the incident occurred. Nurse #1 stated the specifics were not given to her at that time. Nurse #1 reported that the facility had always required 2 staff members be present when using the mechanical lift device for transfers. She commented that if staff were busy when NA #1 was ready to get Resident #1 up she should have waited until someone was available to assist her and she should not be transferring him alone.

A member of the maintenance department (Staff #1) was interviewed on 04/03/14 at 2:30 PM. He stated he was paged to come to Resident #1's room the morning of 03/20/14. He stated upon entrance into the room Resident #1 was positioned on the floor and staff members were attempting to get him up. Staff #1 reported that he checked the mechanical lift device that morning after the incident and it was functioning properly.

NA #2 was interviewed on 04/03/14 at 4:00 PM. She stated she had been instructed not to use the mechanical lift alone and to always get another staff member to assist. She stated one staff member operated the device and the other staff member assisted the resident with guiding them to the destination.

Nurse #2 was interviewed on 04/03/14 at 4:10 PM. She stated the nurses as well as the nurse aides were trained in operation of the mechanical lift devices. She stated the aides had been

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F 323	Continued From page 7	F 323		

instructed to operate the devices with another staff member present. Nurse #2 stated if another aide was not available they were expected to request assistance from the nurses.

The US was interviewed again on 04/03/14 at 4:30 PM. She stated all incidents werer discussed in the morning meetings. She stated the last time Resident #1 fell they placed a dycem cushion into his electric wheelchair to keep him from sliding. The US stated she did not attend the meeting the day Resident #1's incident was discussed.

The Administrator and the DON were interviewed on 04/03/14 at 5:00 PM. The Administrator reported that an investigation was conducted when residents fall to determine the cause. She stated she had identified the problem with the incident of 03/20/14 and had placed an in-service into the paychecks on 03/24/14. She stated all staff members were asked to read the agenda and sign it. The DON stated when residents fell the investigation was completed and reviewed to determine the root cause and identify interventions to prevent future falls. She stated staff members as well as residents were educated when appropriate. The DON stated when she interviewed NA #1 she reported nothing happened so she did not continue with the investigation. After discussion about the telephone interview with NA #1, the DON commented that if NA #1 had reported the event as was explained she would have treated the situation differently.

A copy of the "CNA In-service for March 2014" was provided. It was noted that #3 on this document indicated to "Please remember to use

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	345181	A. BUILDING ______ B. WING ______	C **04/03/2014**

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F 323	Continued From page 8 two people when using Hoyer or Stand up lift."	F 323		