PRINTED: 06/01/2011
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345531	A. BUILDING ______ B. WING ______	C 05/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CAROLINA STATE VETERANS NURSING HOME SALISBU	1601 BRENNER AVE, BLDNG #10, PO BOX 599 SALISBURY, NC 28145

JUN 14 2011

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F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff and family interviews and record review, the facility failed to notify the physician	F 157	A. Resident #1 no longer resides at the facility. B.Corrective action will be accomplished for those resident having potential to be affected by the same deficient practice by the following: The Director of Nursing will assign License nurses to do a 100% audit of medical records to review for notification of family and physician of any changes in the patient/resident's health status for the last 30 days. C. The Clinical Competency Coordinator, under the direction of the Director of Nurses will in-service all license nursing staff regarding notification of family and physician of any changes in patient/resident's health status and of any occurrences. Daily clinical meetings will review new physician orders, and 24 hour nursing reports to address significant changes in health status a review of medical records related to 24 hour nursing reports and new physician orders will occur at the clinical meeting to insure that the family and physician has been properly notified.	6-14-11 6-14-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE 6-10-11

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 157	Continued From page 1 and a family member of a fall for 1 of 3 sampled residents (#1) until two days after the fall. The findings include: Resident #1 was admitted to the facility 1/4/2011 and was re-admitted 5/12/2011. His diagnoses included Coronary Artery Disease, Aortic Stenosis, Diastolic Heart Failure, and Depression with Psychosis. Resident #1's most recent Quarterly Minimum Data Set (MDS) dated 4/6/2011 indicated that he had short and long term memory deficits, had moderately impaired decision making skills. The MDS revealed that Resident #1 needed extensive assistance from 1 person for transfers, dressing, hygiene, and toileting. A review of Nurses' Notes dated 5/3/2011 revealed that Resident #1 stated that he fell out of bed two evenings ago while trying to pick up an object off the floor. The note also indicated that Resident #1 complained of left hip and leg pain. Nurses' Notes reviewed for 5/1-5/2/2011 contained no documentation related to a fall. A Change of Condition note dated 5/3/2011 reviewed pointed out that Resident #1 told staff that he slipped off his bed on 5/1/2011 while reaching for something on the floor. He indicated that two people helped him back to bed. The note revealed that the Physician's Assistant (PA) assessed Resident #1 and the family was notified on 5/3/2011 at the time Resident #1 reported his fall. A review of the Incident Report dated 5/3/2011	F 157	D. The Performance Improvement (PI) Nurse will ensure monitoring of the results of the clinical meetings daily for 2 weeks weekly for 2 weeks and monthly for 3 months. Tracking and trending of these results will be reported to the monthly PI Committee for recommendations and suggestions.	6-14-11

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F 157	Continued From page 2 found that Resident #1 was reported to have fallen on 5/1/2011 and the Administration was not aware of the fall until 5/3/2011. A Falls Investigation was initiated on 5/3/2011 and revealed that Nurse #1 together with Nursing Assistant (NA) #1 assisted Resident #1 back to bed from the mat beside his bed. The report indicated that Nurse #1 failed to initiate an occurrence report, notify the Physician or family, or document the fall on Resident #1's chart. On 5/15/2011 at 12:40 pm a family member who was visiting Resident #1 stated in an interview that they were notified 5/3/2011 of the fall that occurred on 5/1/2011. In an interview on 5/16/2011 at 2:37 pm Nurse #2 stated that she had worked with Resident #1 since his admission. She indicated that she worked with on Monday 5/2/11 and 5/3/11. She became aware of Resident #1's fall when he reported it on the morning of 5/3/11 and she immediately notified the PA who was in the facility. The PA and Nurse #2 assessed Resident #1, orders were written and the family was notified. In a telephone interview on 5/17/11 at 10:30 am NA #1 stated that she was in another resident ' s room when she heard Resident #1's bed alarm sound. She went into the room and found Resident #1 off the edge of his bed with his back on the edge of the low bed and feet on the mat beside the bed. NA# 1 indicated that she could not assist Resident #1 back onto the bed so supported his back to lower him to the mat. She revealed that she then asked Nurse #1 to help her and they assisted Resident #1 back to bed.	F 157		

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F 157	Continued From page 3 She stated that Resident #1 did not complain of any pain. On 5/17/11 at 12:20 pm Nurse #1 stated in an interview that since Resident #1 was lowered to the mat, he did not consider it a fall. Therefore, he did not write a Nurse's Note, fill out an incident report or notify the Physician or family. Nurse #1 revealed that he knows better now and should have done all of the above. In an interview on 5/17/11 at 1:53 pm the Director of Nurses (DON) stated that as soon as she was made aware on 5/3/11 of Resident #1's fall on 5/1/11 she initiated an investigation. She indicated that any time a resident is on the floor (even on a bedside mat), it should be investigated as a fall, the Physician notified, the family notified and appropriate documentation done. At this time the DON and Administrator stated it was not acceptable to not report or document a fall.	F 157		