STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345089	A. BUILDING _____ B. WING _____	C 11/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT COVE HEALTH AND REHABILITATION CENTER	511 WINDMILL ST WALNUT COVE, NC 27052

(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=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 record review and staff interviews the facility left Resident #1 unattended in the bath room which resulted in a fall with injury (a skin tear to the left upper arm) for 1 of 3 residents reviewed for falls. Findings included: Resident #1 was re-admitted to the facility on 10/17/11 with cumulative diagnoses included of fracture of the Left Hip, Abnormality of Gait, Abnormal Posture, Alzheimer's Disease, and Difficulty in Walking. Review of the Re-admission Minimum Data Set Assessment (MDS) dated 10/22/11 indicated Resident #1 required extensive assistance with bed mobility, for transfers and locomotion on the unit and totally dependent on staff for locomotion off the unit. An interview was conducted with the MDS Assessment Nurse on 11/22/11 at 4:30 PM. The Assessment Nurse indicated Resident #1 had a significant change in Functional status due to the	F 323	**This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law.** F323 Accident Free Environment 1 .Resident #1 is not left unattended in the Bathroom. 2. Residents that are currently identified to be at risk for falls are at risk of the alleged deficient practice. Current nursing staff has been re-educated to maintain awareness of residents. 3. Current nursing staff has been re-educated to maintain attendance with residents identified at risk for fall as evidence by use of preventative devices. Newly hired nursing staff will be orientated to this requirement during orientation. The Director of nursing and or RN Unit managers will complete a Quality Improvement tool as follows: daily five times a week for four weeks, weekly times four weeks, monthly times ten months to review falls identified as in bathroom to address need for any corrective action to be completed. 4. The Director of Nursing or designee will report the results of the quality improvement tool monthly to the Quality Improvement/Risk Management Committee to identify trends and the need for further education and or monitoring.	12/15/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Glenda Pulliam LNHA — TITLE: Administrator — (X6) DATE: 12/15/2011

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

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F 323	Continued From page 1 fall of 10/13/11. Review of the Change of Condition Evaluation form dated 10/13/11 at 22:40 hours (10:40 p.m.) read in part, "Found on floor/sent to hospital. Vital signs: Temperature 97.8, Blood Pressure 113/73, Pulse 96, Respirations 20. Currently reports pain at 10. (a pain scale of 0-10, with 10 being most painful) Location: L (Left Hip. What exacerbates pain, moving leg . Notes: Resident found on floor, couldn't touch L (Left) leg or move without screaming in pain." Review of the facility Fall Investigation dated 10/13/11 indicated, date of Incident: 10/13/2011, Type of Incident: Fall Unwitnessed, Time of Incident 10:00 PM Location: Resident room, Injuries Sustained: Fracture Suspected Allegation of: Injury of unknown origin. Changes to Care Plan: Recommendations for changes: Room change, alarm. Evidence of Changes: Bed alarm applied 10/17/11. D/C (discharge) to hospital. Review of the Admission/Re-Admission Data Collection & Initial Plan of Care dated 10/17/11 read in part, Interventions initiated on 10/17/11 included assist with toileting Q (Every) 2 hrs(hours). Provide a bedpan, apply a bed alarm, floor mat, and scoop mattress while in bed. Review of the Change In Condition Evaluation Form dated 11/06/11 revealed a second fall. NA#3 ambulated Resident #1 to the bathroom and sat resident on the toilet. NA#3 left the resident and went to answer a call light across the hall. When NA#3 returned, Resident#1 was on the floor.	F 323		

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F 323	Continued From page 2 A staff interview was conducted with NA # 3 on 11/22/11 at 7:30 PM. NA#3 was assigned to the resident when the resident fell off the toilet. When asked why the NA#3 left the resident alone on the toilet the NA#3 indicated, "When I sat (Resident #1) on the toilet, I had to let other people (other staff/other NA's) know where I was at because other lights were going off. I had to let them know what room I was going to. Usually, I would put (Resident #1) on the toilet and(Resident #1) wouldn't fall. Now (Resident #1) is more agitated and afraid to fall. (Resident #1) gets shaky real bad. Normally before that (Resident #1) would use the walker to walk around and go to the toilet by self. (Resident #1) fell and hurt (Resident #1's) hip, and doesn't walk anymore. (Resident #1) is not the same person anymore. (Resident #1) uses a wheelchair now. Now, when the alarm goes off I stand (Resident #1) up and walk (Resident #1) to the Bathroom and walk back to the bed or chair." When asked how the NA knows what to do for a resident, the NA replied, "We get a report when we change shifts. There is some information in the Computer System for NA documentation /Care Tracker." When asked if NA #3 received any different training after the accident off the toilet, the NA #3 indicated, "We went over the policies of taking them (residents) to the toilet and I was told to stay with them (residents) at all times." Review of the Facility Fall Investigation form dated 11/06/11 indicated: a left arm skin tear was sustained. NA #3 on 11/08/11was provided a moment to moment teaching session regarding not to leave a resident unattended in the bathroom. All staff was educated on 11/11/11 to not leave a resident unattended in the bathroom.	F 323		

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F 323	Continued From page 3 A staff interview was conducted on 11/22/11 at 12:30 PM with the Unit Manager who completed the Fall Investigation of 11/06/11 when Resident #1 was left alone unassisted on the toilet, and fell, subsequently having a skin tear to the left upper arm. When asked what interventions were put in place to keep Resident #1 from having additional falls, the Nurse indicated, " The DON called the responsible NA (NA #3) and gave (NA #3) a Moment to Moment Teaching and had (NA #3) sign it. (NA#3) was a fairly new Aide at the time, and it was the first issue we have had since (NA #3) has been here. (NA #3) told (the DON) (NA #3) left (Resident #1) on the toilet to either answer an alarm or a call light." A staff interview was conducted with NA #1 on 11/22/11 at 5:50 PM who was assigned to Resident #1 on the second shift. When asked how the Aide knew what care the resident required, the Aide indicated, "I look in the Computer System for NA Documentation /Care Tracker; it tells us toileting, weight, mood, behavior. It tells us how many people (Resident #1) needs for assistance, and also required vitals, and weight. Also that (Resident #1) requires an alarm. (Resident #1) has a bed alarm and an alarm on the wheelchair. When asked about toileting, (Resident #1), the aide replied, "If I take a resident to the toilet I stay in there with the resident until he's finished, and clothes back on ready to come out. "When asked what happens if the call bell rings for another resident. What do you do? " I have to make sure that resident I am caring for is safe before I can move on to the next person."	F 323		

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F 323	Continued From page 4 A staff interview was conducted with second shift NA #2 on 11/22/11 at 6:01 PM. The NA indicated, "I work with (Resident #1) everyday. When asked how NA #2 knows what care (Resident #1) required, NA #2 indicated, "Everything is in the Care Tracker. (Resident #1) is toileted every two hours and has a chair alarm and bed alarm. When a call light rings in anther room, I stay with (Resident #1) until (Resident #1) is finished on the toilet." Interview was conducted with the DON on 11/22/11 @ 5:36 PM regarding her expectations of staff when a resident has fallen off the toilet, "My expectation is not to leave a resident unassisted on the toilet that has been a previous fall risk with an alarm." An interview was conducted on 11/22/11 at 5:50 PM with the facility Administrator regarding the facility policy for managing falls. The administrator indicated there was no written policy. However, the administrator indicated her expectations of the staff for managing falls included, "The staff should remain with a resident at all times while in the bathroom, when the resident has been identified as a fall risk."	F 323		