

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

PRINTED: 10/13/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2014
NAME OF PROVIDER OR SUPPLIER DAVIS HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1011 PORTERS NECK ROAD WILMINGTON, NC 28411		
(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	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to use a mechanical lift for transfers for 1 of 3 sampled residents (Resident #1) reviewed for transfers, resulting in three left lower extremity fractures. Findings included: Resident #1 was admitted to the facility on 12/1/2003 with admitting diagnosis that included osteoporosis and muscle weakness. Review of resident ' s most recent comprehensive MDS (Minimum Data Set) dated 2/21/14 revealed the resident was severely cognitively impaired and required extensive assistance with the physical assistance of two people for transfers. Resident ' s quarterly MDS dated 7/23/14 had documentation that the resident continued to need extensive assistance with the physical assistance of two people for transfers. During review of the medical record on 9/17/14 there was not a formal care plan written regarding resident ' s ADLs (Activities of Daily Living) or how she was to be transferred. A review of Resident #1 care card (A card that is in each resident ' s closet stated the care needed for the resident) revealed documentation that the resident was to be lifted with a mechanical lift and</p>	F 323	<p>The care plan for Resident #1 was reviewed and determined to be appropriate for the resident. The identified nursing assistant was interviewed and confirmed her knowledge of the residents care plan and the facility lift policy acknowledging she did not follow the policy. The identified employee was suspended pending investigation.</p> <p>Other residents requiring a mechanical lift were reviewed to ensure the care plan and care card accurately reflected the need for a mechanical lift. Retraining for other staff regarding the use of mechanical lifts and safety during transfers was completed.</p> <p>The use of mechanical lifts is noted on the resident's care card in their room for staff access where appropriate. Staff will continue to be trained, upon hire, on the use of mechanical lifts. Upon investigation, regarding Resident #1, staff was retrained regarding the proper use of mechanical lifts and safety during</p>	10/6/14	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/03/2014

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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F 323	<p>Continued From page 1</p> <p>with the assistance of two people. The care card wasn ' t dated; however it was revised after the incident that that the resident was to be lifted with a mechanical lift with the assistance of three people.</p> <p>Further review of the resident ' s medical record it was noted that on 8/25/14 at 12:31pm the NP (Nurse Practioner) documented that the resident had been seen today at nursing request due to sudden onset of left knee pain after being transferred today by staff. The NP assessed the resident ' s knew the and documented her assessment as the resident was having pain with when her leg was moved, swelling to the resident ' s knee and that is was warm to the touch. The assessment/plan was documented as acute knee pain: x-ray and pain meds as needed. Further interventions based upon findings.</p> <p>Review of mobile x-ray report dated 8/25/14 revealed the resident had acute fractures of the tibia and the fibula.</p> <p>A nursing note was written on 8/25/14 at 6:21pm stated earlier in the shift, resident ' s left knee was observed swollen, warm and painful to touch. NP in facility and assessed (resident ' s name) left knee. Orders received for x-ray of left knee. X-ray results showed acute fracture at the proximal tibia. Results called to NP. Orders to send to emergency room to evaluate and treat left knee.</p> <p>Hospital records for the resident ' s emergency room visit on 8/25/14 were reviewed. A form from the emergency department had documentation of diagnosis for visit as closed fracture of left Fibula and Tibia. The discharge directions were for the resident to wear an immobilizer and see an orthopedist.</p> <p>On 9/17/14 at 12:25pm, an observation was</p>	F 323	<p>transfers.</p> <p>Observations and audits of the use of mechanical lifts will be conducted by the clinical leadership team. 3-5 observations will occur weekly for four weeks and monthly for three months to ensure staff is properly using mechanical lifts.</p> <p>The Quality Care Committee will review and monitor the mechanical lift audit system to ensure completion. The Quality Care Committee will meet monthly for four months to review the audits and ensure solutions have been sustained.</p>		

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F 323	Continued From page 2 made of staff transferring resident to the bed from a chair. Three staff members were present for the transfer. Two staff members used a mechanical lift and the other staff member held the residents left leg during the transfer. The resident ' s left leg had an immobilizer in place. Her left foot appeared to be rotated towards the left and edema was visible. The resident did grimace during the transfer. During an interview with the administrator on 9/17/14 at 10:30 am, the administrator indicated Resident #1 was transferred by a nursing assistant and the hair stylist on 8/25/14 and did not use a mechanical lift. She stated the facility did investigate the incident and that both employees were suspended during the investigation. She further stated that neither staff member still worked at the facility; that both resigned while the facility was conducting the investigation. The administrator provided the facility's investigation which included statements from both the nursing assistant and the hair stylist. She also stated that once determined an incident occurred from an improper transfer that all staff were inserviced about using mechanical lifts as well as safety during transfers. During an interview with Nurse #1 on 9/17/14 at 2:00pm, the nurse indicated that she was working the day the resident was injured. She stated that she is the resident ' s usual nurse on days. She stated that on 8/25/14, NA #1 came and got her to report the resident was yelling and that her leg was hurting. She further stated that once she was in the room she noticed the resident did not have a mechanical lift pad under her. Nurse #1 said that she asked the nursing assistant at that time if she used the lift for the transfer and the nursing assistant said no. She further indicated there are care cards in every resident's closet that	F 323			

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F 323	Continued From page 3 communicates the resident's specific care needs to the care givers and that Resident #1 care card states that the resident is to be transferred using a mechanical lift. She explained that once she was in the room the resident was assessed and it was noted that the resident's left knee was warm and swollen. She indicated she immediately notified the Nurse Practioner and orders were given for x-rays. During a telephone interview with NA #1 on 9/17/14 at 3:02pm, the nursing assistant stated she was assigned to resident #1 on 8/25/14. She indicated she got the resident up that morning after providing morning care and with the assistance of another nursing assistant transferred her to her recliner using a mechanical lift. She stated the resident was ok when she left the room. The nursing assistant further stated that later in the morning the hair stylist had requested the resident be brought to the beauty shop to have her hair done. The nursing assistant stated she asked the stylist if he was comfortable helping her lift the resident from the recliner to a wheelchair and he said yes. She explained that she was on one side of the resident and the stylist was on the other side. She indicated that she put one arm under the resident ' s arm and one under her thigh and that the stylist did the same on the resident ' s other side. She further stated they lifted the resident from the recliner to the wheelchair and the resident yelled out. She stated she did not notice anything specific about the resident but did report to the nurse that she thought the resident was in pain. The nursing assistant continued to explain the incident by saying she was providing care for another resident in the shower room and was using one of the facility ' s mechanical lifts. She stated she could not find another lift and knew the	F 323			

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F 323	Continued From page 4 resident needed to get her hair done and " obviously used poor judgment in asking the stylist to help her lift the resident because now her leg is broken. " Additionally she stated she knew the resident was supposed to be transferred with the use of a mechanical lift and this was not new information. She indicated she was aware of the resident ' s care needs and had taken care of her frequently. She added every resident has a care card in their closet to communicate resident specific information and that the care card did have that resident was to be transferred with a mechanical lift and two people at all times. On 9/17/14 at 3:25pm and attempt was made to interview the hair stylist via telephone, but there was no answer for either phone number provided. An interview was conducted with a MDS nurse on 9/17/14 at 4:00pm. The MDS nurse stated that a care plan would not be written for the resident ' s ADL ' s if it did not trigger on the MDS to be considered for care planning. She further stated resident specific care needs are communicated to the staff on care cards that are kept in each resident ' s closet. An interview with the DON (Director of Nursing) on 9/17/14 at 4:15 pm was conducted related to Resident #1. The DON stated that it had been more than a year since Resident #1 had been determined that she should be transferred by mechanical lift. She indicated that she expected all nursing assistants to transfer residents with mechanical lifts if the resident had been identified as requiring transfer with a mechanical lift. She explained that all care needs are kept in each resident ' s closet with specific information related to the resident ' s care needs.	F 323			