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

PRINTED: 11/02/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		-	(X3) DATE SURVEY COMPLETED	
		345473	B. WING _		_	10/2	20/2015
NAME OF PROVIDER OR SUPPLIER  WILORA LAKE HEALTHCARE CENTER			STREET ADDRESS, CITY, S' 6001 WILORA LAKE ROAI CHARLOTTE, NC 2821	D			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	( (EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323 SS=D	HAZARDS/SUPERVI The facility must ensuenvironment remains as is possible; and eadequate supervision prevent accidents.	SION/DEVICES  ure that the resident as free of accident hazards ach resident receives and assistance devices to	F	323			
	by: Based on observation interview the facility for total lift sling size per recommendations for fall for 1 of 1 resident (Resident #1). The findings included Review of manufactur disposable sling record pad used to transfer the stated that it was an Information located urin part: "IMPROPER attachment or impropican cause death or so instructions and warm Review of medical relevant was admitted to far acute care hospital working lymphedema and surfusured to the subcutaneous tissue Review of Resident # indicated that Reside 2 person assist.  Review of the facility's criteria dated 9/30/15	safe transfer resulting in a reviewed for accidents  :  r's Tollos single pateint use mmendations attached to lift Resident #1 on 10/09/15 extra extra large in size. Inder a warning label stated sling size, improper sling er sling and lift inspection erious injury. Read		TITLE			(X6) DATE

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

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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		345473	B. WING		C 10/20/2015	
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  6001 WILORA LAKE ROAD  CHARLOTTE, NC 28212		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION	
F 323	required the use of large sling. Review of the admis (MDS) dated 09/30/cognitively intact an 2 people with transf Further review of th Resident #1 had limbilateral upper extremotion to one lower Review of a resident nursing staff revealed and required an ext Review of incident/a revealed that during chair to the bed one and the resident was Resident #1 compla extremeities. The reprevent reoccurence assessed for approplift. Review of physician PM stated to transferency room for Review of nurses not perform the resident was emergency room winew orders. Observation of total transfer Resident #1 wheel chair to bed rextra large total lift shaniterview with nuat 2:11 PM confirmed #1 on 10/09/15 and She stated that Resident lunch, set to bed after lunch, set to be af	assion Minimum Data Set 15 revealed Resident #1 was d required extensive assist of ers and walking did not occur. e admission MDS noted dited range of motion to emeties and limited range of extremity. It care guide utilized by the ed Resident #1 was a total lift ra large sling size. Excident report dated 10/09/15 In a transfer from electric wheel e of the lift pad straps slipped solowered to the floor. Initiating of pain in bilateral lower eport indicated steps taken to be would be for residents to be oriate sling size to accompany  order dated 10/9/15 at 1:05 er Resident #1 to the revaluation. Otes dated 10/09/15 at 9:00 so returned to the facility from the no noted injuires and no  lift sling that was used to 1 on 10/09/15 from electric evealed that it was a extra	F 32			

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NAME OF PROVIDER OR SUPPLIER  WILDRA LAKE HEALTHCARE CENTER  CARLOTTER, DR. 2812  CANIDADE STATEMENT OF REPORTMONES  DR. CARLOTTER, DR. 2812  CONTINUED STATEMENT OF REPORTMONES  FOR MILDRA LAKE ROAD  FROM REPORTMONE ACTION SIGNATION  FROM REPORTMONE ACTION  FROM REPOR	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
MANG OF PROVIDER OR SUPPLIER  WILORA LAKE HEALTHCARE CENTER    CAN   ID   PREFIX   (EACH IDENTIFY NOT REPOSITIONED IN THE PROPERTY OF THE PROP			345473	B. WING				
(CHARLOTTE, NC 28212  (CHARLOTTE, NC 28212  CHARLOTTE, NC 28212  CHARLOTTE, NC 28212  PROVIDER'S PLAN OF CORRECTION (CHARLOTTE, NC 28212  PROVIDER'S PLAN OF CORRECTION (CHARLOTTE, NC 28212  PROVIDER'S PLAN OF CORRECTION (CHARLOTTE, NC 28212  F 323  Continued From page 2 she hooked up on the straps on one side and Nurse #1 hooked up the straps on the other side. NA #1 stated she started to lift Resident #1 and as the resident was being lifted to approximate chair height she heard a pop sound and the residents right leg came out of the sling. She immediately lowered the lift and Resident #1 to the seat of her electric wheel chair. NA#1 stated she left Nurse #1 in the room with Resident #1 and went to get further assistance.  An interveiw with NA#2 on 10/20/15 at 2:44 PM confirmed that she had gotten Resident #1 told her that the lift pad was in the closet and which mechanical lift to use. NA#2 stated that she had not consulted Resident #1 vas alert and oriented and was able to tell her what to use. NA #2 stated she was aware of the facility practice to consult the care guide for proper sling size for safe transfers. She could not recall the size of the lift pad that she used to get Resident #1 up on 10/09/15.  Review of email communication from Nurse #1 to the facility revealed Nurse #1 assisted with the transfer of Resident #1 on 10/09/15 and that Nurse #1 had attached 2 of the straps on the lift sling to the mechanical lift. This communication also revealed that she had never been trained to use a mechanical lift in the facility. An intervelw with Director Of Nursing (DON) on				STREET ADDRESS, CITY, STATE, ZIP		0/20/2015		
(X4)ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MIST BE PRECEDED BY FULL TAG (EACH OFFICIENCY MIST BE PRECEDED BY FULL TAG (EACH OFFICIENCY MIST BE PRECEDED BY FULL TAG (EACH OFFICIENCY)  F 323  Continued From page 2 she hooked up on the straps on one side and Nurse #1 hooked up the straps on the other side. NA #1 stated she started to lift Resident #1 and as the resident was being lifted to approximate chair height she heard a pop sound and the residents right leg came out of the sling. She immediately lowered the lift and Resident #1 to the seat of her electric wheel chair to the base of the electric wheel chair to the base of the electric wheel with 1 to the seat of her electric wheel with 1 to the seat of her electric wheel with 1 to the seat of her that the lift pad was in the closet and which mechanical lift to use. NA#2 stated that she had not consulted Resident #1 slodent #1 slodent #1 sroom. NA #2 stated that was in Resident # had not consulted Resident #1 sear guide find mechanical lift to use. NA#2 stated that she had not consulted Resident #1 was alert and oriented and was able to tell her what to use. NA #2 stated she was aware of the facility practice to consult the care guide for proper sling size for safe transfers. She could not recall the size of the lift pad that she used to get Resident #1 up on 10/09/15.  Review of email communication from Nurse #1 to the facility revealed Nurse #1 assisted with the transfer of Resident #1 on 10/09/15 and that Nurse #1 had attatched 2 of the straps on the lift sling to the mechanical lift. This communication also revealed that she had never been trained to use a mechanical lift in the facility. An intervel with Director Of Nursing (DON) on	WIL ODA I	AVE UEALTUCADE CE	NTED		6001 WILORA LAKE ROAD			
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the NA's and Nurse's to look at the care guide and use the care guide for proper lift size for safe transfer. She confirmed that the lift that was used	F 323	she hooked up on the Nurse #1 hooked up NA #1stated she start the resident was being height she heard a pright leg came out of lowered the lift and Felectric wheel chair a from the seat of here base of the electric will left. Nurse #1 in the rewent to get further as An interveiw with NA confirmed that she hat morning with a lift shad was in mechanical lift to use not consulted Reside morning, because Resoriented and was ab #2 stated she was as to consult the care grafe transfers. She collift pad that she used 10/09/15.  Review of email come the facility revealed National transfer of Resident: Nurse #1 had attack sling to the mechanical lift An interveiw with Dir 10/20/15 at 3:45 PM the NA's and Nurse's and use the care gui	the straps on one side and the straps on the other side. Ited to lift Resident #1 and as any lifted to approximate chair op sound and the residents the sling. She immediately Resident #1 to the seat of her and then Resident #1 slipped electric wheel chair to the wheel chair. NA#1 stated she room with Resident #1 and seistance.  #2 on 10/20/15 at 2:44 PM and gotten Resident #1 up for pad that was in Resident #1 told her in the closet and which is NA#2 stated that she had ent #1's care guide that esident #1 was alert and lee to tell her what to use. NA ware of the facility's practice uide for proper sling size for could not recall the size of the late of the straps on the lift call lift. This communication is had never been trained to it in the facility.  The sector Of Nursing (DON) on revealed that she expected is to look at the care guide de for proper lift size for safe					

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NAME OF PROVIDER OR SUPPLIER  WILORA LAKE HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  6001 WILORA LAKE ROAD  CHARLOTTE, NC 28212			10/20/2015	
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F 323	use. She also confirr agency nurse and th agency staff in the fa An interveiw with the on 10/20/2015 at 3:4 an agency nurse and expectation that the basic knowledge of p with the correct sling provided education of	ned that Nurse #1 was an ey are no longer using cility. corporate Nurse Consulant 5 PM revealed Nurse #1 was	F3	323			