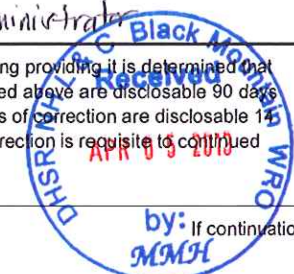
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345097	A. BUILDING ___ B. WING ___	C 03/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JESSE HELMS NURSING CENTER	**1411 DOVE STREET MONROE, NC 28111**

(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 observation, staff interviews and record review, the facility failed to provide supervision of an unsteady sitting balance for 1 of 3 sampled residents at risk for falls (Resident #1). The findings are: Resident #1 was admitted to the facility on 04/25/12 with diagnoses which included dementia. Review of Resident #1's quarterly Minimum Data Set (MDS) dated 01/01/13 revealed an assessment of severely impaired cognition. Resident #1 required extensive assistance of two persons with transfers and the assistance of one person for bathing. Review of Resident #1's hospital discharge summary dated 02/27/13 revealed Resident #1 received treatment for an acute urinary tract infection. Review of Resident #1's care plan dated 02/27/13 revealed interventions for fall prevention included	F 323	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F 323 Resident #1 has been re-screened by OT regarding shower chair positioning. The resident's Care Guide has been reviewed & updated to ensure accuracy & the staff has been re-educated regarding the resident's care needs. Bathing assistance needs for the facility's residents have been reassessed by Nursing. The Care Guides have been reviewed & updated accordingly. Walking rounds education conducted with Nursing staff regarding the bathing assistance needs of facility residents. During Quality Zone Rounds, designated management staff will ensure compliance with the implementation of resident's bathing assistance needs identified in the Care Guides. Designated management staff will monitor a minimum of 10% of residents each week to ensure that the bathing assistance needs of facility residents have been implemented. Results of the monitoring will be shared with the Administrator on a weekly basis & with QAPI Committee monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	4/16/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature] RN	Administrator	4/4/2013



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 provision of assistance with transfers to chair, remain with resident when on toilet, and frequent visual checks. Review of nursing notes dated 03/05/13 revealed Resident #1 leaned forward and fell out of a shower chair which resulted in a forehead abrasion which measured 2 centimeters (cm.) by 1 cm. and a 4 cm. diameter purple bruise on the forehead. The nurse practitioner received notification and ordered a CT (computed tomography) scan without contrast. Review of the CT scan dated 03/05/13 revealed no evidence of an acute intracranial injury. Review of the facility's investigation report of Resident #1's fall on 03/05/13 revealed Resident #1 fell forward out of the shower chair at 8:05 PM with Nurse Aide (NA) #3 in attendance. The report documented the immediate application of sensor alarms and direction to use a shower stretcher for future showers. Observation on 03/20/13 at 11:50 AM revealed NA #1 and NA #2 transferred Resident #1 from the bed to a wheelchair. NA #1 placed her hand on Resident #1's shoulder to steady Resident #1's sitting balance. NA #1 and NA #2 assisted Resident #1 to stand, turn and pivot to the wheelchair seat. NA #1 repositioned Resident #1 to a correct sitting position in the wheelchair. Resident #1 did not follow one step commands. Interview with NA #1 on 3/20/13 at 11:58 AM revealed Resident #1 required two persons with transfer and regular checks for position when seated.	F 323		

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F 323	Continued From page 2 Telephone interview with NA #3 on 03/20/13 at 12:11 PM revealed she assisted Resident #1 with a shower on 03/05/13. NA #3 reported Resident #1 leaned to the side and forward "a bit" when first seated in the shower chair. NA #3 explained she physically assisted Resident #1 with sitting balance during the shower since Resident #1 "leaned forward but not a lot." After completion of the shower, NA #3 moved behind the shower chair. Resident #1 leaned forward and fell out of the shower chair. Telephone interview with Nurse #1, evening shift supervisor, on 03/20/13 at 12:36 PM revealed he assessed Resident #1 immediately after the fall and notified the nurse practitioner. Nurse #1 reported he determined the fall occurred when NA #3 was in back of the shower chair and unable to stabilize Resident #1. Nurse #1 explained he directed use of two persons for transfer, chair alarms and utilization of a shower stretcher for future showers. Interview with the Director of Nursing on 03/20/13 at 3:10 PM revealed she expected nurse aides to inform the nurse should a resident require more assistance or not be able to maintain a sitting balance. Telephone interview with Nurse #3, evening shift charge nurse, on 03/20/13 at 3:53 PM revealed Resident #1's endurance was poor after the recent hospitalization. Nurse #3 explained Resident #1's poor sitting balance would require either two persons or a shower stretcher. Nurse #3 reported NA #3 informed her of Resident #1's unsteadiness on the shower chair after Resident	F 323		

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F 323	Continued From page 3 #1's fall.	F 323		