

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

SEP 24 2013

PRINTED: 09/06/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/03/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SOUTH VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2221 W RALEIGH BLVD ROCKY MOUNT, NC 27803
---	---

(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, resident interview, staff interview, and record review the facility failed to follow its procedure for transferring residents using lifts which resulted in 1 of 3 sampled residents (Resident #1), who experienced falls, sustaining a laceration requiring sutures. Findings included:</p> <p>Resident #1 was admitted to the facility on 08/05/11 and readmitted on 01/10/12. The resident's documented diagnoses included multiple contractures, multiple sclerosis (MS), and legal blindness.</p> <p>A 04/17/13 care plan identified Resident #1 as being at risk for falls secondary to use of psychotropic medications. This care plan also identified, "Requires extensive to total assistance with all ADLs (activities of daily living) r/t (in regard to) impaired mobility, non-weight bearing, contractures BUE/BLE (bilateral upper and lower extremities), impaired memory and decision making, dx (diagnosis) of MS and dependency on staff for ADLs, and requires mechanical lift for transfers," as a problem. Approaches to this problem included, "Mechanical transfers as</p>	F 323	Past noncompliance: no plan of correction required.	
---------------	---	-------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Erica D. Sharrington TITLE: Administrative (X6) DATE: 9/19/13

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.

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

PRINTED: 09/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/03/2013
NAME OF PROVIDER OR SUPPLIER SOUTH VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2221 W RALEIGH BLVD ROCKY MOUNT, NC 27803		
(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	<p>Continued From page 1</p> <p>indicated, Resident requires mechanical lift with assist of 2 staff for all transfers."</p> <p>The resident's 07/25/13 Quarterly Minimum Data Set (MDS) documented she had moderately impaired cognition, and during the seven day look-back period the resident did not transfer herself nor did the staff transfer the resident.</p> <p>A 08/01/13 incident report documented on 08/01/13 at 7:20 PM Resident #1 fell to the floor from a lift as a nursing assistant (NA) #2 was attempting to transfer her.</p> <p>A 08/01/13 8:00 PM electronic progress note documented Resident #1 fell to the floor as she was being put to bed resulting in a laceration to the left side of her forehead above the eyebrow. The on-call physician was notified and a message was left for the resident's responsible party.</p> <p>A 08/01/13 physician order sent the resident to the hospital for evaluation and treatment due to a head laceration.</p> <p>A 08/01/13 9:13 PM emergency room note documented, "Longitudinal laceration medial to the left eyebrow. Procedure: laceration repair. Location: face. Length: 4 centimeters. Remove stitches in 3 - 5 days."</p> <p>A 08/22/13 physician order documented Resident #1 could have the sutures removed from her left forehead.</p> <p>A 08/22/13 7:00 PM electronic progress note documented Resident #1 had returned from suture removal, and the laceration above her left eye was healed.</p>	F 323			

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

PRINTED: 09/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/03/2013
NAME OF PROVIDER OR SUPPLIER SOUTH VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2221 W RALEIGH BLVD ROCKY MOUNT, NC 27803		
(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	<p>Continued From page 2</p> <p>At 9:42 AM on 09/03/13 the Administrator stated the facility's policy had always been that two staff were needed to complete lift transfers, but after Resident #1's 08/01/13 fall due to a staff member attempting to complete a lift transfer alone, all nurses and NAs were re-educated about the facility policy.</p> <p>At 11:04 AM on 09/03/13, during a telephone interview with NA #1, she stated on 08/01/13 she was training a new employee (NA #2), stepped out of Resident #1's room to answer a call bell in another resident's room, and while she was gone NA#2 attempted to transfer Resident #1 by herself from the chair to the bed using a lift. She reported Resident #1 was very cooperative, and had not experienced any falls in the past. She commented during in-servicing after Resident #1's fall she was reminded that two staff members were required to complete all lift transfers, watched a demonstration of proper lift transfer technique, and passed a skills check off afterward when she was observed completing a lift transfer.</p> <p>At 11:10 AM on 09/03/13, during a telephone interview with NA #2, she stated on 08/01/13 she was told by NA#1 and Resident #1 that she could complete a lift transfer by herself. She reported when she attempted to transfer Resident #1 via lift on 08/01/13, the resident slipped out of the straps before she could lower her to the bed, hitting her head on the base of the lift. She commented the resident sustained a cut above her eye which bled a lot. She stated during in-servicing after Resident #1's fall she was reminded that two staff members were required to complete all lift transfers, watched a</p>	F 323		

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

PRINTED: 09/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/03/2013
NAME OF PROVIDER OR SUPPLIER SOUTH VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2221 W RALEIGH BLVD ROCKY MOUNT, NC 27803		
(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	<p>Continued From page 3</p> <p>demonstration of proper lift transfer technique, and passed a skills check off afterward when she was observed completing a lift transfer.</p> <p>At 11:28 AM on 09/03/13 Resident #1 stated a new NA attempted to transfer her from her chair to the bed by herself using a lift. She reported the cut above her eye was completely healed up, and she thought the management team reviewed with all staff the need to have two people present for lift transfers.</p> <p>At 12:10 PM on 09/03/13 NA #3 and NA #4 were observed transferring Resident #1 from her bed to a geri-chair. They placed a pad under the resident, attached pad straps to the lift hooks, and raised and lowered the resident appropriately. One NA operated the lift while the other guided the resident with her hands. Resident #1 reported she felt safe, and the NAs did a good job.</p> <p>At 2:22 PM on 09/03/13 the Administrator stated between 05/23/13, the date of their last annual survey, and 08/01/13 Resident #1 experienced no falls. She also commented between 08/02/13 and present the resident experienced no additional falls.</p> <p>Between 2:57 PM and 3:10 PM on 09/03/13 three nurses (Nurse #1, #2, and #3) and two more NAs (NA #5 and #6) were interviewed. They all verified that lift re-in-servicing began on 08/01/13 which included a reminder that two staff were needed to complete a lift transfer, a visual demonstration of correct lift technique, and completion of a skills check off.</p> <p>Review of facility documents revealed corrective</p>	F 323			

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

PRINTED: 09/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/03/2013
NAME OF PROVIDER OR SUPPLIER SOUTH VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2221 W RALEIGH BLVD ROCKY MOUNT, NC 27803		
(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	<p>Continued From page 4</p> <p>action taken by the facility in response to Resident #1's 08/01/13 fall included a 08/01/13 facility-wide audit which revealed there were 34 other residents in the facility who were transferred via lifts. In its investigation the facility determined that none of the 34 had sustained falls as a result of faulty lift transfer technique.</p> <p>Review of facility documents revealed in-services were held with all nurses and nursing assistants working in the facility after Resident #1's 08/01/13 fall. These in-services were conducted on 08/01/13, 08/02/13, 08/04/13, 08/05/13, 08/06/13, 08/07/13, 08/09/13, and 08/19/13. They included verbal reminder of the policy requiring two staff members for the completion of all lift transfers, a visual demonstration of correct lift transfer technique, and subsequent skills check offs to verify understanding by all participants.</p> <p>Review of facility documents revealed corrective interviews and individual counseling sessions were held with NA #1 and NA #2 on 08/02/13. The facility educated these employees that failure to follow facility procedure requiring two staff members for completion of all lift transfers resulted in Resident #1 sustaining a fall and injury.</p> <p>The staffing schedule for the week of 09/01/13 through 09/07/13 was reviewed, and all nurses and NAs on the schedule attended in-services per review of sign-in sheets. Skills check off lists were also located for all these staff showing that they had successfully demonstrated competency with lift transfers.</p> <p>At 2:22 PM on 09/03/13 the Administrator stated all nurses and NAs were in-serviced about lift</p>	F 323		

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

PRINTED: 09/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/03/2013
NAME OF PROVIDER OR SUPPLIER SOUTH VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2221 W RALEIGH BLVD ROCKY MOUNT, NC 27803		
(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	<p>Continued From page 5</p> <p>transfers except a couple of staff who were coming back after leave and a very PRN (as needed) staff member who had not worked in the facility since 08/01/13. She explained these staff would be required to complete the lift in-service, observe a lift demonstration, and complete a skills check off before they clocked in to begin work.</p> <p>At 3:10 PM on 09/03/13 the director of nursing (DON) stated after the completion of all lift transfer in-servicing on 08/19/13, she began random observations of lift transfers on 08/21/13 to make sure they were done correctly. She reported she was completing two random lift audits a week for a month, and would continue with them if she observed any problems. She provided audits which met her criteria, and no problems were identified with the transfers. According to the DON, the results of these audits would be discussed in the facility's next quality assurance (QA) meeting on 09/20/13, and based on the results of the audits, a decision would be made as to whether lift transfers would need to be audited for another month and then shared with the QA committee again.</p>	F 323		

South Village
2221 W. Raleigh Blvd.
Rocky Mount, NC 27803

South Village Corrective Action Plan F 323

Resident #1 sustained a fall on 08/01/13. She was assessed and transferred to the ER for treatment on 08/01/13. Resident #1 was assessed for the need of mechanical lift transfers by the interdisciplinary team on 08/02/13. The Resident Care Guide and Care Plan were updated on 08/02/13 to reflect Resident #1's need for a mechanical lift transfer with assist of two staff members.

All other residents were assessed for the need for mechanical lift transfers by the interdisciplinary team on 08/02/13. 100% audits of Resident Care Guides and Care Plans to reflect mechanical lift transfers were completed by the MDS Nurse and Administrator on 08/02/13. All new admissions will be assessed for the need of mechanical lift transfers. Care cards and care plans will reflect need for mechanical lift transfer.

In-services were conducted by the DON and ADON on the facility policy for two person mechanical lift transfers beginning on 08/02/13 for all nurses and nursing assistants. Return demonstrations and skills checklist for correct lift transfer technique were conducted by the DON and ADON beginning on 08/02/13. In-services, return demonstrations and skills checklist were conducted on each nurse and nursing assistant before they began their next scheduled shift after 08/02/13.

All new hire nursing staff will be in-serviced on the facility mechanical lift policy and will be required to demonstrate proper technique for the use of mechanical lifts during orientation.

The DON or ADON will conduct two random mechanical lift transfer audits per week for one month. The results of the audits will be forwarded to the QA committee on 09/20/13 for review and further recommendations.