STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345264	A. BUILDING _____ B. WING _____	C 05/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEY TOTAL LIVING CENTER	614 OLD MOUNT HOLLY ROAD STANLEY, NC 28164

(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 000	INITIAL COMMENTS The original complaint survey was conducted on May 8, 2012. Based upon management review, the survey dates were extended. The survey team reentered the facility on May 21, 2012 to complete the investigation.	F 000		
F 323 SS=G	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 staff interviews and record review the facility failed to implement Physician ordered fall interventions for one (1) of three (3) sampled residents who fell and sustained a fracture in the facility (Resident #4). The findings are: Resident #4 was admitted to the facility on 3/20/12 diagnosed with Alzheimer's disease. The Minimum Data Set (MDS) dated 4/3/12 specified the resident had short and long term memory impairment and moderately impaired cognition for decision making. The MDS also specified the resident required extensive assistance with Activities of Daily Living (ADLs) that included transfers. Additionally, the MDS specified the resident used a wheelchair and was not steady	F 323	Resident #4 is no longer a resident at this facility—she was discharged on 4/15/12. NA #1 was counseled regarding the incident with Resident #4 on 4/18/12.	4/18/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer D Kelley | TITLE: Administrator | (X6) DATE: 6/8/12

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	Continued From page 1 moving from seated to standing position. Also, the MDS indicated the resident had fallen twice in the facility. Resident #4's medical record was reviewed and revealed a Physician's order dated 3/20/12 that the Resident was to have chair pad alarm to alert staff of unsafe movement. A document titled "Fall Risk Assessment" dated 3/21/12 specified the resident was "high" risk for falls and recommended a bed and chair alarm. Resident #4's Fall risk care plan dated 4/3/12 specified the resident was at risk for falls related to poor balance during transitions and difficulty maintaining standing position without assistance. The care plan included interventions to prevent the resident from sustaining any trauma due to a fall that included: - chair pad alarm while in wheelchair to alert staff of unsafe movements Further review of Resident #4's medical record revealed a nurses' entry dated 4/15/12 that specified the nurse responded to the resident's cry for help and found the resident lying in the hallway on her back with her left leg bent underneath her lower torso and her right leg dislocated. The entry specified the resident was crying in pain and her vital signs were abnormal. The entry revealed licensed nurse (LN) #3 called for additional assistance and requested that 911 Emergency be called. A Physician's order dated 4/15/12 specified the Resident was ordered to be sent to the Emergency Department.	F 323	All current resident's will be reassessed to ensure proper use of safety measures as determined by care plans, fall risk assessments, and Fall Committee meetings. All required safety devices will be checked to ensure that each is in place and working properly. Nursing staff, including licensed Personnel, were in-serviced and re-educated on the Falls policy/procedures/protocols, completion of incident reports and follow-up, risk factors, and avoidable versus unavoidable falls.	6/8/12 6/8/12

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F 323	Continued From page 2 The Emergency Department (ED) report dated 4/15/12 specified the resident had a fractured left femur and hip. On 5/21/12 at 11:15 a.m. LN #1 was interviewed and reported that on 4/15/12 at 7:50 p.m. she responded to Resident #4's cry for help and found her in the hallway on the floor beside her wheelchair. She stated she was the first person to respond to the resident and confirmed the resident's chair alarm was not sounding. She stated that the resident was in obvious pain as evidenced by her crying. LN #1 obtained Resident #4's vital signs that were abnormal. LN #1 reported her initial response was to call 911 Emergency because she feared the resident was going into shock. She stated she called for assistance from LN #2 and asked that he call 911 Emergency. LN #1 also reported that prior to the fall Resident #4 had been left in the hallway after the evening meal at approximately 6:30 p.m. LN #1 stated she stayed with the resident until Emergency Service Responders arrived. On 5/21/12 at 2:45 p.m. nurse aide (NA) #1 was interviewed and reported she had been assigned to care for Resident #4. She stated that Resident #4 required a chair alarm when in her wheelchair because of her frequent attempts to stand and get out of the wheelchair. She added that the resident required frequent monitoring because of her poor safety awareness and that the Resident had fallen several times in the facility. The NA also reported that Resident #4's family visited often and would at times turn the chair alarm off while they visited. NA #1 stated that she was trained to make a "safety round" first thing when	F 323	The Falls Committee, an Interdisciplinary team, will meet weekly to review all falls. Each fall will be analyzed in terms of medications, toileting needs, nutrition/hydration status, therapy referrals, timeliness of answering call lights/alarms, interventions and modifications to reduce future falls. This Committee will document its analysis as well as action plans in the clinical record immediately. The QA Nurse will follow up to ensure all interventions are in place and working properly. The Falls Committee will implement a new fall risk assessment tool to replace the current Morse Fall Risk tool. This new assessment will be conducted on every in-house resident to determine those truly "at risk" for falls. From this tool, an "At Risk For Falls" identifiable list will be created and placed at each nursing station for communication.	6/18/12 6/18/12

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F 323	Continued From page 3 reporting for her shift (3 p.m. to 11 p.m.) that included checking residents' personal alarms to ensure they were functioning properly. She added that she was also trained to check alarms periodically throughout her shift. NA #1 reported that she was assigned to care for Resident #4 on 4/15/12. She added that she did not check the resident's chair alarm for proper functioning during the "safety round" because the family was in the facility visiting the resident. The NA added that on 4/15/12 at 6:00 p.m. Resident #4's family brought the resident into the dining room for the evening meal and left. She added that she was in the dining room for the evening meal and did not check the resident's chair alarm at 6:00 p.m. to verify if it was on or off. NA #1 revealed Resident #4 was assisted to the hallway after the evening meal around 6:30 p.m. NA #1 added that following the evening meal she was assisting another resident and heard cries for help. She reported that once she finished providing care to the other resident she walked out into the hallway and observed Resident #4 lying in the floor. She added that LN #1 had responded to Resident #4's cry for help. NA #1 stated she observed the resident's chair alarm panel box and noted the alarm was turned "off." NA #1 stated she then turned the alarm panel box "on." She added that from the start of her shift at 3:00 p.m. until the time the resident fell at 7:50 p.m. she had not checked the resident s alarm to ensure it was functioning properly because the resident's family was visiting. She stated she should have checked the alarm when the family brought the resident into the dining room. On 5/21/12 at 3:30 p.m. the Director of Nursing	F 323	These residents will have safety rounds conducted by the assigned nursing assistant every 2 hours to ensure all interventions are in place and functional. The Falls Committee will redesign The current Falling Leaf program In accordance with these updated fall risk assessments. The updated fall risk tool will be used for all residents upon admission and at least quarterly to review any changes. Nursing staff will be in-serviced on any changes made to the Falls Management Program.	6/18/12 6/18/12 6/18/12

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F 323	Continued From page 4 (DON) was interviewed and reported he would expect nurse aides to check placement and functioning of personal alarms during "safety rounds." He stated that his investigation into Resident #4's fall accident revealed another resident s alarm had sounded the same time Resident #4 fell; but he was unaware Resident #4 cried out for help. He stated he was aware Resident #4's alarm was off at the time of the fall but declined to answer if he expected it to be on. He offered no further explanation why NA #1 failed to check the resident's personal chair alarm during safety rounds or any other time during her shift.	F 323	Weekly Safety Rounds will be conducted by a member of the Nursing Management team to ensure all safety devices and fall interventions are in place and are working properly. Tracking and trending of all falls will be monitored by the QA Nurse—results will be reviewed by the QA&A Committee on a monthly basis.	6/18/12 6/18/12