STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 06/27/2012

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SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

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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 observations, record review and interviews with facility staff, the facility did not place a resident on 1:1 when the resident was transferred to the wheelchair and the resident fell to the floor (Resident #1); the facility failed to ensure the bed alarm was in place and the bed was in the low position for Resident #2 who sustained a fall. This was evident in two of three sampled residents. The findings include: Resident #1 was admitted to the facility on July 25, 2006. The Resident's diagnoses included Severe Dementia, Closed Fracture to Upper Humerous, Falls, Weakness, Contractures and Osteoarthritis. Record review of the most recent Quarterly Minimum Data Set dated June 12, 2012 indicated the resident had problems with short and long term memory. The resident was coded as not having the ability to transfer or walk and was total assist with assistance of one person for bed mobility. The resident was coded as have had functional limitations with range of motion and having impairment on both sides with both	F 323	**Nursing assistants # 1, 2, and 3 were educated by the Director of Nursing/designee on resident #1's plan of care including 1:1 care when up in the chair.** **Resident #1 and 2's Plan of care was reviewed on 6/18/2012 for resident #2 and 6/20/2012 for resident #1 by DON/designee to ensure it includes specific interventions for assistive devices and adequate supervision to prevent accidents.** **Current resident plans of care were reviewed on 7/13/2012 by DON/designee and no further residents required 1:1 care when up in the wheelchair for fall prevention.** **An in-service developed by Teepa Snow MS, OTR/L, FAOTA was completed for current staff on Mobility and Safe Movement of the Elderly. Improving Your Skills to Prevent Injuries and Reduce Falls on 7/12/2012 with a make-up on 7/13-16/2012**	7/16/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 7/13/12

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 upper and lower extremities. The resident was coded as having no falls. Review of the Resident CAAs (Care Area Assessment Summary), dated 12/20/11, revealed that the resident was alert and verbal with confusion. She had a history of Severe Dementia and Osteoporosis. She had not had any falls. She was non-ambulatory for some time and remained in bed. She required total care with ADLs (Activities of Daily Living), and mobility. She was incontinent of bowel and bladder, with care provided by staff. Record review of the "Customer Information Record" updated 2012, the care guide used by the Nurse Aid (NA) included the limitations the resident had and the care NA #1 was to provide, had hand written on the left of the care guide, "If at anytime pt. (patient) is up in a w/c (wheelchair), provide 1:1 care. Do not leave pt. alone." At the bottom of the care guide was written, "Do not get pt. up. If anytime she is up, provide 1:1 care." Record review of the Care Plan last updated June 12, 2012 revealed the following interventions, in part: Bed wedges while in bed. Mats on floor Low bed Place call light within reach at all times. Remains in bed at all times. If pt. (patient) is up at any time staff to provide 1:1 care. Do not leave pt. alone in wheelchair. Record review of the "Resident Patient Incident Report" dated 6/20/12, in the section titled	F 323	**DON/ADON/Designee will monitor for specific interventions for fall prevention every shift x 2 weeks, then daily x 2 weeks, then monthly x 3 months to ensure fall prevention interventions are in place. Findings will be brought to QI committee for continued quality improvement.** **Nursing assistant #4 and 5 were reeducated on #2's plan of care.** **Current resident plans of care were reviewed and updated to ensure the order of bed alarm and floor mats were care planned appropriately and available in the room. These interventions were placed on the nursing assistant kardex and placed in the Activity of daily Living(ADL) books.**	

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F 323	Continued From page 2 "Description of Incident" revealed, "Resident was up in w/c (wheelchair) in room so that maintenance can fix red rail on her bed. CNA (nurse aid) left the room to get foot rest. Pt. (patient) observed to fall out of w/c. ROM (range of motion) to exts. (extremities) WNL (within normal limits). C/o (complained of back pain, appears to be chronic. In the section titled "Description of Injury" revealed, "Bruises to forehead, both knees, left ring finger with laceration." Physician's order dated 6/20/12 revealed to place ice pack to forehead for five minutes as tolerated three times daily for three days. Cleanse left ring finger with wound cleanser and apply antibiotic ointment daily times two weeks. Interview on 6/27/12 at 9:25 AM with the NA#1 revealed that Resident #1 required the bed wedges need to be on the bed, mats always on the floor and low bed. Resident #1 never got out of bed per the family request. NA #1 continued that she had been there two weeks and this was the first time on day shift having Resident #1. She continued she did not have time to look at the care guides because she had residents that required being ready early for physical therapy. Interview on 6/27/12 at 11:00 AM with Nurse #1, when asked about any precautions she utilized during care, she replied that Resident #1 was not to be left unattended if she was out of bed, she could use the call light, the bed was to be kept in low position with mats on each side of the bed, turn and reposition resident and Resident #1 required to be fed by staff.	F 323	**Reeducation was provided on 7/13/2012 by DON/designee for the licensed nursing staff on ensuring nursing assistant appropriate interventions are placed on the kardex from the resident plan of care related to fall prevention and placed in the ADL book.** **DON/ADON/Designee will monitor for specific interventions for fall prevention every shift x 2 weeks, then daily x 2 weeks, then monthly x 3 months to ensure fall prevention interventions are in place. Findings will be brought to QI committee for continued quality improvement.**	

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F 323	Continued From page 3 Interview on 6/27/12 at 11:15 AM with NA #3, who assisted NA #2 when the resident fell, revealed that she assisted NA #2 while she was in the middle of her assignment. She continued that she asked NA #2 if she needed anything else, after Resident #1 was placed in the wheelchair and NA #2 told her that the resident was fine. NA #3 reported that she had taken care of Resident #1 about one year ago and did not know the resident required supervision when she was in the wheelchair. Interview on 6/24/12 at 12:20 PM with NA #2 revealed that she got the resident up out of bed to the wheelchair so the side rail on her bed could be fixed. She said she needed to get a foot board to help the resident keep from sliding, after the resident was transferred to the wheelchair. She continued, "I knew we didn't get her up that often, but I didn't know why." Since taking care of the resident she now looks at the ADL (Activities of Daily Living) book. She continued that she did not ask NA #3 to stay with the resident, the maintenance man was there working on the bed. When she left the room to get the foot board, Resident #1 fell out of the wheelchair. Interview with Director of Nursing on 6/27/12 at 3:30 PM revealed that the NA #2 was reeducated in proper positions and safety awareness was done. 2. Resident #2 was admitted to the facility on 8/5/2002 with diagnoses including Hypoxia, Asphyxia, Rheumatoid Arthritis, Dementia, history	F 323		

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

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F 323	Continued From page 4 of compression fractures and Stroke. Review of the most recent Minimum Data Set (MDS) dated 3/27/12 revealed extensive assistance is required by one staff member for bed mobility, transfers, dressing, eating and hygiene. This MDS assessed Resident #2 as non-ambulatory. A review was conducted of the careplan, with a review date by the careplan team of 6/22/2012. This careplan addressed a problem of "Resident is at risk for falls: cognitive loss, lack of safety awareness." The goal for this problem was "Resident will have no falls with injury x (times) 90 days." The target date for meeting this goal was 9/26/2012. The interventions to meet this goal included the following: "Utilize low bed/mats on floor at bedside, bed wedges for positioning, bed alarm, assist resident getting in and out of bed with +1-2 (one or two staff) assistance, Remind resident to use call light when attempting to ambulate or transfer, when resident is in bed, place all necessary personal items within reach, monitor for and assist toileting needs and Fall risk assessment per protocol." Record review of the Treatment Administration Record (TAR) for the month of June 2012 revealed a physician's order for licensed nurses. The instructions read: "Bed alarm per _____ (family member's) request" which was dated 8/5/2009. Nursing staff had initialed the TAR indicating this intervention was in place. Further review of the TAR revealed these instructions had a strike through line and were changed on 6/20/2012. The changes called for the bed alarm to be "on at all times". Review of the TAR	F 323		

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F 323	Continued From page 5 documentation to verify nurses were checking for the bed alarm revealed no nurse initials from 6/20/2012 through 6/27/2012 on any of the three shifts. Review of the nursing notes dated 6/18/2012 at 7:09 AM revealed Resident #2 was heard by an aide in the hallway calling out she had fallen and could not get up. Resident #2 was observed by staff to be lying in the floor, on the right side with the left hip rotated and complained of pain when the leg was touched. Resident #2 was sent to the local hospital emergency room for evaluation and treatment at 7:05 AM. Review of the hospital records dated 6/18/2012, revealed a fall was sustained by Resident #2 while she was in a supine position (lying flat on her back) in the bed. The bed was about 1 foot off the floor. Skin tears were noted on both lower legs which had been cleansed and dressed by the nursing home prior to the hospital visit. The hospital completed Xrays which were negative for fractures. Interview on 6/27/12 at 11:00 AM with aide # 4 revealed she could not remember if Resident #2 had a bed alarm in use prior to the fall on 6/18/12. Interview on 6/27/12 at 2:00 PM with aide #5 revealed she could not remember if Resident #2 had a bed alarm in use prior to the fall on 6/18/12. Interview on 6/27/2012 at 3:30 PM with MDS nurse #1 revealed one mat is appropriate for Resident #2. The mat had been in place on the careplan since 6/29/2011. The bed alarm had not been used, and was added to the careplan on	F 323		

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F 323	Continued From page 6 6/21/2012. Continued interview confirmed an order had been given for the bed alarm, but it was not updated on the careplan until after the fall. Interview on 6/27/2012 at 3:40 PM with the acting administrator revealed Resident #2 had fallen on 6/18/2012 at 7:00 AM and the fall was discussed that morning in the clinical meeting. During this interview, it was asked if the bed alarm was sounding when Resident #2 had fallen out of bed. The response given was, she was not aware. When asked how high the bed was positioned, the response given was, the hospital physician documented it was about 1 foot from the floor. Further interview regarding if 1 foot from the floor was the lowest position possible, received a response that she did not know. We proceeded to observe Resident #2's bed and it would lower about 6 inches from the floor. Continued interview revealed falls are investigated with an interdisciplinary team each day. The fall report is reviewed, interventions already in use are reviewed and new approaches are discussed. The acting administrator confirmed she had not investigated the events surrounding the fall. The careplan had been updated by the acting administrator after a family meeting was held. The family had requested the interventions. An interview was conducted on 6/27/2012 at 5:10 PM, with the aide #3, who had responded to Resident #2's call for help. Interview with aide #3 revealed the bed was not in the lowest position and was about 1 foot from the floor. She was not aware Resident #2 should have the bed positioned to the floor. Aide #3 further explained, an administrative nurse had questioned her after the fall, and wanted to know why the bed was not	F 323		

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F 323	Continued From page 7 all the way down. During the interview, Aide #3 confirmed a mat had been beside the bed. The interview concluded with the question regarding the bed alarm. Aide #3 stated "no" there was no bed alarm in place the night of the incident.	F 323		